NHS GRAMPIAN

Clinical Governance Committee

Maternity Services at Dr Gray's Hospital Elgin

Introduction

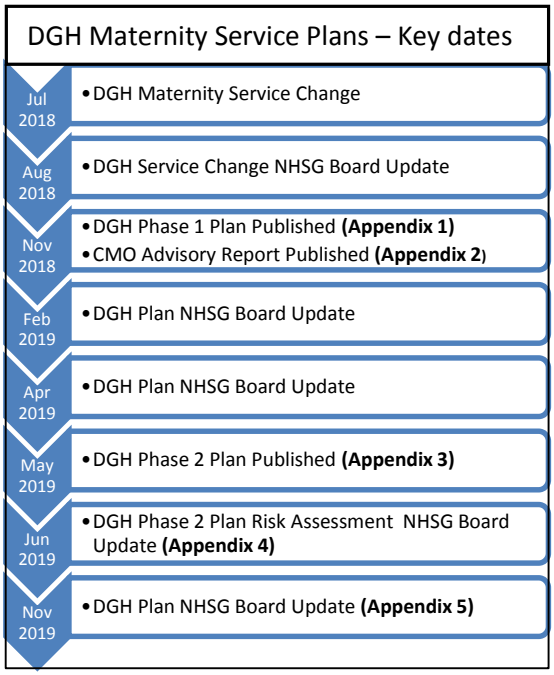
NHS Grampian is in receipt of an externally led report reviewing Dr Gray's Maternity Services. All recommendations have been accepted by the Chief Executive, Medical and Nurse Director and commissioning officers.

Aim

The aim of this paper is to assure the NHS Grampian Clinical Governance Committee (GCGC) of our response to the recommendations from the Dr Gray's Maternity Services Review, led by Alan Cameron in 2019. We will also outline the rationale for seeking this externally led review. Furthermore, we will explain how these recommendations, together with our previous Phase 2 Plan, risk assessment and additional information relating to National Clinical Guidance requires us to reconsider the Phase 2 Plan in its entirety.

Background

The GCGC has been regularly updated on Maternity Services in Dr Gray's Hospital (DGH), Elgin. In July 2018 the service profile was changed in response to significant staffing issues mainly related to Paediatric services, which provided neonatal support to the unit, as well as junior doctor vacancies across both Paediatrics and Obstetrics. The Dr Gray's unit was reconfigured to provide intrapartum care (the time period spanning child birth from onset of labour to delivery of placenta) for lower risk mothers following recognised Midwife Unit guidelines. Higher risk mothers continued to receive local antenatal care, but their intrapartum care was provided in the Aberdeen Maternity Hospital.



It was recognised by NHS Grampian that both Paediatric and Maternity services in DGH had a high dependency on locum doctors and difficulty recruiting and retaining permanent medical staff. Plans were developed in collaboration with local staff, the public, specialist advisors and Scottish Government to re-establish safe and sustainable services whilst maintaining as much care as locally as possible. The Paediatric plan has progressed well over the last 18 months and is on track to be fully operational by summer 2020 and Public consultation on the new service model has been positive.

The Maternity plan has been more challenging. The first phase of this work focused on enhancing communication, establishing the clinical pathways of care for low risk mothers, supporting higher risk women who were traveling to Aberdeen, maximising consultant led antenatal care delivered locally and reintroducing elective caesarean sections for low risk mothers. This moved the DGH Maternity unit profile to one that was described as a 'hybrid' model of care. The work was supported with an expert advisory report commissioned by the Chief Medical Officer. Collaborative working was established with NHS Highland. The Raigmore Maternity Unit agreed to be the pathway of care for

intrapartum women requiring transfer from DGH. At an early stage the possibility of booking women (registration for antenatal care), who lived closer to Raigmore Hospital than Aberdeen, with the NHS Highland Maternity Unit was also explored but so far has not been possible.

A further consultation process was undertaken with clinical teams and local stakeholders, to look at alternative models for a DGH Obstetric consultant intrapartum service. An options appraisal process selected the preferred model of care. This was incorporated into a DGH Maternity Service Phase 2 plan which was published 17th May 2019. The plan was predicated on the Paediatric service reconfiguration, the development of a composite workforce to reduce service delivery reliance on junior doctors and support the recruitment of additional Obstetric consultants. In June 2019 following concerns being raised by the clinical teams they identified two main areas of risk. Firstly, relating to the level of available anaesthetic support required for this model and secondly that the actual model was non-standard. This mainly related to no provision for epidural anaesthesia and no resident specialist to provide immediate support for the labour ward overnight and at weekends. This risk assessment was cross checked with the local service and presented to the NHS Grampian Board on 25th June 2019. The Board requested an update on the proposed risk mitigation plans to allow the plan to proceed. A review of the Anaesthetic service in DGH was commissioned to understand the service development requirements. The Obstetric model was recognised as non-standard but was considered to be a necessary compromise to support deliverability of the model.

Rationale for commissioning an externally led review

Prior to the change in the DGH Maternity service profile there had been a number of clinical safety concerns and alerts which had been escalated to the Clinical Governance Committee. National attention on the safety of Maternity services was significantly heightened after the publication of the Morecambe Bay report in 2015. Reflection at the August 2015 GCGC of this report highlighted concerns about working relationships between the Dr Gray's and Aberdeen Maternity teams and the need to move to a single system of clinical risk management. In addition, staffing of the service particularly at a junior doctor level was extremely challenging. Significant work was undertaken to address these issues. However there remained concern that the culture change required for the DGH service to work within the whole system was not moving forward. National outlier reports did not demonstrate harm but a review of the cases suggested that the DGH risk management systems and some aspects of clinical practice were suboptimal. The requirement to change the service configuration in the DGH Maternity unit in July 2018 allowed these concerns to be considered in more detail whilst higher risk women were receiving their intrapartum care in the in Aberdeen. It was hoped that this would both establish the underlying veracity and causes of these concerns and in doing so support the development of a more robust future service. A

number of approaches were considered, and regular advice was sought from national speciality officers and experts. By early 2019 the Medical and Nurse Director of NHS Grampian supported a commission, on behalf of NHS Grampian, of an externally led review of safety in the DGH Maternity service and the terms of reference were considered by the GCGC. The review was led by Professor Alan Cameron, Obstetrician, Glasgow, and former Vice President of Clinical Quality Royal College of Obstetricians and Gynaecologists (external medical advisor) together with Ms Aileen Lawrie, Head of Midwifery/Nursing in the Women and Children's Directorate, NHS Fife (external midwifery advisor) and supported by Dr Kevin Sim, ICU Consultant, Aberdeen Royal Infirmary (Human Factors advisor) and Mr Philip Shipman, HR Manager, (coordination of administrative support and advisor on Grampian staff processes).

Communication of the DGH Maternity Service Report

The Alan Cameron report was received on the 11th November 2019 (**Appendix 7**). It was initially considered by the Medical and Nurse Directors together with the Acute Sector Senior Leadership Team and Maternity Services Clinical Leadership. The NHS Grampian Clinical Governance Committee (22nd November 2019) and the NHS Grampian Board (27th November 2019) were briefed on the key findings of the report and our approach to communication and action. The report was discussed with clinical staff in DGH, clinical leadership in the Aberdeen Maternity service, elected public representatives from the Maternity Liaison Committee at Dr Gray's of which Keep Mum are part of in line with the Maternity Planning Group membership. The report was also shared with the Chief Medical Officer and her advisors, the Chief Midwife and the Scottish Government Policy Unit.

The DGH Maternity Service Report Findings and Recommendations

The Alan Cameron report detailed seven key findings in its executive summary and has made seven recommendations.

Executive Summary Findings

- There is no evidence of a trend in adverse outcomes for patients of the DGH Maternity Service.
- Clinical Governance in the DGH Maternity Service is not fully functional and presents a risk to patient safety.
- Working relationships in the DGH Maternity Service are dysfunctional and damaged to the extent that they may impact upon patient safety.
- There are increasing concerns regarding safety with the current hybrid model within the DGH Maternity Service.
- Circumstances have changed such that it is now not possible to revert back to the previous model of care.
- There are a number of significant concerns regarding the proposed enhanced MDT model of care.
- A Best Start Hub Model of Midwifery Led care could provide a safe and sustainable Maternity Service for the population of Moray.

Recommendations

- NHSG transitions from the current hybrid model of care to a Best Start Hub Model of Midwifery Led care as soon as it is safe to do so.
- NHSG undertakes a full and detailed review of clinical cases to assure themselves of the historical outcomes for individual patients within the DGH Maternity Service.
- NHSG timeously utilises appropriate employment policies in relation to any findings that result from the detailed case review referred to above.
- NHSG adopts robust clinical governance arrangements within the Maternity Service that fulfil the requirements of the Clinical and Care Governance Framework.
- NHSG clarifies the management arrangements for DGH.
- NHSG develops a clear vision for DGH and the DGH Maternity Service.
- NHSG develops a full package of support for all staff who have been adversely affected by the issues within the DGH Maternity Service.

Analysis and approach to the DGH Maternity Service Report Recommendations
The communication and engagement around the report allowed the Clinical Leadership team to develop an initial high level response to these recommendations and they will be taken forward. These are detailed below under each specific recommendation.

- ***NHSG transitions from the current hybrid model of care to a Best Start Hub Model of Midwifery Led care as soon as it is safe to do so.***
  1. We will support our Midwifery leaders to move away from the current hybrid model and implement a fully autonomous Midwifery led model of intrapartum care as quickly and safely as possible.
  2. We have a Best Start Project Team in place and have commenced the 'Continuity of Midwifery Carer' model in Moray, in line with Best Start principles. The first pilot team began working in this way from 9th December 2019 and are now piloting providing intrapartum care to their caseload of women when they labour in DGH
  3. We will work on current policies, procedures and behaviours that create the conditions to accelerate that full transition.
  4. The provision of an antenatal day assessment service will continue to be delivered at Dr Gray's Hospital, and out-patient antenatal care will continue to be supported by consultants.

- ***NHSG undertakes a full and detailed review of clinical cases to assure themselves of the historical outcomes for individual patients within the DGH Maternity Service.***
  1. Since January 2018, all clinical cases have been reported through the Grampian maternity risk management committee, and these cases have all been reviewed within the system. Dr Gray's also has a dedicated risk management Midwife who is part of the Grampian-wide specialist maternity governance team.
  2. The review team were given access to governance processes and clinical cases and no additional concerns were highlighted.
  3. We have reviewed the detailed report to identify any individual cases mentioned by staff. We are also reviewing the last 5 years of National exception reports and extracting individual cases that have been highlighted. We are collating all these cases and ensuring they have had appropriate review and if not undertake additional review.
  4. We recognise that this recommendation may give rise to concerns for some women who have given birth at Dr Gray's, and we will make arrangements to provide a contact point for support with any concerns that may arise in this regard following publication of the report.

- ***NHSG timeously utilises appropriate employment policies in relation to any findings that result from the detailed case review referred to above.***
  1. This is a consideration in all case reviews although the principle purpose is to promote reflection, learning and improvement.
  2. Organisational policies are adhered to and enacted as required so as to encourage and support an open and transparent safety culture.
  3. We take very seriously what we have read and recognise the importance and impact of culture and professional relationships in any clinical service, particularly where delivered across multiple teams and sites.
  4. We have instigated dedicated support for the Dr Gray's teams from within our Organisational Development team, with a focus on culture and developing positive professional relationships.

- ***NHSG adopts robust clinical governance arrangements within the Maternity Service that fulfil the requirements of the Clinical and Care Governance Framework.***
    1. These systems are well established in NHS Grampian at the specialist service level, though the review team recognised that the Dr Gray's Maternity service favour engagement with local Governance arrangements.
    2. In January 2018, a specialist Risk Management Midwife commenced in post at Dr Gray's, supporting consistent engagement with specialist maternity governance arrangements and case review.
    3. It has been noted that under the interim service arrangements there has been full engagement with specialist service governance processes by the midwifery team at Dr Gray's.
    4. Further work is underway to ensure that the specialist maternity governance processes are engaged with, as this provides the appropriate expertise to help learn and reflect on any adverse outcomes.
    5. Effective engagement with the general clinical governance and clinical risk management processes within the Acute Sector has improved.

- ***NHSG clarifies the management arrangements for DGH.***
    1. These have been clarified in terms of line management. In this regard we are working to develop a more resilient local service which supports the leadership and management of Dr Gray's as a 'whole hospital' while ensuring improved connections within the overall management and governance arrangements of Grampian-wide and specialist services. Further related work is underway focusing on the essential engagement between local and specialist governance processes, and professional leadership arrangements

- ***NHSG develops a clear vision for DGH and the DGH Maternity Service.***
    1. Work is already underway to clarify the vision for Dr Gray's Hospital as a District General Hospital within a networked Healthcare system. We have established a Moray Transformation Board led by the Chief Officer of the Moray Health and Social Care Partnership
    2. The implications of this review on the current DGH Phase 2 Maternity Plan have been carefully considered and in combination with additional information outlined below mandate a full review of the Phase 2 Plan.

- ***NHSG develops a full package of support for all staff who have been adversely affected by the issues within the DGH Maternity Service.***
    1. The impact on staff is recognised as is their hard work and dedication.
    2. We are taking steps to ensure that staff affected by the issues outlined in the report are supported in their reflection on its content and are offered objective and independent support. This is offered in addition to the above noted support already provided via our organisational development team.
    3. In addition, we will provide a means of contact and support for those staff members who may feel they have been affected but who may no longer work with Dr Gray's service.
    4. Wider work on Values, Culture and Behaviours is being taken forward to promote a safe and supportive workplace environment.

These high level actions will be progressed and overseen by Mr Paul Bachoo, Medical Director Acute Services. A supporting detailed action plan is in development and will be shared at the May GCGC.

Implications for the current DGH Maternity Service Phase 2 Plan.
The report must also be considered in the context of the current Phase 2 Maternity Plan. Three main issues and one consideration are relevant to the future plan.

- The Anaesthetic service in DGH was identified in the June 2019 risk assessment as insufficiently resourced to support a consultant level Obstetric unit. An option appraisal was developed to establish potential models of care and will report by the end of February 2020. The Royal College of Anaesthetists have recently published (31st January 2020) national guidance supporting this requirement (**Appendix 8**).
- The proposed model of care without resident Obstetric specialists or the provision of epidural anaesthetics is a non-standard model of care and not consistent with national guidance (Standards for Maternity Care – Report of a working party RCOG 2008) (Providing Quality care for women – A Framework for maternity service standards RCOG 2016**).** The Alan Cameron review also identified concerns around this proposed future model of care.
- The Alan Cameron review identified safety concerns related to the current hybrid model of care and recommended rapid transition to a 'Best Start Hub Model of Midwifery Led' care.
- Consideration should also be given to the maintenance of clinical skills in an expanded team dedicated to a small unit (Best start – A five year plan for maternity and Neonatal services 2017 recommendations 60 and 61). From a practical point of view this will require medical staff to work across the region to ensure adequate clinical exposure. Such as joint Consultant appointments between DGH, Aberdeen Maternity Hospital and Raigmore.

In light of these considerations, as it currently stands, the Maternity Phase 2 Plan cannot be delivered. It is recognised that this report will raise an understandable level of concern with the Moray community and therefore our first step is to respond in detail to the recommendations to ensure that safety and capacity within the maternity service are fully addressed. Prior to receiving the report we had already discontinued elective caesarean sections and ensured adherence to Midwifery Unit guidelines moving us away from the hybrid model. Secondly, we have committed to producing a new approach in collaboration with NHS Highland to replace the Phase 2 Plan. Thirdly, we recognise that these issues identified relating to maternity services are almost certainly not confined to DGH and have therefore reached an agreement across the North of Scotland Region to explore the development of a fully integrated Maternity Services Network. Beyond Maternity Services the Moray Transformation Board will clarify the role of DGH as a modern District General within the context of the wider North of Scotland Health and Social Care system.

Accountability

- The development and delivery of the response to the Alan Cameron report recommendations will be overseen by the Medical Director for Acute Services, Paul Bachoo.

- The new approach will be developed in collaboration with NHS Grampian and NHS Highland and be overseen by the Chief Executive NHS Grampian, Amanda Croft and Chief Executive NHS Highland, Paul Hawkins.

- The North Regional Maternity Services Network integration project will be led by the NHS Grampian Nurse Director, Caroline Hiscox and the Chief Executive NHS Highland, Paul Hawkins.

- The Moray Transformation Board is co-chaired by the Medical Director for Acute Services, Paul Bachoo and Chief Officer of the Moray Health and Social Care Partnership, Pam Dudek.

Conclusions

The Alan Cameron Dr Gray's Hospital Maternity Services Review has identified a number of important safety concerns that must be addressed. The report has an impact on current service development plans. When considered in the context of other recognised risks around the DGH Phase 2 Maternity Plan a full review and a different approach needs to be followed. We appreciate that both the uncertainty of service provision and concerns relating to safety has the potential to generate anxiety and questions from Moray women, families and staff across Grampian. This requires a comprehensive communication, engagement and support package for all of these potentially affected individuals.

Recommendations

- The NHS Grampian Clinical Governance Committee is assured by and supports the proposed approach to addressing the Alan Cameron report recommendations.
- The NHS Grampian Clinical Governance Committee requests a plan underpinning the high levels outlined in this paper with timescales and specific actions on progress at the May 2020 meeting
- The NHS Grampian Clinical Governance Committee escalates this report to the NHS Grampian Board
- Acknowledges that the DGH Maternity Phase 2 Plan in its current state cannot be delivered and requires to be modified in collaboration with the North Region Health Boards.

Professor Nick Fluck
Medical Director
NHS Grampian

Professor Caroline Hiscox
Nurse Director
NHS Grampian

17th February 2020

Appendix 1
DGH Phase 1 Plan Published

NHS Grampian

A phased approach to the re-establishment of Obstetric services at **Dr Gray's Hospital**

Phase 1 - Increasing choices for pregnant women in Moray & Banffshire

Foreword

NHS Grampian is firmly committed to restoring a safe, sustainable and comprehensive maternity service at Dr Gray's Hospital offering women local choices in line with the principles of 'Best Start', the Scottish Government's 5 year plan for maternity and neonatal services.

We completely understand people are keen for this to happen as soon as possible. I would like to offer my personal assurance that we are working very hard to do this, however it is vital that before the service is restored, that we are confident that we have enough staff to make it sustainable and, most importantly, safe.

The temporary service we've had to put in place has been endorsed by the Chief Medical Officer and Chief Nursing Officer for Scotland as well as by the Royal College of Midwives as the safest and only option available given the staffing challenges we currently have at Dr Gray's.

While we work towards the re-establishment of services, people have been very clear they want us to do everything possible to increase choices for women giving birth in Moray during the interim period.

The following document outlines the short to medium term steps NHS Grampian have already put in place and will continue to implement over the coming weeks and months to step up maternity services where it is safe to do so.

The plan incorporates the recommendations made in the Chief Medical Officer's expert advisory group report which is be published by Scottish Government in tandem with this document.

This phase 1 action plan for obstetrics will be closely followed by a similar plan for Children's services. Phase 2, which will detail the long-term plans and include a timeline of key milestones will be published in the New Year.

Dr Gray's has a bright future as a key hospital in the north of Scotland network, there should be no doubt about that. The hospital will celebrate its 200th anniversary in a few months' time and we are determined to ensure it remains a strong feature of NHS Grampian's health care services.

Amanda Croft

Amanda Croft
Interim Chief Executive
NHS Grampian

1. Introduction

This plan outlines the first phase of effort to increase choice for pregnant women in Moray and to maximise the local provision of treatment. It has been developed in line with the agreements reached with the Cabinet Secretary for Health and Sport regarding the stabilisation and optimisation of available maternity services at Dr Gray's in the short-term.

The plan incorporates the recommendations made in the Chief Medical Officer's expert advisory group report, the responses to which are cross-referenced in the main body and in appendix 1. The advisory group report will be published by Scottish Government in tandem with this document. A specific reference to points raised by the KeepMUM campaign group has been included at appendix 2.

2. Paediatric services at Dr Gray's

Maintaining safe paediatric services at Dr Gray's is a priority. Despite intensive efforts by local staff, support from Aberdeen based consultants and a high profile recruitment campaign, during the course of 2018 the numbers of medical staff at senior and trainee grades fell to a level which meant overnight inpatient paediatric services could not be maintained. This required an interim change in service model in order to maintain patient safety and between March and July 2018 there was a stepping up and down of service in line with available staffing. However, consistently since July 2018 these services have been provided via an ambulatory model of care (non-inpatient). This now operates between the hours of 0800-2200, 7 days per week. Arrangements are in place locally to support the emergency stabilisation and transfer of children outwith these times, supported by other areas of the Hospital, notably the Emergency Department. The shortage of consultant paediatricians and trainee grade doctors has had a significant impact on the provision of both paediatric and obstetric services at Dr Gray's.

Obstetric led services are heavily reliant on the availability of senior, secure and comprehensive local paediatric care in order to function, e.g. to safely support the provision of moderate to higher risk care during pregnancy and labour where women may require interventions such as induction of labour or caesarean section. Significant efforts have been and continue to be made to stabilise and develop paediatric services for the future in Moray and this will be reflected in a Paediatric-focused 'Phase 1' plan. We aim to gradually step up paediatric services where it is safe to do so. However, the short-term impact on maternity provision at Dr Gray's has required the development of this obstetric focused document.

Both plans will support the joint planning for a sustainable future of Women & Children's services in Moray (Phase 2).

3. Increasing the number of women receiving intrapartum care in Dr Gray's Hospital

Aim

To reduce patient transfers, improve birth choice and experience, and safely maximise the number of women receiving intrapartum care in Dr Gray's by December 2018.

Impact

315-380 Moray low risk mothers per year will have the opportunity to give birth at Dr Gray's.

Actions (including responses to advisory group recommendations 2, 3, 7 and 8)	**By when**
• We will ensure that Moray women can make a fully informed choice and share accurate information about risks and benefits of giving birth at Dr Gray's	Ongoing for all women at booking
• We will promote Dr Gray's as a safe place to give birth for low risk Moray women and build confidence in the service	Ongoing for all women at booking
• We have established a 24-hour contact point for mothers who have concerns or questions, via ward 3	In place
• We will challenge misinformation which overestimates risks of delivery at Dr Gray's and/or the requirement for intrapartum transfer by: - Proactive use of social media - Direct contact with midwifery team - Close working with Maternity Liaison Committee including KeepMUM	From September 30th 2018 and ongoing
• We are gathering, reviewing and acting upon feedback from Moray women labouring at Dr Gray's, Raigmore Hospital and Aberdeen Maternity Hospital (AMH)	From November 13th 2018 and ongoing
• We have developed and will utilise a framework of performance metrics and quality outcome measures	Weekly and ongoing
• We will continue to refine the robust process of routine analysis of instances of green pathway women receiving intrapartum care outwith Moray	Since service change and ongoing
• We are reviewing adherence to green pathway criteria and robustly maintain CMU entry guidelines	From September 2018 and ongoing
• We are ensuring clarity for staff as to when Obstetrician support should be called upon via: - Weekly meetings with clinical staff - Written and verbal communication	Weekly meetings commenced with Midwifery staff & Senior Management from 22nd October 2018

4. Recommencing elective caesarean sections

Aim
We aim to offer elective caesarean sections at Dr Gray's for low risk women from 39 weeks gestation

Impact
Recommencing this service will enable 45-84 more women per year (5-8% Moray births) to choose to deliver locally based on recent historical activity.

Actions (including responses to advisory group recommendations 6, 12 and 13)	**By when**
• We are recommencing elective caesarean sections as women are identified by clinical team, with approximately 3-4 weeks notice	Bookings can made for DGH as of November 2018
• We have secured senior level paediatric medical cover for the medium term	Complete
• We will provide adequate junior Doctor cover for routine post-operative maternal care	Complete (see risk para below)
• We have recommenced SCBU level care at Dr Gray's	In place from October 2018
• We will communicate plans to staff and affected women - Via the Maternity Liaison Committee - Via community midwifery team - Via social media - Via verbal and written updates to staff	Ongoing from November 2nd 2018
• We will audit postnatal readmissions of mothers and babies and consider whether these can be managed at DGH as part of a 'transitional care service'	November 30th 2018
• We will ensure staff have updated training in neonatal resuscitation and recognising the sick infant – this will be a single accredited NLS training consistently across Grampian in the medium term	November 30th 2018
• We will work to address medium-longer term sustainability issues as part of phase 2	In agreement with Scottish Government, plan due early 2019

Potential risks

As highlighted by the expert advisory team, there are a number of risks in restarting elective caesarean sections in Elgin. While the staffing model is felt to be sufficient to provide this safely in the short-term, the sustainability of this moving into February 2019 is uncertain, linked to junior Doctor availability. There is also a concern that some women may choose to have an elective section to avoid travelling to Aberdeen for a normal spontaneous birth which otherwise may have been their preference.

We will monitor/mitigate these risks by:

- Maintaining close working with NES regarding trainee fill rates
- Open communication with women and staff re sustainability challenges (feedback from Maternity Liaison Group supports step-up in service even if temporary)
- Continuing efforts to recruit junior Doctors within safe staffing parameters
- Developing site-wide alternative workforce reducing reliance on trainee Doctors
- Monitoring rates of elective caesarean sections among Moray women

5. Maximising antenatal care at Dr Gray's

Aim
Every opportunity will be taken to provide antenatal care locally, minimising the need for travel/transfer, through the development of individualised packages of care.

Impact
This is largely maximised already with in excess of 1300 maternity related consultations taking place locally per month across the various professional disciplines involved. However, we estimate 7-8 more women per month may be supported by these actions.

Actions (including response to advisory group recommendation 9)	**By when**
• We have implemented day assessment at Dr Gray's 7 days per week	Complete
• We have ensured all potential Consultant led clinics are being delivered locally	Complete
• We have ensured local ability for booking, scanning and assessment for antenatal care is maintained	Complete
• We are exploring the role of telemedicine technology in the delivery of care, e.g. using 'Attend Anywhere' software to remove/reduce need for travel. This is already being successfully used within NHS Grampian.	Ongoing from October 31st 2018
• We will establish with DGH colleagues the feasibility of extending the hours of operation of the day case triage and assessment service and by how much	Underway, for conclusion by November 30th 2018

6. Joint working with NHS Highland

Aim

In addition to our intention to reinstate consultant-led Obstetric services in Dr Gray's as far as possible, we aim to provide the opportunity for moderate risk Moray mothers to choose to book their birth in Inverness should they wish to.

Impact

We anticipate that the development of a 3 bed 'Alongside' Community Midwife Unit (AMU) facility at Raigmore Hospital will allow approximately 300 red pathway ladies per year from Moray to book to give birth in Raigmore Hospital with all of the associated care support requirements across obstetrics, midwifery, neonatology and general paediatrics.

Actions (including responses to advisory group recommendations 3, 14 and 16)	**By when**
• We will seek agreement in principle to work collaboratively between NHS Grampian and NHS Highland to support this development	Complete
• We will conduct a joint review of existing clinical accords and associated emergency transfer activity	30th November 2018
• NHS Highland are preparing the business case for the Inverness AMU. This is nearing completion and will: - Establish physical requirements and preferred site within Raigmore Hospital - Establish clinical delivery and workforce model - Establish capital and revenue resource requirements	Business case from NHS Highland anticipated in November
• NHS Highland have indicated that the earliest their CMU could be operational is from April 2019 subject to agreement by both Health Boards, including funding requirements being met.	April 2019 (timescale TBC on receipt of business case from NHSH)
• We will develop a SOP for continuity of carer between NHS Grampian and NHS Highland for intrapartum transfers	November 30th 2018
• We will revisit with NHS Highland whether any Moray women can book to give birth in Inverness ahead of the new AMU being operational (e.g. from West Moray)	November 30th 2018
• We will clarify regarding when Moray women can book to give birth in forthcoming Raigmore AMU	December 2018

7. Expert Advisory Group – additional actions

A number of the recommendations of the advisory group are firmly aligned with those in the preceding sections and have been included therein. However, this section outlines additional steps to be taken in direct response to the team's feedback.

Aim
To improve communication, confidence, informed choice and relationships and minimise impact of service change on welfare and travel.
Impact
Minimising anxiety, building confidence in the local service and in NHS Grampian (further to actions in section 2)

Actions (including responses to advisory group recommendations 2, 4 and 5)	**By when**
• We have provided additional senior management expertise dedicated to DGH/Moray – to have a key focus on communications and relationship building	In place from 22nd October 2018
• We have developed an updated communication priority action plan which ensures additional focus on issues highlighted by the advisory team. The Moray leadership team is working closely with Corporate Communications to achieve this.	Completed October 29th and underway
• We will outline a clear strategy and timeline for service restoration as far as possible in phase 2 of this plan, (see section 9)	November 30th 2018
• We will reiterate clear information for women regarding who to contact for triage and other essential information using a variety of media and will be shared with frontline staff: - Via the Maternity Liaison Committee - Via community midwifery team - Via social media - Via verbal and written updates to staff	Complete and ongoing from November 9th 2018
• We have established a multi-agency group to support transport and welfare issues: - We are reimbursing travel expenses - We have arrangements in place with taxi providers for short-notice transfers where clinically appropriate - We have ensured consistent provision of income maximisation advice & literature via Dr Gray's Healthpoint & our midwifery team - We are working with Moray council to engage transport providers re 'up-front' support for transport costs for women & families (e.g. vouchers) - We are working with SAS to maximise use of patient transport vehicles (as opposed to emergency vehicles, where clinically appropriate)	Work commenced at point of service change, outstanding actions to be concluded by 30th November 2018
• We will increase trust and relationships between DGH staff and NHS Grampian leadership through increasing local decision making and continuing increased visibility and open discussion with all parties	Increased focus ongoing from October 22nd
• We will, where feasible, adopt the recommended national 'Best start' approach ahead of receiving feedback from the early adopter sites. A package of local recommendations will be developed.	30th November 2018

8. Collaboration with the Scottish Ambulance Service (SAS)

Aim
To minimise frequency and time of inter-Hospital transfers

Impact
Improved robustness of local emergency ambulance cover

Actions	By when
• SAS have confirmed the commencement of a test of change model for tasking homebound vehicles in order to increase local emergency ambulance cover in Moray.	22nd October 2018 ongoing
• We have implemented a bi-weekly action review group which is attended by senior SAS representation	Two-weekly

9. Planning of next phases

This document outlines short to medium term actions and is reflective of local clinical input in terms of what has been deemed safely feasible in the short-term. As mentioned in section 2, a complementary paediatric phase 1 plan will be developed by the end of December. Phase 2 will outline the steps and timeline for sustainable restoration of all possible elements of obstetric and paediatric care in Elgin. The phase 2 plan will be completed in early 2019, will require extensive public and partner agency engagement and will incorporate the longer-term planning recommendations of the Chief Medical Officer advisory group.

Appendix 1 – Responses to the advisory group recommendations

Communication:

Recommendation 1: NHS Grampian urgently need to produce a comprehensive strategy with a clear timeline for the restoration to obstetric services. Service users including fathers and families should be involved in discussions from an early stage. This should be shared with staff and the public.

We are committed to delivering sustainable, safe consultant led care as far as possible and this is the focus of our phase 2 plan. This will be developed with our stakeholders, including the public, partner agencies and the Scottish Government in early 2019.

Recommendation 2: NHS Grampian should provide clear information to women on who to contact, where they should go for triage and other essential information. This should be provided through a number of different channels and communicated to frontline staff. Daily bulletin updates could be created and widely publicised.

The community midwife team provide all women with a list of contact details at their first appointment. If a mum is unsure of who to contact, they are now actively encouraged to contact Ward 3 at Dr Gray's. This option is available 24 hours a day. Please refer to sections 3 and 7 of the phase 1 plan, communication is a significant focus for the strengthened local leadership team and clinical staff, using all appropriate media, and to ensure the accurate provision of information to women.

Recommendation 3: All women should be given an informed choice about their options of place of birth. Women should be offered, homebirth, DGH, AMH and Raigmore as real options and their personal risk factors as well as the general risks and benefits of each type of units including, for example, information about rates of transfer (for both primigravidae and multigravidae) from the CMU to Aberdeen and Raigmore should be clearly communicated to women at booking so they can make an informed choice about place of birth. The current leaflet is not up to date and needs urgent revision.

Please refer to sections 3 and 6 of the phase 1 plan.

Recommendation 4: NHS Grampian should provide clarity around cost of travel, accommodation and easy access to support for women travelling to AMH.
v*Please refer to section 7 of the phase 1 plan.*

Recommendation 5: Relations between NHS Grampian management and staff at DGH need to improve as the staff at DGH perceive a "them and us" situation. They need reassurance that they are valued and their opinions and concerns meaningfully considered. This attitude is embedded over many years and will take time, effort and a willingness to improve on both sides.

Please refer to section 7 of the phase 1 plan.

DGH Services short/medium term:

Recommendation 6: DGH should restart elective caesarean sections only once appropriate paediatric cover is in place. A full risk assessment of this must be undertaken. We would expect this could be in place by the end of the year. Monitoring for increase in ELCS is needed once an ELCS service returns. Obstetric referral and interventions should be monitored closely if ELCS services recommences.

Please refer to section 4 of the phase 1 plan.

Recommendation 7: DGH must maintain strict adherence to CMU entry criteria guidelines and not relax these as a result of obstetric presence until such a time as this can be relied upon for full service. However we recognise that once a women is in labour in the CMU, due to the presence of obstetricians, extreme emergency situations may be dealt with differently than in a normal CMU and we recommend that there is complete clarity for staff on professional responsibilities in these situations.

Please refer to section 3 of the phase 1 plan.

Recommendation 8: DGH should review each transfer/referral to ensure women who wish to book for DGH are not being sent to Aberdeen unnecessarily. AMH and Raigmore should provide feedback on the cases to DGH staff in a constructive manner.

Please refer to section 3 of the phase 1 plan.

Recommendation 9: DGH should, with caution, expand triage and day assessment hours – this would not be a CMU model though and clarity is required round roles in emergencies including ventouse practitioners.

Please refer to section 5 of the phase 1 plan, there are no short-term plans to support ventouse cases taking place at Dr Gray's.

Recommendation 10: DGH should not consider introducing induction of labour as next step up until a round the clock obstetric service is restored.

There is no intention to reintroduce IOL at Dr Gray's under the temporary arrangements.

Recommendation 11: NHS Grampian should not implement targets for birth and bookings at DGH, this is a risky strategy and we need to learn from the findings of the Morecambe Bay report.

We have not set targets for births at Dr Gray's, though we seek to encourage the confidence to choose to labour and birth locally where clinically appropriate.

Recommendation 12: NHS Grampian should audit postnatal readmissions of mothers and babies and consideration given to whether postnatal readmissions can be managed at DGH as part of a transitional care service.

An action has been added to section 4.

Recommendation 13: NHS Grampian must ensure all current staff have the same updated training in basic neonatal resuscitation and recognising the sick infant – Scottish Maternity/NES courses offer NLS with additional advanced skills training in line with national guidelines.

An action has been added to section 4.

NHS Grampian/ Highland relationship:

Recommendation 14: NHS Grampian should confirm with NHS Highland that Raigmore will take emergency transfer cases as if they were Highland women and that these can be referred straight to Raigmore without the need for negotiation. This should be communicated clearly to all staff on the Labour wards at both DGH and Raigmore.

This has been agreed and an action has been added to section 6 reviewing this agreement (the clinical accord).

Recommendation 15: NHS Grampian and NHS Highland should work together to develop and implement shared clinical guidelines for Grampian, and Highland services and for both hospital and community teams will help avoid confusion and disagreement as mothers and babies are transferred between units.

Aspects of this will be addressed in the phase 2 plan, however, clinical accords have been agreed to support maternity and paediatric care. Further, a draft SOP (Standard Operating Procedure) has been developed to support the continuity of carer between Dr Gray's and Raigmore Hospital, to enable Dr Gray's midwives to travel with mothers to Raigmore where required. This has been shared with NHS Highland for comment and an orientation programme is being put in place for Dr Gray's staff supporting Moray births at Raigmore.

Recommendation 16: NHS Grampian and NHS Highland must work together to allow women from west of NHS Grampian area to choose to deliver there. This includes increasing capacity at Raigmore and must ensure staff can work across health board boundaries and continuity of care after discharge. These discussions may need Scottish Government facilitation and funding may also be required to facilitate this.

Over and above the actions in section 6 we will continue to work with NHS Highland to identify and seize any opportunities to allow some Moray women (e.g. West Moray) to choose to give birth at Raigmore Hospital.

Recommendation 17: Consideration should be given to seeking and considering data from NHS Highland on length of stay, occupancy rates and birth rates in Raigmore.

This information has been requested.

Long term planning for restoration of Obstetric services:

Recommendations 18-21 - all of these actions will be addressed in phase 2 of the plan, if not before.

Recommendation 18: NHS Grampian must look to engage and empower DGH staff in looking to sustainable models for the future by drawing on a variety of innovative solutions suggested by staff.

Recommendation 19: In the longer-term. The main challenge will be finding junior staff for service. The Post Graduate Deanery can't be relied upon to provide GP trainees on a regular basis. Advanced nurse/midwifery practitioners will help. The employment of salaried medical officers for general service could be considered.

Recommendation 20: NHS Grampian should identify which staff require additional skills in Advanced Neonatal Resuscitation – NALS and update if required

Recommendation 21: NHS Grampian should consider identifying a nominated link neonatal paediatrician from Aberdeen who has responsibility for the DGH neonatal service and supports their QI tests of change with review for safety and outcome audits.

Appendix 2 – key concerns raised by KeepMUM

Concerns have been expressed regarding:

1. **Assurances that local clinical staff have been involved in developing plans**

   Local clinical staff have been involved in developing the plan and their input has identified e.g. that among the limited options for stepping any service element back up in the short-term, elective caesarean sections should be focused on.

2. **Current arrangements are not working well and have not been communicated clearly to women**

   Initially we saw a low level of uptake of women choosing to give birth at Dr Gray's but this has markedly improved during September and October 2018. Communication with women will continue to be prioritised and we have seen significant engagement with our online video featuring the local midwifery team leader, which provides essential information for women. We also trialled a helpline number and publicised this via social media and assessed that this was not being utilised by women, (only 1 call during its operation). Women can always can contact their community midwives during working hours or ward 3 at other times with concerns that they may have.

3. **Queries regarding the role of the Scottish Ambulance Service in transferring obstetric emergencies and timeliness of these**

   The Scottish Ambulance Service is one of our key partners in the delivery of health services in Moray and we continue to collaborate with them in all relevant aspects of planning. They have a key role in transferring patients where that is the most appropriate clinical option. Reassuringly we have seen declining numbers of obstetric related transfers since the first weeks post service change. We have routine processes of review of transfer activity and analysis as to whether any transfers could have been prevented. In addition, the Scottish Ambulance Service has recruited staff for the Moray areas and are trialling new ways of working in order to enhance local emergency ambulance provision.

4. **Queries how the original criteria in the phase 1 plan were arrived at**

   These were agreed in discussion with the Cabinet Secretary for Health and Sport and with the Chief Medical Officer for Scotland after discussion with local clinicians about what we might safely focus on in the short-term.

KeepMUM have asserted that our plans should address:

5. **Local recruitment and retention of staff**

   This has been a significant focus for or phase 1 planning and will remain so during the important work focused on the future sustainable service. 2 additional locum consultant paediatricians have been recruited and support has been provided by paediatric consultants from Aberdeen. A further effort to recruit to the 1 substantive paediatric consultant vacancy has proven unsuccessful (5th attempt) and requires to be reattempted or redesigned in collaboration with Raigmore Hospital.

6. **What is in place to address issues which influence doctors decisions to work in Moray – e.g. availability of good quality accommodation**

   We have established a short-life working group SLWG to focus on accommodation which has made a number of recommendations. We are also working with NES to make changes which we hope will improve the attractiveness of GP trainee roles at Dr Gray's.

7. **Clear steps/actions to incrementally step up services with timescales for returning to a full consultant led service, and what can be available with the successful appointment of two paediatricians**

   The phase 1 plan details the only initial options for service step-up in the short term and in accordance with the views of local clinicians. The phase 2 plan will develop a sustainable model for women and children's services at Dr Gray's, this plan will be developed with all stakeholders and made available in early 2019.

8. **Innovative ways of providing support for obstetricians at Dr Gray's so they can safely undertake more procedures**

   Innovation could have a potential role in supporting antenatal care through the use of 'attend anywhere' software. Its role in supporting additional procedures is likely to be secondary to the availability of the workforce to allow further service step-up e.g. paediatric and/or junior doctor or alternative roles.

9. **Concerns that benchmarking with Borders will set the bar unachievably high in terms of staffing levels**

   Borders is the most appropriate Scottish District General Hospital for comparison but there is no desire to mirror that service in unrealistic or unattainable ways. Dr Gray's faces some shared challenges with BGH and some differing ones and these will be explored further. In addition, we are engaged with work at a national level to develop a framework for advanced midwifery practice in Scotland. We will consider the recommendations from this national work in developing our future planning around advanced midwifery roles.

10. **Why safe minimum level of staffing must be provided by permanent staff – concerns this is setting an unachievably high bar and is not consistent with other services in NHSG/NHS.**

    Safe staffing levels have been determined with local clinical teams and services can be safe without being 100% provided by permanent staff.

11. **Clinical Governance to make sure the maternity service in Moray is safe**

    Dr Gray's Hospital is firmly linked into the wider NHS Grampian acute sector and Board clinical governance processes for review of safety and quality service aspects.

12. **Quality of the birth experience.**

    We are increasingly gathering feedback from Moray women related to their birth/care experience Dr Gray's, Raigmore Hospital or Aberdeen Maternity Hospital. The learning from these experiences is shared where appropriate to contribute to improving services and to continue to build on the growing confidence in the current local model of midwifery led care, which is currently performing very well in comparison to many more established midwifery led units.

This publication is also available in other formats and languages on request. Please call Equality and Diversity on 01224 551116 or 01224 552245 or email grampian@nhs.net

Ask for publication CGD 180731

Appendix 2
CMO Advisory Report Published

Maternity and Paediatric Services at Dr Gray's Hospital, Elgin

Chief Medical Officer's Advisory Group Report

November 2018

Scottish Government
Riaghaltas na h-Alba
gov.scot

Dr Gray's maternity and paediatric services
Report of the CMO Advisory Group

Remit

1. The Chief Medical Officer requested that this small expert group provide insight and guidance on the measures proposed by NHS Grampian to maximise the maternity care which can be provided in Dr Gray's Hospital (DGH) following the change in service to a Community Midwifery Unit (CMU) in August 2018. The full Terms of Reference for the group can be found at Annex 1. The CMO asked the Group to look at NHS Grampian's Phase One plan for the improvement of existing provision of Maternity and Paediatric Services at Dr Gray's Hospital and the future plans for the return of obstetric services.

2. As part of our work, the team worked with NHS Grampian Management team and engaged with local clinicians, Maternity Services Liaison Committee (MSLC) and the KeepMUM campaign group to gain a range of views on the existing service and the proposals provided by NHS Grampian. We also spoke with clinicians at NHS Highland (Raigmore).

3. The Chief Medical Officer requested that a short report be provided to include:

    1. Exploration of the development areas set out by NHS Grampian and agreed with the Cabinet Secretary. Including the feasibility and likely success of these additional measures and any advice which can be given to ensure success and/or improve upon the plans.
    2. Further recommendations to improve the care provided locally for women in DGH in the CMU setting including obstetric emergency triage, antenatal and postnatal care.
    3. Review of clinical pathways for the CMU, for transfer (both emergency and elective), and for antenatal care, and comparison with national/professional body standards and experience in other parts of Scotland.
    4. Engagement with local clinical staff to allow inclusion of local solutions to break down barriers to different ways of working and to build on communication with NHSG staff in Aberdeen.
    5. Engagement with and feedback to NHSG management
    6. Exploration of NHS Highland capacity and referral pathways to increase number of women able to travel to Raigmore for antenatal care or birth if this is a shorter journey for them.

Group Members:
Dr Rennie Urquhart – retired Obstetrician, NHS Fife
Justine Craig – Chief midwife, NHS Tayside
Una McFadyen – retired Paediatrician, NHS Forth Valley
Margaret McGuire – Executive Director of nursing NHS Greater Glasgow and Clyde*

*Provided senior input into development of report, but not involved in visits or discussions with staff.

Introduction

4. This paper considers the provision of maternity and paediatric services in the short and medium term at Dr Gray's Hospital, Elgin (DGH) and is prepared to the terms of reference provided by the Scottish Government . The Cabinet Secretary for Health and Wellbeing has instructed NHS Grampian to develop a plan as to how they will return an obstetric led service to DGH as soon as possible.

5. The Cabinet Secretary has agreed several priority actions for Dr Grays Hospital, Elgin (DGH) with NHS Grampian:
   I. Reinstating elective caesarean sections
   II. Increasing number booked for delivery at CMU to 35% of total bookings (currently 25%)
   III. Reducing unnecessary transfers to AMH by reviewing reasons for maternal transfer.
   IV. Increasing antenatal care delivered at DGH by reviewing what specialist antenatal/postnatal services currently provided in Aberdeen Maternity Hospital (AMH) can be delivered locally.
   V. Working with NHS Highland to increase capacity in Raigmore to allow more women from Moray to receive care there in addition to the emergency transfers which have already been agreed.
   VI. Working to improve historically poor experience of trainees in O&G/Paeds at DGH.

6. The current service provision has been predicated on the unavailability of paediatric cover and this is the primary reason for the temporary service change.

7. It should be acknowledged that the group had a limited timetable for completing the work and therefore were not able to follow up some suggestions to gain a deeper insight into particular options. In particular there was not sufficient time to discuss current experience and views on future plans with clinicians in the Aberdeen Royal Infirmary.

8. Before the priority actions are considered, below, the group would like to thank all the NHS Grampian and NHS Highland staff and service users with whom the advisory group engaged for their time and their honesty in discussing a wide range of aspects of the current situation; this was wholly appreciated by the advisory group. Our group listened to and considered all the views expressed and there were many similar themes emerged. These are outlined below.

Public relations and communication

9. We repeatedly heard from a variety of sources that communication with both staff and public has been poor and women remain confused and lacking confidence in NHS Grampian and the safety of the service provided, for example women were particularly concerned about the risk of delivering at the roadside on a dangerous road during a transfer to AMH. There was a sense that communication is improving but is still not sufficient. It was appreciated that this is a rapidly changing landscape, but immediate communication about any issues to expectant mothers and frontline staff need to be improved.

10. Communication with women could be improved by making sure that there are clear, regularly updated instructions about how to, and when to contact services, and where to go. All staff including community staff and GPs **must** be included and updated about changes in the plan so that consistent clear messages and information are being sent out to women. There are many ways to do this including Facebook, web pages, midwife phone calls and routine visits, text message and potentially through the electronic handheld notes. A variety of routes should be used to ensure all women are kept informed. The information must be accurate, reliable and consistent and accessible 7 days a week around the clock, e.g. through a communication hub.

11. An action time line is required immediately to share with staff and services users. It must be acknowledged that this will be subject to change, this would be a critical tool in engaging and communicating with the local community and would reduce anxiety at many levels. If there are specific issues, such as unsuccessful recruitment efforts, then explaining what can be done to overcome barriers would help engage the representatives of the public in supporting NHS Grampian, and would show progress is being made. Greater inclusion of members of the MSLC is required in working groups and discussions. Long periods of no communication and communication only in response to questions is creating a lack of trust. A proactive, inclusive and open strategy is required.

12. Fathers and families seem to be excluded in the temporary process with their needs appearing to be unrecognised, for example in relation to accommodation in Aberdeen. Concerns were raised by women and midwives that care is not individualised to women and families circumstances.

13. Aberdeen Maternity Hospital Clinicians were perceived by members of the MSLC to have an inflexible mind set and to have not been visible at public and staff meetings. The public remain concerned that there is not a commitment to reopening full services and that the temporary situation will become permanent.

Travel, safety, cost and choice

14. In the short and medium term there are very real and understandable concerns regarding these issues. The temporary change has fallen over the critical winter months creating additional anxiety across all stakeholder groups. Concern about travelling long distances to Aberdeen in bad weather is significant and this must be considered as part of the overall safety picture.

15. We understand that NHSG and NHSH have agreed that women labouring in DGH who require emergency transfer will be taken to Raigmore. However we were told of two occasions where this was declined at the time of transfer and the women diverted to AMH. The extended travel time in emergency cases places women and babies at increased risk.

16. Prior to the change women could opt for care at Raigmore from early in pregnancy, this option has now been discontinued in order to build capacity for emergency transfers during labour from DGH. Removing this choice is a contradiction to the ethos of the Best Start and Realistic Medicine in enabling

cross boundary working, choice of place of birth, keeping families together, and enabling and facilitating care as close to home and the local community as possible.

17. For many women in the north-west of the region, transferring their planned care to Raigmore would be beneficial in terms of travel, safety and cost. However it is acknowledged that NHS Highland has capacity issues. Enabling DGH midwives to provide continuity of carer and accompany women who are in their care to Raigmore should be explored using the Memorandum of Understanding between NHSH and NHSG and as an extension of the Best Start 'Early Adopter' scheme.

18. The cost of travel to Aberdeen we were told by both midwives and women was, for some, prohibitive. Staff, service users and DGH management provided differing accounts of the provision of support for transport. It is essential that this is clarified so that staff, including community midwives and GP's, and service users know what support is available and how to access this.

19. We were told by staff that two types of training in neonatal resuscitation are in place, this risks staff confusion and needs to be addressed urgently.

Staff morale, inclusion, training and communication.

20. We were impressed with the new management and leadership structure that is now in place in DGH. We think this is very positive and a good step forward, and were encouraged by the proactive attitude demonstrated and the good grasp of what was needed locally.

21. It is our perception, from our discussions with medical, midwifery and paediatric staff at DGH that morale is low. Staff also told us that communication has been poor and that the current crisis is not unexpected and that plans should have been in place at a much earlier juncture. Some staff feel patronised and told us that they felt that the issues they have raised were not being treated seriously.

22. Staff also told us that they want to see a firm clear plan with a timescales for the restoration of obstetric and paediatric services. They are concerned that they will become deskilled and worry about the security of their jobs under the current arrangements.

23. We got a strong sense that staff are willing to adapt and explore options, however they feel discouraged and disempowered. Midwives told us that they are keen to accompany women who are transferred to Raigmore and continue to look after them there. However they perceive existing red tape is making this difficult and they don't feel encouraged to do so due to uncertainty about their role, their contracts and differing NHS Board procedures.

24. We heard some innovative ideas about the future of paediatrics and maternity services at DGH from staff. The ideas proposed included changing models of care and training opportunities, increased use of telemedicine, and introduction of a Service Level Agreement to allow NHSG midwives to continue care into NHS Highland.

25. There is a perception by staff that NHS Grampian sees DGH as an ‘add-on’ to the main service in AMH with concerns raised about the level of commitment from NHSG management to restoration of the service at DGH. Staff were also of the view that the priority for staffing is focussed on AMH, and posts in DGH are a secondary and lesser concern for recruitment. There was also a perception that AMH would not be willing to share or rotate staffing because of impact on AMH capacity.

26. Paediatric staff feel that too much of the shift and focus was on restoring the maternity and obstetric service with little consideration given to paediatric staff or services in DGH

Feasibility and comments regarding the 6 priorities for service

1. Reinstating elective caesarean sections (ELCS)

27. Reinstating elective caesarean sections (ELCS) would provide a more accessible service for women and their families. Service users would appear to welcome this as would staff members across all specialities. However it is unclear whether women and their families fully understand the implications of providing this service.

28. Our opinion is that ELCS can be provided safely at DGH with the right infrastructure, risk management and emergency process in place and assuming all staff are appropriately skilled and maintain competencies. In our view this service could resume as soon as paediatric cover is in place, and our understanding is that this cover is in hand and will be in place in the immediate short term, although questions remain about the nursing capacity to reopen a SCBU or operate transitional care beds. Once Paediatric support is in place ELCS provision could be returned within weeks. This is based on the assumption that appropriate and competent anaesthetic, obstetric and midwifery staffing is in place to deliver services. The details of the planned onsite and on call paediatric cover for neonates should be clarified with clear agreed clinical guidelines and pathways for assessment, immediate life support, stabilisation and post resuscitation care.

29. There is a need for some local discussion between the specialties to ensure cover. For example, in replacement for the GP trainee the A&E junior doctor could provide medical cover (rarely required) out of hours with back up from the obstetrician at home. In the very rare event of an ELCS requiring a return to theatre, the obstetrician has surgical assistance via a local arrangement in place. We are therefore satisfied that with the competency and risk management caveats and appropriate escalation processes in place, a safe level of staffing could be provided consistent with current acceptable standards of care.

30. There are risks to placing an ELCS service in what purports to be a CMU. There is a risk that obstetricians feel compelled to act in emergency and urgent situations when women are in labour because they are on site, rather than

following the agreed model of transferring those emergency cases to Raigmore. This may then lead to unsafe situations and uncertainty. At present Obstetric staff remain on call for 'life and limb' emergencies as per the paediatric model in place and described by local staff. This creates a difficult model to describe to women, so that they can make an informed choice of place of birth. The model does not follow a generally recognised definition of CMU/ Freestanding Midwifery Unit, and is not consistent with NHSG's guidelines for midwife care. There is therefore a need, at the point at which the new model is introduced, that this is accompanied by clear guidelines for staff on when a woman should be transferred and when local obstetric provision should be used.

31. There is also a concern that women would choose ELCS to avoid travel to Aberdeen Maternity Hospital (AMH). All groups discussed this and felt that this may emerge. Maternal request for primary C/S is increasingly common throughout the country however clinicians should continue to provide full information of risks and benefits applicable to the women's individual situation in providing advice in relation to C/S. This would need to monitored.

32. From the figures provided, returning a ELCS service to DGH would see 50-80 additional babies per year born at DGH rather than AMH. The obstetric staff are keen to resume this service and they believe that to restart ELCS at DGH is safe. They fear losing skills if unable to operate regularly, reduced job satisfaction and potential problems with senior staff retention /recruitment. The midwifery opinion is that the risk is as outlined previously, difficulty in communicating informed choice and introducing a level of risk not normally found in a traditionally operating CMU.

33. The reinstatement of elective caesarean sections at DGH requires:

- Confirmation the paediatric cover is in place
- Agreement with staff in A&E that their resident doctor will provide medical cover for post C/S patients out of hours.
- Clear pathways for who is being referred for emergencies and when local obstetricians are to be called on.
- Clear protocols and guidelines on emergency transfer.

2. Increasing number booked for birth at CMU to 35% of total bookings (currently 25%).

34. The criteria for CMU intrapartum care are consistent across NHS Grampian and are similar to CMU guidelines throughout the country. We would caution and advise against any alteration to these. If alteration is unavoidable, this should be undertaken only after an assessment of risk and risk mitigation. NHSG are hoping to achieve a rate of 35% of women delivering in the CMU, however this is an ambitious and possibly unrealistic target based on rates in other CMU's across Scotland. It also must be acknowledged that there will be a high percentage of transfers for primigravids, (36 % - Birthplace Study 2014).

35. Setting such a target may have unintended consequences and may lead to 'overselling', or a lack of objectivity in place of birth discussions. A fine balance is

required when this type of target is in place, there may be perception from staff they have to achieve the target and managers may find they are focusing on the target not holistic care, maternal choice and safety.

36. Attention should also be given to ensuring options for home birth are in place, as indicated in The Best Start. The Birthplace study points to home birth as the optimum place for birth for low risk parous women.

37. Bookings should be audited regularly to ensure that all women who are eligible to receive intrapartum care at DGH have all of their options explained to them, bearing in mind that some women who are eligible for birth at DGH may choose to birth in Aberdeen and this choice must be respected.

38. The fact that DGH is in the unique situation of having a CMU service with obstetricians available during the day and on call overnight (for gynaecology and "life and limb" obstetric emergencies) should not allow entry (or exit/transfer) criteria for the CMU to be relaxed. It should be made clear to women who book for birth in the CMU that in most cases, if complication arise during labour, transfer to Raigmore will be arranged. Development of emergency antenatal complications will trigger referral to AMH.

39. Information about benefits and risks of all births setting should be clearly communicated to women at booking so they can make an informed choice about place of birth. This should include information on risk of transfer for both primigravidae and mutigravidae from CMU to AMH or Raigmore,

3. **Reducing unnecessary transfers to Aberdeen Maternity Hospital (AMH) by reviewing reasons for maternal transfer.**

40. Reasons for transfer and referral to and booking at AMH will need regular review and audit to ensure that women are not having to travel to Aberdeen unnecessarily.

41. Transfers should be reviewed by the multidisciplinary team in a non-judgemental and learning environment. This should become routine for all cases of CMU transfer. However it may undermine the clinicians if transfers are termed unnecessary in retrospect. The decision of the clinician at the time has to be respected the right environment needs to be created and an appropriate balance found to avoid a culture of fear of transferring and adverse outcomes.

42. This new service represents a big change for midwives in building safety and confidence in a new CMU service a high transfer rate would initially be expected, this is normal, until staff and women start to trust processes and their judgement.

43. The blurred lines of potential obstetric presence also need to be considered in terms of transfers or non transfers as has already been highlighted above.

4. Increasing antenatal care delivered at DGH by reviewing what specialist antenatal/postnatal services currently provided in Aberdeen Maternity Hospital (AMH) can be delivered locally.

44. Triage hours at DGH are currently 9am – 5pm weekdays only. Women are required to phone DGH for triage during these hours and phone AMH out of hours. This has caused confusion amongst some women and needs to be clarified with both staff and service users. Out of hours there is no medical cover at DGH, so if a pregnant women turns up at DGH out of hours and her care cannot be managed by a midwife, she must be transferred to AMH.

45. Telemedicine options were suggested by some clinicians however others thought that this would not be possible due to the availability of staff at AMH. It is important that DGH and AMH explore use of telehealth technology (e.g. attend anywhere) to reduce further the requirement to transfer to AMH for assessment.

46. Extending triage, day assessment and antenatal assessment clinics until 10pm was widely discussed across all groups, this would reduce the number of women going to AMH for triage especially in the early evening and be a good use of obstetric skills. There is a risk that if an emergency occurs, practitioners may be obliged to act as previously outlined, this risk exists in the current configuration. Extending the hours for triage would reduce unnecessary transfers to AMH, it would also provide women additional reassurance that if they do need to transfer it is safe and appropriate to do so.

47. Staff fed back that the higher numbers of women attending AMH for triage and assessment was creating additional pressure on staff at AMH who have, on occasion, felt required to admit women unnecessarily rather than discharging them in the early hours of the morning due to their long journey time.

48. There seems to be confusion on where pre-assessment for caesarean sections should take place. Some (all?) Women are being required to travel to AMH for assessment. Concerns were also expressed over these assessments in AMH due to long wait times, calls to be seen during the night and in some cases, and no pre-assessment being received prior to caesarean section due to capacity issues at AMH. These pre-assessments should be carried out at DGH working to NHS Grampian wide protocols and with easy communication between the professionals in AMH and DGH to avoid unnecessary travel.

49. In line with NICE guidelines women should be offered induction of labour between 41+0 and 42+0 weeks to avoid the risks of prolonged pregnancy. Concerns were raised by both women and community midwives regarding long inpatient waits for induction at AMH and frequent rescheduling of induction dates (one example was given of a women who was told to call back three days in a row then told that she should wait by the phone for AMH to phone her). Capacity issues were cited as the reason for this. It is important that when women who are traveling to AMH for induction, clinicians give consideration to the practicalities of distances travelled and communicate clearly with women of possible delays, where that can be anticipated to avoid premature travel. It would not however be safe at this time to return inductions to DGH.

50. Keep MUM and the Maternity Services Liaison Committee raised some concerns about early transfer home post-birth from AMH, quoting the 6 hour discharge as having a negative effect on breastfeeding rates. Whilst DGH has high rates of

breastfeeding due to longer postnatal stay with midwifery support, early discharge is now the norm throughout Scotland with the focus on community midwifery support for establishing breastfeeding, support services appear to be in place from community midwives to do so, and this service can continue to be enhanced. There is potential for community services to increase support given they are now called in less frequently to cover DGH

Paediatric Support

51. It was concerning to hear that a number of jaundiced babies are having to be referred back to Aberdeen. We would recommend that the numbers of these babies are being audited and if this is the result of early discharge then there needs to be a review of postnatal guidelines that includes paediatric review in DGH and provision of local phototherapy, NG feeding if required, and breast feeding support. We suggest this is developed as Transitional Care rather than SCBU so that any elective section mothers and babies can stay together with the additional nursing support of the trained midwives.

52. We suggest that there is a nominated link neonatal paediatrician from Abderdeen who has responsibility for the DGH neonatal service and supports their education needs, QI tests of change with review for safety and outcome audits.

53. To cover the needs of babies in a maternity unit there is a need for resources that are substantially well developed in DGH with appropriately trained midwives already in post and keen to maintain their skills e.g:

- An appropriate environment for safe birth
- 'Warm bundle' or equivalent,
- Staff trained in assessment at birth and effective intervention if indicated – Neonatal Resuscitation skills
- Baby Friendly postnatal care – support for establishing feeding and early attachment
- First steps for parenting skills
- Examination of the newborn
- Recognition of the sick infant
- Stabilisation of the sick infant for ongoing care on site or for transfer
- Assessment and guideline led management of common perinatal problems including moderate jaundice requiring phototherapy, hypoglycaemia
- Preparation for home – car seat, safe sleeping, GP registration
- Post discharge support

54. Taking the Best Start and Scottish Patient Safety Programmes as national initiatives some of these requirements could be adapted to help re-establish the maternity service at DGH that is suitable for the population of Moray. There is also a need for neonatal assessment and stabilisation competencies in all the current settings possibly including Primary Care and Ambulance staff while at risk transfers in labour may be delayed or prolonged.

5. Working with NHS Highland to increase capacity in Raigmore to allow more women from Moray to receive care there in addition to the emergency transfers which have already been agreed.

55. The group agree this is a significant area for exploration and although we were unable to schedule further meetings with NHS Highland, further feasibility work is needed in this area.

56. NHSG and NHSH have agreed, via a "memorandum of understanding" that women who experience complications in labour will be transferred from DGH to Raigmore for obstetric care. However on two occasions the transfers were not accepted by Raigmore (capacity/staffing issues being cited by NHS Highland) leaving the staff at DGH feeling vulnerable and requiring women in an emergency situation to transfer to AMH. Transfer in these emergency situations should be direct and automatic and not dependant on the situation at the time in Raigmore as it would be for transfers from any NHS Highland CMU. This needs to be clearly communicated across all levels of staffing at Raigmore.

57. Staff at Raigmore reported that their capacity had also been influenced by the change in service at Caithness and so the needs of both their north and east communities are needing to be accommodated.

58. Strong consideration **must** be given to directing higher risk women to Raigmore for planned antenatal and postnatal care, and to allowing women to choose to birth there. It is unacceptable that women from North West Grampian have to travel to AMH and are expressly 'forbidden' from attending Raigmore. Over 1/3 of the DGH catchment area (43,000) live in Elgin, Forres and Lossiemouth (EFL) less than 35 miles from Inverness. Previously some of these woman could elect to deliver at Raigmore. This option was removed from their choices (by NHS Highland) in order to facilitate the intake of emergencies from DGH. There are many areas across Scotland which achieves this cross border working, for example in Tayside women from North East Fife have care in Ninewells and women from Lanarkshire may travel to Glasgow.

59. Capacity issues at Raigmore need to be further investigated and the development of the alongside unit should not preclude higher risk women from neighbouring areas choosing to have their care there. Consideration should be given to seeking and considering data from NHSH on length of stay, occupancy rates and birth rates in Raigmore.

60. During this interim period until services are restored to DGH, staffing resources from DGH should be diverted to Raigmore to support women from the Moray area to opt for birth at Raigmore. The barriers that prevent NHS Grampian staff from working in NHS Highland (and vice versa) must be removed:

    Midwifery: DGH midwives work on the Raigmore Bank so it must be possible to redeploy underused staff in DGH to Raigmore. All Scottish midwives should be trained to the same standard and be able to work anywhere in the country across different Health Boards.

Medical Staff: Locums are quicker to appoint than substantive posts and could be advertised immediately. Joint NHSH/NHSG substantive consultant posts should be funded. These doctors could work in Inverness in the short/medium term with redeployment to DGH when the junior/resident doctor issues are resolved. There are many examples of consultant posts in Scotland that are funded jointly (e.g. recent Fife/Lothian consultant gynae-oncologist)

Capacity: Precedents are set in all Scottish hospitals , Winter bed crises happen every year. Acute surgical wards are taken over for medical emergencies. Obstetric beds could be increased at the expense of another "cold" speciality. Obstetrics is a core service and MUST take priority. The acceleration of the opening of the AMU at Raigmore also has the capacity to free up more space within the obstetric unit and needs to be accelerated. It is essential that safe local care for mothers and babies is prioritised even at the risk of an impact on elective non urgent surgery waiting times/ targets

61. Previously approx. 1000 women per year delivered at the obstetric unit in DGH. We estimate based on current uptake that this will drop to about 250 deliveries per year in the CMU (although NHSG are hoping that the figure will be higher). The remainder (about 750 women per year) will have to travel to AMH under the current arrangements

62. Our estimates are that if women from the Elgin, Forres and Lossiemouth (EFL) area were able to book to deliver at Raigmore this, combined with resuming ELCS would reduce this number to nearer 400.

CMU deliveries at DGH (based on current 25%)	250women/year
Restarting ELCS at DGH	70women/year
Elgin, Forres and Lossiemouth 'high risk' to Raigmore	250women/year
Total "Local" Deliveries	570women/year

This leaves about 400-450 women who will still need to travel to Aberdeen Maternity Hospital.

63. There is some anxiety within DGH and Moray that this move would jeopardise the reopening of Dr Gray's as an obstetric led unit. KeepMUM and the MSLC welcome the return of the option to deliver at Raigmore in the short /medium term but are concerned that this option may quietly become long term and that plans for the return of full obstetric services at DGH will be shelved. It therefore must be communicated clearly to service users and staff that it is a **temporary** short to medium solution and that the only acceptable long term solution is the return of obstetric services at DGH.

64. Urgent discussions are needed at Board level with strong support from Scottish Government to ensure that discussions between NHS Grampian and NHS Highland are progressed to reduce barriers in this area as a matter of urgency. Agreements must also be communicated clearly with staff in Raigmore and DGH.

6. Working to improve historically poor experience of trainees in O&G/Paeds at DGH.

65. We have not spoken with the Post Graduate Dean but trainee recruitment will continue to be a recurring problem every few months unless changes are made, making it difficult to run a sustainable service. The Post Graduate Dean has responsibility for training not service. Trainees should be supernumerary and can't be relied upon for service work. Therefore the service needs to consider other options for staffing a safe obstetric service without the inclusion of trainees.

66. With regards to paediatrics, there is evidence that ANNPs can provide safe alternative model of service to junior doctors. ANNPs are in short supply but they might be attracted to posts in Elgin and are likely to cost less than medical locums. Similarly APNPs should also be considered for the paediatric ward. Both ANNP's and APNPs can be trained in non-medical prescribing. Physician Assistants have a variable set of skills and specialties and should also be considered.

Recommendations

Following all our discussions and observations we have developed the following recommendations:

Communication:

- NHS Grampian urgently need to produce a comprehensive strategy with a clear timeline for the restoration to obstetric services. Service users including fathers and families should be involved in discussions from an early stage. This should be shared with staff and the public.

- NHS Grampian should provide clear information to women on who to contact, where they should go for triage and other essential information. This should be provided though a number of different channels and communicated to frontline staff. Daily bulletin updates could be created and widely publicised.

- All women should be given an informed choice about their options of place of birth. Women should be offered, homebirth, DGH, AMH and Raigmore as real options and their personal risk factors as well as the general risks and benefits of each type of units including, for example, information about rates of transfer (for both primigravidae and mutigravidae) from the CMU to Aberdeen and Raigmore should be clearly communicated to women at booking so they can make an informed choice about place of birth. The current leaflet is not up to date and needs urgent revision.

- NHS Grampian should provide clarity around cost of travel, accommodation and easy access to support for women travelling to AMH.

- Relations between NHS Grampian management and staff at DGH need to improve as the staff at DGH percieve a “them and us” situation. They need reassurance that they are valued and their opinions and concerns meaningfully considered. This attitude is embedded over many years and will take time, effort and a willingness to improve on both sides.

DGH Services short/medium term:

- DGH should restart elective caesarean sections only once appropriate paediatric cover is in place. A full risk assessment of this must be undertaken. We would expect this could be in place by the end of the year. Monitoring for increase in ELCS is needed once an ELCS service returns. Obstetric referral and interventions should be monitored closely if ELCS services recommences.

- DGH must maintain strict adherence to CMU entry criteria guidelines and not relax these as a result of obstetric presence until such a time as this can be relied upon for full service. However we recognise that once a women is in labour in the CMU, due to the presence of obstetricians, extreme emergency situations may be dealt with differently than in a normal CMU and we recommend that there is complete clarity for staff on professional responsibilities in these situations.

- DGH should review each transfer/referral to ensure women who wish to book for DGH are not being sent to Aberdeen unnecessarily. AMH and Raigmore should provide feedback on the cases to DGH staff in a constructive manner.

- DGH should, with caution, expand triage and day assessment hours – this would not be a CMU model though and clarity is required round roles in emergencies including ventouse practitioners.

- DGH should not consider introducing induction of labour as next step up until a round the clock obstetric service is restored.

- NHS Grampian should not implement targets for birth and bookings at DGH, this is a risky strategy and we need to learn from the findings of the Morecambe Bay report.

- NHS Grampian should audit postnatal readmissions of mothers and babies and consideration given to whether postnatal readmissions can be managed at DGH as part of a transitional care service.

- NHS Grampian must ensure all current staff have the same updated training in basic neonatal resuscitation and recognising the sick infant – Scottish Maternity/NES courses offer NLS with additional advanced skills training in line with national guidelines.

NHS Grampian/ Highland relationship:

- NHS Grampian should confirm with NHS Highland that Raigmore will take emergency transfer cases as if they were Highland women and that these can be referred straight to Raigmore without the need for negotiation. This should be communicated clearly to all staff on the Labour wards at both DGH and Raigmore.

- NHS Grampian and NHS Highland should work together to develop and implement shared clinical guidelines for Grampian, and Highland services and for both hospital and community teams will help avoid confusion and disagreement as mothers and babies are transferred between units.

- NHS Grampian and NHS Highland must work together to allow women from west of NHS Grampian area to choose to deliver there. This includes increasing capacity at Raigmore and must ensure staff can work across health board boundaries and continuity of care after discharge. These discussions may need Scottish Government facilitation and funding may also be required to facilitate this.

- Consideration should be given to seeking and considering data from NHS Highland on length of stay, occupancy rates and birth rates in Raigmore.

Long term planning for restoration of Obstetric services:

- NHS Grampian must look to engage and empower DGH staff in looking to sustainable models for the future by drawing on a variety of innovative solutions suggested by staff.

- In the longer term, the main challenge will be finding junior staff for service. The Post Graduate Deanery can't be relied upon to provide GP trainees on a regular basis. Advanced nurse/midwifery practitioners will help. The employment of salaried medical officers for general service could be considered.

- NHS Grampian should identify which staff require additional skills in Advanced Neonatal Resuscitation – NALS and update if required

- NHS Grampian should consider identifying a nominated link neonatal paediatrician from Aberdeen who has responsibility for the DGH neonatal service and supports their QI tests of change with review for safety and outcome audits.

Annex 1

CMO Advisory group – Terms of Reference

Provision of advice for maternity service at Dr Gray's Hospital Elgin and improving links with Aberdeen maternity hospital and Raigmore hospital Inverness

Membership:
Dr Rennie Urquhart – retired Obstetrician, NHS Fife
Justine Craig – Chief midwife, NHS Tayside
Una McFadyen – retired Paediatrician, NHS Forth Valley
Margaret McGuire – Executive Director of nursing NHS Greater Glasgow and Clyde

Background:
The Cabinet Secretary has agreed several priority actions for Dr Grays Hospital, Elgin (DGH) with NHS Grampian:

1. Reinstating elective caesarean sections
2. Increasing number booked for birth at CMU to 35% of total bookings (currently 25%)
3. Reducing unnecessary transfers to AMH by reviewing reasons for maternal transfer.
4. Increasing antenatal care delivered at DGH by reviewing what specialist antenatal/postnatal services currently provided in Aberdeen Maternity Hospital (AMH) can be delivered locally.
5. Working with NHS Highland to increase capacity in Raigmore to allow more women from Moray to receive care there in addition to the emergency transfers which have already been agreed.
6. Working to improve historically poor experience of trainees in O&G/Paeds at DGH.

The Ask:
This is a light touch intervention by experienced clinicians working outside NHS Grampian and NHS Highland. The group will sense check the measures proposed by NHS Grampian to maximise the maternity care which can be provided in DGH following the change in service to a Community Midwifery Unit (CMU) in August 2018.

As part of their investigations, the team should work with NHS Grampian management and local clinicians- doctors, midwives, nurses. The group should also engage with the maternity services liaison group and the KeepMUM campaign group.

<u>The CMO would expect this to include:</u>
1. Exploration of the points set out above and agreed with the Cabinet Secretary. This will include the feasibility and likely success of these additional measures and any advice which can be given to ensure success and/or improve upon the plans. Your experience with successful CMU in other HBs will be invaluable here.

2. Further recommendations to improve the care provided locally for women in DGH in the CMU setting including obstetric emergency triage, antenatal and postnatal care.
3. Review of clinical pathways for the CMU, for transfer (both emergency and elective), and for antenatal care, and comparison with national/professional body standards and experience in other parts of Scotland.
4. Engagement with local clinical staff to allow inclusion of local solutions and to break down barriers to different ways of working and to build on communication with NHSG staff in Aberdeen.
4. Engagement with and feedback to NHSG management
5. Exploration of NHS Highland capacity and referral pathways to increase number of women able to travel to Raigmore for antenatal care or birth if this is a shorter journey for them.
6. A short report covering the above points to be send to CMO by mid-October.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-78781-383-0 (web only)

Published by The Scottish Government, November 2018

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS499926 (11/18)

Women & Children's services in Dr Gray's Hospital

A DRAFT plan for safe and sustainable services, promoting choice and optimal local service provision (the Phase 2 plan)

1. Introduction, background and purpose

This draft plan builds upon and follows on from two previous submissions to the Cabinet Secretary for Health and Sport during the latter part of 2018. These documents each represented a first phase of planning to stabilise and optimise choices for women and families to receive care at Dr Gray's (DGH) in the short-term. The 'phase one' plan for obstetric/maternity services at DGH was published in November 2018 and its equivalent for paediatric services was submitted and shared with stakeholders the following month.

During the course of 2018, Paediatric and Maternity services at DGH were required to adopt interim service delivery models in response to severe workforce challenges, particularly relating to the availability of medical staff. In response to concerns regarding the impact on patients, families and services the Cabinet Secretary made two visits to DGH, in June and November to hear from public, patients and staff. At the latter visit, it was agreed that once the phase one initial stabilisation focused plans had been prepared and actioned, efforts should be made to prepare a joint plan, for the sustainable future of women and children's services over the medium to longer-term.

The previous and ongoing challenges are well documented and it is not within the scope of this document to unduly rehearse what has gone before. It is future-focused by necessity, and seeks to articulate a way forward taking cognisance of the interdependent and complex relationships between services at DGH. Prior to the submission of the phase one plans, the Chief Medical Officer (CMO) arranged the input of an external expert advisory group who made numerous recommendations, most of which were addressed at the first stages and the remainder of which are addressed via the options identified herein.

We have taken opportunities to learn from our previous attempts to achieve secure and resilient staffing and to learn from elsewhere e.g. through benchmarking and via advice from other centres (such as St. John's Hospital). Through this work, options were generated which are relevant to the unique context within which Dr Gray's is set e.g. in terms of distance from a tertiary centre (65 miles to Aberdeen Royal Infirmary and Maternity Hospitals, with challenging transport options and

infrastructure). Dr Gray's is an essential District General Hospital for Moray and the North of Scotland for the foreseeable future.

This document has been prepared and its content determined in close collaboration with local DGH and Moray stakeholders as well as Scottish Government officials and expert advisors, to whom we are grateful for their support.

Purpose

This draft plan seeks to describe and evidence the steps taken to achieve our aim, namely that we:

> ***Ensure the development of a locally deliverable and sustainable plan for women & children's services at DGH in the medium to longer-term***

2. The process of developing the plan

It was essential to develop a process that would allow the generation of a co-produced plan, involving all relevant stakeholders while placing an emphasis on local clinical leadership and inclusivity of approach.

A dedicated planning group was formed and a co-chair arrangement established between a senior DGH Consultant Paediatrician and the Divisional General Manager for Women & Children's Services (who has been seconded to DGH on a full-time basis to support this work in the interim). This group determined the need for a tier of sub-groups to focus on:

- The model for Paediatric services in DGH
- The model for Women's services in DGH
- Communication and Engagement

The two clinically focused sub-groups were chaired by senior DGH clinicians and all groups had a multi-professional membership, along with public and staff partnership representatives. The communication and engagement group was led by the NHS Grampian Public Involvement Manager. These sub-groups reported into the over-

arching planning group, which set the terms of reference for this work, and comprised of local senior clinical leaders, the DGH management team, public and campaign representatives along with staff partnership. The terms of reference, which includes the membership of this group, can be viewed at appendix 1.

The planning group set a timeline of 5 fortnightly meetings at DGH over ten weeks, in-between which the sub-groups would meet and provide feedback to the over-arching group. Group members agreed and understood that this was not a decision-making group, and accepted the need for close working with the Senior Leadership Team and Board of NHS Grampian, and with Scottish Government officials.

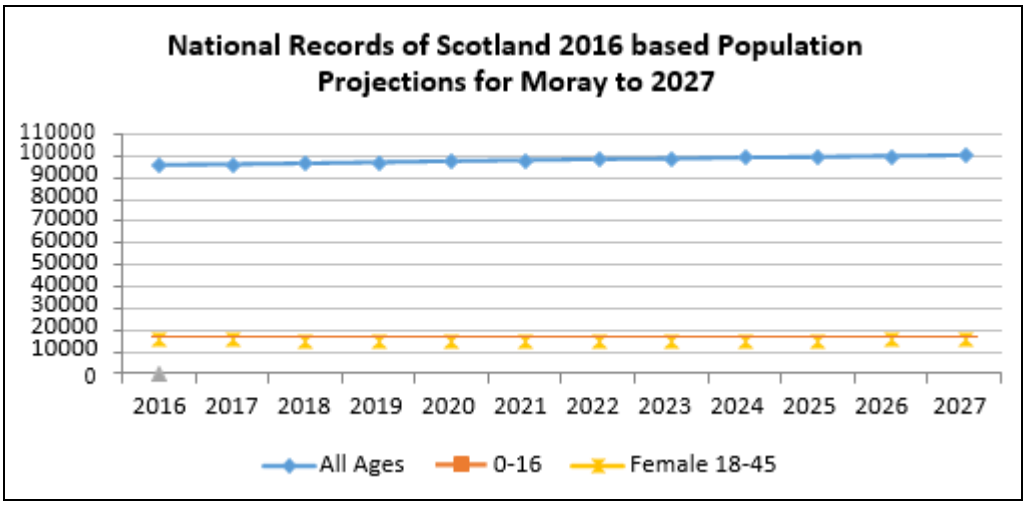
3. A composite workforce model

An essential component for sustaining many services at DGH, Women and Children's included, is the requirement to develop a Hospital–wide composite workforce which will bring about reduced dependence on doctors in training. What we envisage is a blended tier of substantive staff across a number of professional disciplines who work together to ensure safe care is provided, at a level broadly commensurate with that of junior trainee Doctors. The principle aim is to ensure resilience in our service delivery but it is also a means by which we will seek to optimise the local experience of trainees. Achieving this would be an exemplar model in a Scottish context and there are some strong local examples of innovation in this direction. The composite model is an essential element of the initial preferred options outlined below and a significant investment has already been made in the form of 10 Advanced Nurse Practitioner (ANP) roles. It will also involve other roles such as Physician Associates (PA), Prescribing Pharmacists and understanding the contribution of Midwifery and other existing staff.

4. Future demand for Maternity & Paediatric services

The sub-groups were provided with relevant demographic data and an understanding of how this had changed over the last decade. Future population projections were shared and these indicate a fairly static position over the coming years in relation to the populations aged 0-16 and of females aged 18-45. This is outlined in figure 1 and takes account of known population impact linked to any influx or otherwise relating to military families, which is particularly relevant in Moray.

Figure 1: Moray population projections



These projections show an increase in overall population in Moray of nearly 5% over the date range shown, but the position is stable for the most pertinent gender/age cohorts in this context.

5. Options appraisal

On the 21st of March 2019 an options appraisal session was held at DGH with 25 local stakeholders including public, staff and campaign group members with the aim of identifying preferred options for onward recommendation. A commonly-used methodology was adopted for enabling options to be compared against each other in the context of an agreed set of non-financial benefit criteria. These criteria have been included in table 1 below. This approach has previously been extensively used to good effect in a health context for appraising options ranging across capital infrastructure, service modelling or strategic priorities and enables a more objective assessment of options in a manner which leaves a clear governance trail. While no appraisal methodology could be argued to be perfect, this type of approach is routinely used in major projects and NHS Grampian has more experience than many Boards in this regard.

Table 1: non-financial benefit criteria

Criteria	Consideration
Builds on the current/interim service elements	Is it clear in terms of additional benefits, supports principles and parameters as per TOR, Maximises DGH provision of services, taking cognisance of needs/impact on other services
Evidence base	What evidence do we have to endorse the option, what data, what planning assumptions have been made
Safe	Describes a service that is safe and can be delivered within a reasonable timeframe
Sustainability of arrangements (Inc. Deliverable and Affordable)	How confident are we that the model/option can be sustained in the medium to longer-term?
Compliance with local/national policy	To what extent does the option align with national and local policy
Avoids unnecessary travel and promotes choice	Supports choices for women and families and reduces need for travel outwith Moray to access care
Supports innovation and new ways of working with Primary Care and/or regionally in future	Scope for future development in terms of technology enabled, new ways of working across NHS Board boundaries

These criteria were agreed at the commencement of the appraisal session and represent a distillation of a longer-list of decision making criteria which had been used in order to complete a detailed template for each potential option. A blank version of this template has been included at appendix 2.

The criteria were ranked by the group in terms of importance and subsequently weighted prior to each option being either scored or discounted on the basis that it was readily apparent that it would not fit with the objectives and principles of the phase 2 plan (see terms of reference at appendix 1). The ranked criteria can be viewed at appendix 3.

5.1. Initial preferred options from the appraisal

This section provides an outline of the initial preferred options which were arrived at through the appraisal exercise. These represent locally supported recommendations for further feasibility analysis, for example in terms of cost and deliverability. Appendix 3 contains further brief details regarding all of the options considered and scoring. It is not the intention of this document to attempt to replicate or convey the extent of detail available to the sub-groups and planning group, this is therefore appended in abbreviated form.

5.1.1 Paediatric option

Six options were identified and five were subjected to the rigour of the process, one having been discounted by the group on the basis of a lack of clear benefit or impact. Table 2 below provides an outline of the option that emerged as preferred.

Table 2: initial preferred paediatric model outline

Description
The implementation of a 24hr Short-stay Paediatric Assessment Unit at Dr Gray's, 7 days per week, with development of the interface with Primary Care
Key service elements
• Short-stay model of up to 24hrs, 7 days per week for assessment and management (admissions of >24hrs to be transferred to Royal Aberdeen Children's Hospital RACH) • Enhanced primary care paediatric nursing support • Children requiring High Dependency care will be transferred to RACH (as per previous service) • Children requiring Intensive care will be transferred to Edinburgh or Glasgow (as per previous service) • Allows for appropriate day surgery to retain e.g. ENT, Dental • Special Care Baby Unit (SCBU) provision is maintained (thus supporting key local obstetric service elements)
Benefits
• Reintroduces 24hr access to paediatric care/assessment at DGH • Minimises requirement to travel to RACH • Reduced need for Ambulance transfer inter-Hospital – benefitting local emergency ambulance provision • Meets phase 2 objectives in optimising local service delivery • Allows development of enhanced links with Primary Care and

community paediatric nursing support
- Has the potential to form a unique and exemplar model of care with potential recruitment and retention benefits
- Allows for appropriate day surgery to retain e.g. ENT, Dental
- Will carry high levels of public support
- SCBU provision maintained – this is essential for retaining elements of Obstetric care

Key risks and dependencies

- The Hospital-wide composite staffing model requires to be in place (reducing reliance on trainee Doctors)
- Timeline for implementation
- Assuring a minimum 1 in 6 Paediatrician on-call cover is required to support SCBU
- Requires development of revised clear clinical accords between DGH and RACH
- Requires financial support for Consultant expansion (business case submitted for 4 Consultant Paediatricians to be based at RACH, to contribute to DGH, as part of a larger cohort of individuals than has been attempted before e.g. on a minimum 1:6 basis)
- Requires financial support for 2 additional band 6 nursing posts and training costs for community paediatric nursing – (2 to train initially, then 1 per year thereafter)
- Recruitment & retention challenges – it is never possible to be 100% sure that recruitment will be successful, but there is some interest in the currently vacant DGH Paediatrician job, and positive discussions are being held with local trainees within Grampian)

5.1.2. Women's services option

Six options had been identified and all were scored during the appraisal exercise. It should be noted that all of the potential options for women's services included a retention of the pathway of Midwifery-led intrapartum care for appropriate women on a green pathway. This was regarded as highly important by the planning group, and there was no support for moving away from this. Table 3 below provides an overview of the preferred option for women's services.

Table 3: initial preferred women's service option

Description
Sustainable implementation of an Obstetric Unit at Dr Gray's with continued development and emphasis on Midwife-led care as appropriate, and expansion of Consultant numbers from 4 to 6.

Key service elements

- Continued emphasis of Midwifery-led intrapartum care for mothers on a green pathway
- Recommences Consultant-led intrapartum care for women on a red pathway (medium-risk, noting that higher-risk women have always been recommended to access care at Aberdeen Maternity Hospital (AMH)).
- Retains locally delivered day assessment
- Retains locally delivered Consultant-led antenatal care
- Retains Elective Caesarean Sections
- Restores Emergency Caesarean Sections/Instrumental delivery
- Retains full gynaecology service (with potential scope for extended day or 7 day working)
- Requires Consultant workforce expansion by 2 posts taking total to 6

Benefits

- Supports continued delivery and development of Midwifery-led care for appropriate mothers
- Promotes choice for mothers on a red pathway and restores Consultant-led intrapartum care where required
- Avoids unnecessary travel to AMH
- Reduced need for Ambulance transfer inter-Hospital – benefitting local emergency ambulance provision
- Negates need for intrapartum transfer to Raigmore Hospital and relieves some pressure on that system and Scottish Ambulance Service (SAS) also
- Meets phase 2 objectives in optimising local service delivery
- Creates resilient model of care with potential recruitment and retention benefits e.g. through reduced intensity of on-call
- High degree of public support expressed already
- Retains full Gynaecology service
- Increased scope to develop new ways of working with NHS Highland, in support of services across the North of Scotland
- Scope for extended day or 7 day working in support of Gynaecology waiting times

Key risks and dependencies

- The Hospital-wide composite staffing model requires to be in place (reducing reliance on trainee Doctors)
- Timeline for implementation
- Financial support for 2 additional Consultants
- Recruitment & retention potential
- Future ability to recruit candidates with combined Obstetric and Gynaecology abilities
- Potential fit with national Best Start policy vs expectations regarding promoting service access and choice at DGH

As outlined in appendix 3 figure 3.3, a further enhanced option was appraised which included the provision of an epidural service. On the basis of lower confidence in the deliverability of that option it did not outrank the option described above. Of key concern was the added requirement for recruitment to highly specialist medical roles (including up to 6 specialist Anaesthetic Consultant roles) and the additional need for middle grade trainee (or equivalent) presence.

5.2. Timeline, recruitment and retention

The delivery of both of these options is subject to the approval of the NHS Grampian Board. In terms of timeline, they are significantly reliant on the implementation of the composite workforce referred to above, and require degrees of investment in substantive posts and training. It is known that key elements of this composite model will not be in place until December 2019.

As noted above, it is not possible to predict with 100% certainty the prospect that such posts will be recruited to. However, these represent opportunities for essential innovation, new models of working and improved resilience. At an informal level, a number of colleagues have expressed their interest in these new roles, including those requiring working between RACH and DGH. Also, key prior learning will be paid heed to such that these roles are configured in a more sustainable way than in previous attempts. For example, where split site roles have been implemented before, these have been on an intensive (50:50) split basis and staff feedback has been listened to with regard to the challenges that has posed. Where split site roles are recommended within this document they are envisaged as part of wider cohorts of e.g. four or more staff working across sites with less frequency and intensity than would have been the case previously.

6. Governance and approvals

A straightforward governance structure was determined to be that a reporting link was established between sub-group and planning group, and thereafter with the Senior Leadership Team (SLT) of NHS Grampian. It was established that the function of the planning group was to make recommendations to the SLT and

ultimately to the Board of NHS Grampian, where decision-making responsibility rests.

A seminar was held with the Board of NHS Grampian on the 4th April and a presentation was given outlining the outcomes from the process so far. This included discussion of the initial preferred options described above and a question and answer session including clinical representation from DGH. The Board expressed high levels of support and endorsement for the process outlined and the direction set by the options described. Understandably, there was recognition of the need to conduct further important work regarding feasibility and in relation to key dependencies and workforce planning. The Board were also very supportive of seeking feedback from the Cabinet Secretary at this stage.

7. Public consultation

Throughout the process outlined above, we have maintained close links with the Scottish Health Council (SHC) via our Communication and Engagement sub-group and its Chair (NHS Grampian Public Involvement Manager). The SHC has expressed that they are happy with the process outlined and that those options highlighted above are considered not to constitute major service change. The SHC has also recommended that an informing exercise only, with staff and public, would be required with regard to the described maternity/obstetric model. However, they have recommended some more engagement work with regard to the paediatric model described and a continuation of both the communication and engagement group and that it takes on a more focused role and membership around the paediatric services.

8. Links with NHS Highland

Further to the preliminary business case developed by NHS Highland there has been further discussion between the Chief Executives and Medical Directors of the two Boards and it is anticipated that further development work will be jointly undertaken. The timeline for Raigmore Hospital to be in a position to assist Dr Gray's as a birthing location for mothers on a red pathway is likely to be prolonged given infrastructure and workforce challenges at that site. This falls out with the available

time frame for the preparation of this draft plan. It is important to acknowledge that dialogue is ongoing with NHS Highland regarding the future opportunities and requirements for e.g. joint appointments where this may aid recruitment, retention and sustainability overall. Both Boards are positively disposed in this regard.

9. Key Next Steps

The following provides a broad outline of next steps required and/or underway:

- Further feasibility analysis
- Development of composite staffing model
- Providing summary feedback to local DGH W&C planning group
- Submission of draft to the Cabinet Secretary by week beginning 8th April seeking feedback
- Responding to SG/Cabinet Secretary feedback
- Continuation of DGH planning group and communications group
- Developing implementation plans
- Public consultation initiatives to commence in April (timeline subject to Cabinet Secretary feedback)

10. Concluding remarks

This draft plan outlines the locally mounted response to determine safe and sustainable service models for Women and Children's services at Dr Gray's over the medium to longer-term. It conveys the process, structure and approach followed which was significantly led by local clinical colleagues, with the benefit of robust staff, public, campaign group and staff partnership representation.

The options outlined reflect the findings of the planning and sub-groups and are presented as recommended service models at this stage. The Board of NHS Grampian has expressed a high degree of support for the process and the options described herein, although it is acknowledged that a degree of further feasibility analysis is required. This work is underway and we will continue to build on our links with our stakeholders in Moray, the public and with colleagues and advisors at Scottish Government. We acknowledge the support from the many people who

have helped progress matters to their current stage, and in anticipation of their ongoing collaboration.

Appendix 1 – Terms of Reference

Dr Gray's Hospital – Women & Children's Services

Phase 2 Planning Group

Terms of Reference

Release: V1.3

Date: 11th February 2019

Purpose

The Dr Gray's Hospital Women & Children's Services Planning Group has been formed to ensure the development of a locally deliverable and sustainable plan for Women & Children's services in the medium to longer term.

This group will respond to the request made by the Cabinet Secretary for Health and Sport to develop a second phase of service planning and delivery beyond the recent efforts to stabilise services in the short term.

Principles and parameters

- There will be a focus on optimising the provision of care locally within DGH
- No assumption can be made that additional financial resource will be made available
- Any preferred models of service delivery shall be in alignment with local and national clinical strategy
- Workforce planning and availability will be central to the feasibility of any options
- Local commitment, clinical and managerial leadership, and the identification and ownership of potential solutions will be key to success
- Options for service delivery will be objectively appraised
- There will be comprehensive stakeholder input into the development of the plan
- The planning group will commission short life working groups or nominate an individual from within their membership to address specific issues or workstreams and to report progress and outcomes from these to the Planning Group.
- Planning will primarily focus, in the first instance, on the development of a sustainable plan for the next 2-3 years of service development

Aims

This group is responsible for developing the phase 2 combined Women & Children's service plan for DGH

- To work in collaboration with Stakeholders and Scottish Government officials in the development of the plan
- To take cognisance of the ongoing review of child health services work across NoS
- To articulate a stable service provision and provide a basis for development and progression of the wider Moray Alliance child health agenda
- To provide assurance to the Health & Social Care Partnership and NHS Grampian Senior Leadership Team as to the development and direction of the plan

- To ensure effective engagement, communication and partnership working (internal and external)

Ground rules

In order to successfully deliver the phase 2 plan within the time frames agreed with Scottish Government, and to build confidence and commitment in the services at DGH, the group will observe the following:

- People will be listened to respectfully
- Confidentiality will be maintained as to the developing plans, and draft materials. The premature sharing of such materials may give rise to unnecessary concern among public, patients and staff. Therefore these will be shared only with the agreement of the group.
- Group members will arrange for attendance by an appropriately informed deputy where required

Core Membership

Core membership comprises the following members:

Organisational Role	**Name**
Divisional General Manager – Women and Children	Sue Swift (Co-Chair)
Consultant Paediatrician	Shelagh Parkinson (Co-Chair)
Consultant Obstetrician	Mostafa Ali
Chief Nurse – Paediatrics	Caroline Clark
Hospital General Manager - DGH	Alasdair Pattinson
Divisional Clinical Director – Dr Gray's	Jamie Hogg
Senior Planner	Neil Strachan
HR Manager	Karen Innes
GP Lead	Lewis Walker
Workforce Planner	Caron Thompson
Health Intelligence	Pauline Maloy
Unit Operational Manager	Hazel Whyte
Scottish Ambulance Service	Euan Esslemont
Chief Midwife	Jane Raitt
Partnership Representative	Steven Lindsay
Public/MPLSC reps	Joanna Abbott, Laura Tytler, Marj Adams
Senior Charge Nurse	Erin Mackenzie
Senior Charge Midwife	Tracy Stronach
Divisional Clinical Director – W&C	Tara Fairley
Unit Clinical Director – Children's	Hugh Bishop

Non-Core Membership

In addition to the core membership, the group will adjust membership depending on its current priorities.

Meeting Frequency

- Fortnightly
- Duration: 1 hour 30 mins maximum
- Location: DGH

Meeting Arrangements

Chair: The meeting will be co-chaired by Sue Swift Divisional General Manager and a local clinician. The Chairs will be responsible for ensuring the recording of formal minutes, and which will be shared as soon as reasonably possible.

Meeting: Attendance in person at all meetings is encouraged. Video-conferencing will be made available wherever possible to support the participation of members unable to travel. Additional attendees may be invited to attend by the Chairs, in accordance with the agenda subject matter. Additional meetings may be convened to consider urgent matters and e-mail communication will be used where responses and decisions are needed within a shorter timescale.

Quorum: All Planning Group members should identify a deputy to attend in the event of their anticipated absence or non-availability for any reason. The Chairs will have final decision as to whether the meeting progresses or there are sufficiently representative views in attendance.

Agenda and papers: Agenda items will be given in advance of the meeting. Steering Group attendance will be recorded. In the event of a member being unable to attend, apologies for their absence together with the name of a deputy appointed to attend on their behalf should be notified as soon as possible in advance of the meeting to the Chair.

Minutes and actions: All meetings will be minuted, and will contain a list of actions and decisions. The minutes will usually be circulated within one week of the meeting. After the conclusion of each meeting, a copy of the actions and decisions will be logged and held in accordance with the document management methodology.

Changes to the Terms of Reference: Changes to the Terms of Reference (ToR) and functions of the Steering Group may be proposed at any meeting of the Steering Group, with due notice of the proposed change having been given on the agenda of the meeting.

Appendix 2 – Template – decision making aid – complete for every option for consideration by planning group

Option title: XXXXXXX

Option description: (This should be a factual and objective description of service model and what will/will not be provided. What are workforce implications, how does this option differ from the others, how does it impact on other services, what does it enable etc…)

Specifically draw out workforce, other resource/financial implications here:

Complete table (referring to notes appended)

No	Consideration	Impact	Benefits	Risks	Comments
1.	Phase 2 Objectives				
2.	Affordable				
3.	Data (evidence or assumptions)				
4.	Technological / Digital Health				
5.	Escalation protocols or clinical accords required				
6.	Deliverability				
7.	Workforce				
8.	National / Local policy				
9.	Implications for other Hospital services				
10.	Implications for community services				
11.	Demonstrating patient at centre and good governance				
12.	Other risks and				

	dependencies				
13.	Equality Impact Assessment				

Decision-making considerations and basis for option appraisal (not ranked)

1. Phase 2 objectives – does the option deliver on the objectives of phase 2 and if not does it provide flexibility and scope for delivering these in future e.g. through future regional working arrangements
2. Affordable – can the option/model be delivered within existing resource? If not – what would be required and is that feasible, available (e.g. in terms of workforce)
3. Data – what planning assumptions are we making about future demand?
4. Technology/Digital Health – how might technology enable the option/model, are there any major technological developments anticipated ahead that may change how the service is delivered?
5. Escalations and/or clinical accords – are we clear what needs to be in place in this regard?
6. Deliverable – Have we considered whether Equipment, Infrastructure issues impact on the deliverability, can the option be delivered within acceptable timeline (an acceptable number of months not years)
7. Workforce – Do we have or are we developing the WF required to deliver?
8. National and local policy – How do our proposals support these?
9. Implications for other hospital services
10. Implications for community services
11. How do we demonstrate patient centredness and good governance?
12. Risks and dependencies – what are the risks of proceeding with this model, or not, and what is it dependent upon – e.g. training, engagement, support from the Board, investment, new equipment
13. EQIA – Equality Impact Assessment – this can be conducted for us by in-house NHSG staff

Appendix 3 – Option appraisal – additional information

Figure 3.1: Benefit criteria and group ranking in order of importance

Criteria	Consideration	Ranking
Builds on the current/interim service elements	Is it clear in terms of additional benefits, supports principles and parameters as per TOR, Maximises DGH provision of services, taking cognisance of needs/impact on other services	7th
Evidence base	What evidence do we have to endorse the option, what data, what planning assumptions have been made	3rd
Safe	Describes a service that is safe and can be delivered within a reasonable timeframe	1st
Sustainability of arrangements (Inc. Deliverable and Affordable)	How confident are we that the model/option can be sustained in the medium to longer-term?	2nd
Compliance with local/national policy	To what extent does the option align with national and local policy	4th
Avoids unnecessary travel and promotes choice	Supports choices for women and families and reduces need for travel outwith Moray to access care	6th
Supports innovation and new ways of working with Primary Care and/or regionally in future	Scope for future development in terms of technology enabled, new ways of working across NHS Board boundaries	5th

Figure 3.2: Paediatric options and scoring

Brief description	Comments	Score / benefit points
1. Status quo – current interim ambulatory model only	Not considered to be in accordance with objectives/principles – scored only to provide benchmark	406
2. Status quo – ambulatory model plus developed interface with primary care		486

3. 24hr Short-stay Paediatric Assessment Unit (SSPAU) Mon-Fri, 0800-2200 Sat and Sun plus developed interface with primary care	2nd highest scoring	640
4. Ambulatory model only, but up to 12 midnight	Discounted given lack of obvious benefit	NA
5. 24hr Short-stay Paediatric Assessment Unit (SSPAU) 7 days, plus developed interface with primary care	Initial preferred option	706
6. 24 hour ward as per prior to service change		533

Figure 3.3: Women's service options and scoring

Brief description	Comments	Score / benefit points
1. Community Maternity Unit (CMU) intrapartum care only, midwifery-led care for green pathway mothers only. Does not support local birthing for red pathway mothers.	Not considered to be in accordance with objectives/principles – scored in the interest of thoroughness. The implications for Gynaecology services were cited	476
2. Per current interim service model – midwifery-led intrapartum care for green pathway mothers only. Consultant-led antenatal care and elective caesarean sections. Does not support local birthing for red pathway mothers. Existing Gynaecology service maintained.		478
3. Obstetric unit – with existing number of Consultants (4). Retaining midwifery led care and recommencing Consultant led local intrapartum care for mothers on a red pathway. Existing Gynaecology service maintained.	2nd highest scoring option	646
4. Obstetric unit – with expansion to 6 Consultants. Retaining midwifery led care and recommencing Consultant led intrapartum care for mothers on a red pathway. Increased resilience for on-call provision and scope to work in new ways with NHS Highland ahead. Existing Gynaecology service	Initial preferred option	662

maintained.		
5. Enhancement of Obstetric unit service with 6 Consultants. Retaining midwifery led care and recommencing Consultant led intrapartum care for mothers on a red pathway. Increased resilience for on-call provision and scope to work in new ways with NHS Highland ahead. With addition of an Epidural service. Existing Gynaecology service maintained.	Deliverability concerns noted – particularly given requirement to recruit tier of specialist obstetric anaesthetists (approx. 6) and middle grade tier implications.	613
6. Enhanced Community Maternity Unit – with booking for green pathway mothers, no DGH booking of red pathway mothers but Consultant intervention in intrapartum care to avoid transfers. Does not support local birthing for red pathway mothers. Existing Gynaecology service maintained.		547

NHS Grampian

Dr Gray's Hospital – Phase 2 Plan for Obstetric and Paediatric Services

Recommendations

1. The System Leadership Team (SLT) of NHS Grampian has considered the phase 2 plan for the future delivery of obstetric and paediatric services for the women and children of Moray. This is being taken forward in the context of the wider development of Dr Gray's Hospital as a modern District General Hospital (DGH) placed within a wider network of services across Grampian and the North of Scotland. It is recommended that the NHS Grampian Board:

    - Notes the obstetric and paediatric service proposals which have been formulated through engagement with public representatives and staff

    - Acknowledges the benefits and risks associated with delivering and sustaining the proposed services and supports ongoing assessment to ensure that the proposals can be delivered in a safe and sustainable way

    - Supports progression of the paediatric service plan, including further assessment of the requirements of the emergency department, with engagement and phased recruitment progressing in parallel. An update will be provided to the Board seminar on 5 September 2019

    - Requests an update on the risk mitigations which need to be addressed before further progress of the obstetric service at the Board meeting on 1 August 2019.

    - Requests an outline description of the future profile of Dr Gray's Hospital as a modern DGH at the Board meeting on 1 August 2019.

Strategic Context

2. Dr Gray's Hospital plays an essential role in the delivery of services for the population of Moray and west Aberdeenshire. Like other hospitals, its role has responded to changes in clinical practice and technology and this will continue as the hospital develops as part of wider networked pathways of care within the North of Scotland.

3. The proposals related to obstetric services and paediatrics are consistent with the ambition for Dr Gray's Hospital, the Grampian Maternity Services Strategy approved by the NHS Grampian Board in 2013, the Child Health 2020 strategy, and national strategies and policies relating to women and children's services. A key strategy that needs to influence the further development of obstetric and neonatal services is the national "Best Start" strategy which is currently being taken forward in NHS Grampian and other NHS Boards.

4. The key consideration for NHS Grampian for all services is to ensure that they can be delivered in a safe and sustainable way.

Issues Relevant to the Recommendations

5. Appendix 1 includes extracts from the phase 2 plan and sets out a summary of the obstetric and paediatric proposals. The full plan is currently available to the public and can be obtained here: DGH Phase 2 Plan. The proposals have been prepared with the involvement and engagement of staff and public representatives, including Keep MUM, and the Scottish Government. The proposals were considered by the Board with the support of Moray based clinicians and managers at a Board seminar session on 4 April 2019. The benefits of the plan are summarised below:

    - The retention of patient centred services at Dr Gray's Hospital with reduced requirement for travel and transfers from Dr Gray's to Aberdeen or Inverness

    - Promoting choice for Moray women and families, e.g. to birth at home, in a local Midwifery-led unit, a local consultant led unit or a regional tertiary centre when more complex care may be required

    - Future-proofing of services in alignment with the DGH role

    - Meeting public, staff and political expectations

    - More attractive, resilient and sustainable on-call arrangements for staff

    - Improved compliance with Royal College of Paediatrics and Child Health (RCPCH) 'Facing the Future' standards of care when compared with the previous models

    - Reduced reliance on locums

    - Significant benefit in Paediatrician sessional input to Dr Gray's and Royal Aberdeen Children's Hospital (RACH) as part of the investment case

    - Improved training opportunities for junior medical staff, with reduced out of hours commitments and more priority focus afforded to the educational experience

    - Exemplar models of advanced practice Midwifery, Paediatric Nursing and development of an innovative interface between Primary and Secondary Care in Paediatrics

6. Appendix 2 summarises the key risks of the overall plan that have been identified following the engagement process.

7. The direct recurring costs associated with the obstetrics and paediatrics proposals are currently estimated at £2m. The estimated expenditure on wider Dr Gray's Hospital services necessary to sustain the obstetrics and paediatrics proposals is estimated at £1.7m. This includes investment in anaesthetics and the emergency department (ED) and will also contribute to the wider role of the hospital as a modern DGH. The costs will be further reviewed taking account of the issues outlined in appendix 2.

8. The proposals will be further progressed as follows:

a. The Cabinet Secretary is content for NHS Grampian to embark on the planned engagement/consultation process on children's services at Dr Gray's. This will commence from the end of June until September 2019 to ensure that further advice and guidance is available.

b. The initial phase of the recruitment process for paediatrics will commence with immediate effect to ensure that opportunities to make appointments can be taken.

c. The paediatric co-dependencies with the emergency department will be further explored in parallel with the engagement process.

d. Engagement with Dr Gray's Hospital clinicians has resulted in a common understanding of the risks related to the re-introduction of consultant led intrapartum care for women with moderate risk factors in pregnancy, and the subsequent potential for emergency interventions. This will result in a further assessment of the risks and the formulation of mitigation plans in collaboration with staff and public representatives.

Responsible System Leadership Team Member

Pam Gowans
Chief Officer, Moray Health and Social Care Partnership
Strategic Lead, Dr Gray's Hospital
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June 2019

Appendix 1 – Summary of Proposed Models

Obstetric Services (Extract from Phase 2 Plan)

Description
Sustainable implementation of an Obstetric Unit at Dr Gray's Hospital with continued emphasis on Midwifery-led care, does not include Epidural service, and requires expansion of Consultant numbers from 4 to 6.
Key service elements
• Continued emphasis of Midwifery-led intrapartum care for mothers on a green pathway • Recommences Consultant-led intrapartum care for women on a red pathway (medium-risk, noting that higher-risk women have always been advised to book to give birth at Aberdeen Maternity Hospital). • Retains locally delivered day assessment • Retains locally delivered Consultant-led antenatal care • Retains Elective Caesarean Sections • Restores Emergency Caesarean Sections/Instrumental birth • Retains full gynaecology service • Does not include Epidural service • Requires Consultant workforce expansion by 2 posts, taking total to 6 • Requires investment in Midwifery roles and training
Benefits
• Supports continued delivery and development of Midwifery-led care for appropriate mothers • Promotes choice for mothers on a red pathway and restores Consultant-led intrapartum care where required • Avoids unnecessary travel to AMH • Reduced need for Ambulance transfer inter-hospital – benefitting local emergency ambulance provision • Negates need for intrapartum transfer to Raigmore Hospital and relieves some pressure on that system and Scottish Ambulance Service (SAS) also • Meets phase 2 objectives in optimising local service delivery • Creates resilient model of care with potential recruitment and retention benefits e.g. through reduced intensity of on-call • High degree of public support expressed • Retains full Gynaecology service • Increased scope to develop new ways of working with NHS Highland, in support of services across the North of Scotland • Scope for extended day or 7 day working in support of Gynaecology waiting times
Key risks and dependencies
• The Hospital-wide composite staffing model requires to be in place (reducing reliance on trainee Doctors) • Timeline for implementation • Financial support for 2 additional Consultants and Midwifery posts • Recruitment & retention potential

- Future ability to recruit candidates with combined Obstetric and Gynaecology abilities
- Potential fit with national Best Start policy versus expectations regarding promoting service access and choice at Dr Gray's Hospital

Paediatric Services (Extract from Phase 2 Plan)

Description
The implementation of a 24hr Short-stay Paediatric Assessment Unit at Dr Gray's, 7 days per week, with development of the interface with Primary Care

Key service elements

- Short-stay model of up to 24hrs, 7 days per week for assessment and management (admissions of >24hrs to be transferred to Royal Aberdeen Children's Hospital (RACH)
- Enhanced primary care paediatric nursing support
- Children requiring High Dependency care will be transferred to RACH (as per previous service)
- Children requiring Intensive care will be transferred to Edinburgh or Glasgow (as per previous service)
- Allows for appropriate day surgery to retain e.g. ENT, Dental
- Special Care Baby Unit (SCBU) provision is maintained (thus supporting key local obstetric service elements)

Benefits

- Reintroduces 24hr access to paediatric care/assessment at Dr Gray's Hospital
- Minimises requirement to travel to RACH
- Reduced need for ambulance transfer inter-hospital – benefitting local emergency ambulance provision
- Meets phase 2 objectives in optimising local service delivery
- Allows development of enhanced links with Primary Care and community paediatric nursing support
- Has the potential to form a unique and exemplar model of care with potential recruitment and retention benefits
- Allows for appropriate day surgery to retain e.g. ENT, Dental
- Will carry high levels of public support
- SCBU provision maintained – this is essential for retaining elements of Obstetric care

Key risks and dependencies

- The Hospital-wide composite staffing model requires to be in place (reducing reliance on trainee Doctors)
- Timeline for implementation
- Assuring a minimum 1 in 6 Paediatrician on-call cover is required to support SCBU
- Requires development of revised clear clinical accords between Dr Gray's Hospital and RACH
- Requires financial support for Consultant expansion (business case submitted for 4 Consultant Paediatricians to be based at RACH, to contribute to Dr Gray's Hospital, as part of a larger cohort of individuals than has been attempted before e.g. on a maximum 1:6 basis)
- Requires financial support for additional paediatric nursing roles
- Recruitment & retention challenges

Appendix 2 – Key Risks

1. **There is a risk that the proposed plan to re-establish a consultant led intrapartum model of care with provision for operative vaginal birth and emergency caesarean sections at DGH is not configured in line with national guidelines for maternity services.**
   Whilst it is clear that the Dr Gray's Hospital obstetric consultant and midwifery teams have worked collaboratively to produce a plan that they fully support there remain some significant concerns that require exploration, resolution or mitigation. Firstly, the proposed model does not include an epidural service which would be considered to be an essential component of a contemporary obstetric led service. Lack of access to an epidural service may also increase the use of opiate analgesia in labour which can have an impact on the condition of the neonate at birth. Secondly, the current model does not provide any out of hours resident obstetric trained medical staff, but relies on consultants on call from home. There are no obstetric specialist doctors in training at Dr Gray's Hospital. This means that, overnight, women in labour ward and in Ward 3 with antenatal or postnatal complications do not have immediate access to a specialist level of obstetric doctor. Thirdly, the overall number of moderate level risk births and caesarean sections would potentially provide insufficient experience for increased numbers of obstetric medical staff to maintain competencies

2. **There is a risk that the proposed plan is not supported by an adequate and sustainable anaesthetic service.**
   The phase 2 plan has been developed with anaesthetic input but a number considerations have led the local anaesthetic team to identify that their current service model is not suitable to support a consultant level obstetric service. Overall anaesthetic consultant capacity has been recently reduced by increased consultant vacancies and to a further degree following the establishment of the North Emergency Medical Retrieval Service. Recruitment has been difficult and the service is dependent on locum support. Workload analysis has also identified a very high night-time activity rate for the out of hour's anaesthetic consultant service (30-50% call rate) and a high rota frequency (1 in 3.5). In light of this there is a need for significant additional expansion in suitability trained staff (at least 6 additional consultants + other clinicians) on a dedicated resident out of hour's rota providing dedicated support to the obstetric team.

3. **There is a risk that the proposed 'composite workforce' plan does not provide sufficient resilience against the doctors in training workforce shortfall.**
   The development of a multi-professional team to provide support is not yet mature enough to be assured that it will mitigate the expected shortfall in trainee recruitment.

4. **There is a risk that the wider engagement process related to the paediatric service model identifies unrecognised issues.**
   The paediatric model proposed in the phase 2 plan has had strong endorsement from those involved in the service, co-dependent services and stakeholders involved in the options appraisal. Wider engagement is due to commence and this may identify concerns not yet considered.

5. **There is a risk that the Emergency Department is unable to support the transition of the paediatric service to the new model.**
   The Paediatric Model is dependent on our Emergency Department (ED). There is full commitment to support this plan but current staffing pressures are significant and require resolution.

6. **There is a risk that neonatal and paediatric airway management is not comprehensively supported at all times.**
   The Paediatric Model is dependent on training a number of staff groups to manage the neonatal and paediatric airway in an emergency situation. Whilst training has been undertaken provision of comprehensive cover will required further training and a programme of training for all new staff involved in this situation.

7. **There is a risk that the 'Doctors in Training' programme in Dr Gray's Hospital does not provide an attractive trainee experience which encourages higher fill rates or does not meet NHS Education Scotland expectations.**
   The initial difficulties in Dr Gray's Hospital were in part due to low fill rates of the GP training scheme based there. When fill rates are low the training experience can be compromised. It is essential that the new model develops an environment that enhances training and is resilient to low fill rates.

8. **There is a risk that recruitment to the large number of new posts may be unsuccessful or only partially successful.**
   Workforce supply and recruitment difficulties have been a long standing issue at Dr Gray's Hospital. Supply issues remain difficult and the success of the current model depends on attracting new staff to choose to come to work in a new model which is yet to start. Furthermore a failure to recruit may lead to more loss of staff in the face of workload pressure on a small workforce.

9. **There is a risk that restarting services will be delayed until a critical number of staff have joined the new service.**
   Workforce is critical to the success of these new models and partial recruitment may be insufficient to start the proposed service and may generate pressure to appoint locum staff to bridge the gap. This creates potential safety issues and high cost.

Board Meeting
07/11/19
Open Session
Item 4

NHS GRAMPIAN

Dr Gray's Women & Children's Service – Phase 2 Plan Progress Update

The Board has previously considered the Phase 2 plan for the future delivery of obstetric and paediatric services for the women and children of Moray. After its meeting on 25 June 2019, the Board requested an update on progress.

1. Actions Recommended

This paper provides that update and it is recommended that the Board:

- Notes the significant progress toward the implementation of the paediatric service model in accordance with our anticipated timeline
- Recognises the maintained success of the current interim midwifery-led service
- Considers the potential risk associated with the current interim position of consultant involvement in a midwifery-led unit, altering the risk profile of the women cared for in that setting
- Considers the risk associated with seeking to introduce a non-standard future consultant-led service model
- Acknowledges the growing challenge to the timeline for delivery of April 2020 for obstetric services
- Agrees to receive a further update on progress at the December Board 2019

2. Strategic Context

The proposals in the Dr Gray's Phase 2 plan are consistent with the Grampian Maternity Services Strategy approved by the NHS Grampian Board in 2013, the Child Health 2020 strategy, and national strategies and policies relating to women and children's services. A further key strategy that needs to influence the development of obstetric and neonatal services is the national 'Best Start' strategy which is currently being taken forward in NHS Grampian and other NHS Boards.

Further pieces of work may influence the future shape of obstetric service provision. An independent review into obstetric care in Dr Gray's was commissioned by NHS Grampian in spring 2019 and is expected to report in November 2019.

Nationally, there are plans to develop a country-wide maternity network as part of the 'Best Start' arrangements and from a paediatric perspective, a review of child health services is underway across the north of Scotland Boards. We are linked in to these pieces of work.

3. Key matters relevant to recommendations

During 2018, for safety reasons, interim and reduced models of service were adopted in obstetric and paediatric care. An initial 'Phase 1' plan was developed and submitted to the Scottish Government, this was focused on immediate stabilisation and service continuity. The work required of the Phase 2 plan was to determine a medium to longer term sustainable future for these services, which optimised local service delivery. An inclusive process was put in place which delivered two preferred

options, in the form of the Phase 2 plan, which was submitted to the Scottish Government and made publicly available in April 2019.

The proposed model for obstetric care has been recognised as non-standard in that it would restore a level of consultant-led intrapartum care and continue midwifery-led care to enhance local delivery of services, but would not deliver all the features of a full consultant level obstetric service.

At its meeting on 25 June 2019, the Board considered a number of risks linked to the delivery of the Phase 2 plan. The risks that were presented to the Board were developed and agreed with Dr Gray's clinical staff and considered through the local Planning & Implementation process for Women & Children's services. The local oversight group continues to meet, taking forward necessary actions and communication required. These risks were also shared and discussed with Scottish Government officials, with whom we continue to work closely in the planning and development of these important services.

4. Risk Mitigation

The Phase 2 Plan sets out a position which aims to balance risk. For example, between having no consultant-led obstetric service and a service which is in-line with that which might be delivered in a larger centre i.e. a full obstetric service. The concerns which were discussed at the 25 June Board meeting provided an analysis of the risk associated with this approach. To further enable the Board to consider the recommendations of this paper the following points are offered:

- In relation to paediatrics, significant progress has been made. The public consultation on the paediatric model has concluded and the report is undergoing due diligence. The feedback is supportive of us moving forward with implementing the proposed model in line with our anticipated timeline of April 2020. There is no longer considered to be a risk that engagement regarding the model will unearth any new concerns previously not identified. The main issues raised were in relation to clarity regarding the function of the proposed assessment unit model and we are confident that we can address concerns as we refine the model ahead.
- Recruitment to the new paediatric posts is underway. We are confident in our ability to appoint to these roles through a combination of retaining local trainees and expression from external interested parties. The posts are expected to be appointed to by February 2020.
- Delivering any consultant-led service requires a certain minimum capacity, which in smaller centres is often driven by the need to staff out-of-hours emergency on-call arrangements. Modern standards for this require bigger teams than were required previously. Typically, the out-of-hours on-call arrangements require a minimum of six doctors on a rota in order to achieve an acceptable level of frequency and intensity. The preferred options for service delivery that were outlined in the Phase 2 plan were selected on the basis of risk and deliverability, in the knowledge that a degree of compromise was implicit e.g. not providing an epidural service, which would be commonly regarded as an essential feature and is therefore a risk not fully mitigated for within our proposals. Neither do we propose to introduce a model of resident obstetric medical staffing, which also presents a degree of risk. The maintenance of consultant staff skills can be

mitigated for through rotational arrangements where there may be concerns regarding low volumes of activity.

- Within any hospital, the anaesthetic service is critical to enabling many systems to work. In Dr Gray's Hospital, as the profile of the workforce has changed over time, the requirement for the anaesthetist to provide senior medical opinion, out-of-hours, for sick patients has increased. These changes place ever increasing demands on the anaesthetic service, and we are aware that to support the return to a consultant-led obstetric service would demand a significant increase in the workforce of anaesthetists. This risk is being mitigated by providing planning capacity to develop a clinically-led and detailed work programme to establish potential sustainable solutions for anaesthetics in Dr Gray's Hospital, with cross-system benefits. This work will involve many stakeholders and relates to regulatory and educational frameworks. As such it is unlikely to be delivered at pace. The lack of resident obstetric doctors places additional risk considerations upon the anaesthetic service.
- The risk profile has improved in terms of trainee doctor gaps in the Emergency Department (ED) and their support has been expressed for the proposed model. Although workforce challenges remain, we are optimistic that risks can be further mitigated this winter through enhancing the paediatric nursing support to the ED, linked to recent successful recruitment efforts.
- The Board was advised regarding a risk linked to Dr Gray's ability to ensure appropriate arrangements were in place for neonatal and paediatric resuscitation. However, this has progressed and is no longer considered a risk as a result of comprehensive on-call support from consultant paediatricians, training and confirmation of staff competencies via our management structures.

5. Responsible System Leadership Team Member and contact for further information

If you require any further information in advance of the Board meeting please contact:

Responsible System Leadership Team Member	Contact for further information
Pam Dudek Chief Officer, Health and Social Care Moray (HSCM) Pamela.Dudek@moray.gov.uk	Neil Strachan Head of Transformation, Health and Social Care Moray (HSCM) neil.strachan@nhs.net

31 October 2019

Appendix 6
Dr Gray's Terms of Reference

Terms of reference for service level review of patient safety concerns within maternity and newborn services at Dr Gray's Hospital, Elgin

NHS Grampian seeks to commission a review of the maternity and newborn services provided by Dr Gray's Hospital prior to the change to the current service model. The period identified for review is 1st July 2017 to 30th June 2018; and up to present day.

The primary purpose of the review is to address safety concerns held by the medical and midwifery management team responsible for the governance and delivery of the service; but not shared by Obstetric staff at Dr Gray's hospital.

There have been longstanding concerns around adherence of the service to NHSG wide clinical pathways, protocols and governance procedures. In addition there have been intermittent concerns with clinical practice and outcomes; these were heightened with the publication of the National Maternity and Perinatal Audit (NMPA) report in November 2017. This report highlighted that Dr Gray's hospital was an outlier for the number of babies born in the unit between 1st April 2015 and 31st March 2016 with APGAR scores <7 at 5 minutes of age. The unadjusted and adjusted rates were 2.9% and 3.1% respectively against a national mean of 1.2%.

These cases initially underwent local review in Dr Gray's Hospital, but unfortunately this failed to highlight a number of significant concerns with clinical practice that were subsequently identified when the cases under went further multi professional review by a team including staff from Aberdeen Maternity Hospital. This further review followed escalation of the outlier report to the NHSG clinical governance committee.

This discrepancy in findings led to previously agreed, but incompletely implemented, regional risk management policies being strictly enforced by the medical management team. Unfortunately review of cases of low APGAR score occurring in February and March 2018 (and subsequent to this) contained similar concerning features pertaining to intrapartum care to those highlighted in the NMPA report, suggesting that these problems were not exclusively historic in nature.

These ongoing concerns were escalated by the local management team to senior management colleagues. Following consideration of how best to address these concerns and aware of the fact that the local team dispute there are any safety issues to address, a decision was taken to proceed with this independent review.

The aims are to investigate concerns relating to patient safety. Specifically, these are:

- Review the outcomes for mothers and babies occurring during this time and determine if there is evidence that the standard of care was different from other NHS services on indicators derived from routine data

- Assess and make findings as to the ability of the service to deliver consultant led maternity care in line with current maternity and neonatal best practice, and considering essential support services, such as anaesthetics, in this process

- Review the scope of practice of medical and midwifery staff within the unit and comment on any structural or cultural factors influencing this. Specifically, is there evidence to suggest that the Midwifery team inappropriately undertook or were encouraged to undertake high risk intrapartum care without appropriate medical review and input regarding decision making

- Review the service's adherence to agreed NHSG governance processes both within DGH and the wider context of the W&C service in AMH in response to investigating complaints and critical incidents. This should include the process for responding to national reporting frameworks such as MBRACCE and EBC

- Review the service's responses, and any subsequent actions taken, following receipt of the outcomes of level 1 and level 2 reviews of significant incidents, and national outcome data, such as NMPA and MBRACCE reports. Specifically, were the recommendations of any adverse event review process shared with the wider multi professional team and implemented in a supportive manner without discrimination

- Review complaints received and Ombudsman cases during this period, and identify any themes, and the communication of learning from complaints within the service

- Review the multidisciplinary service contribution to the maternity patient safety agenda, the identified quality priorities and the progress achieved

The review team is asked to inform the commissioners

1. If there are lessons to be learned for the service to secure the delivery of high quality care as recommended in 'The Best Start'
2. If there are lessons to be learned regarding whether specific changes to structure or practice are required to achieve outcomes compliant with modern standards
3. If any further investigation is required and whether such an investigation should focus on professional conduct or capability or both

Dr Gray's Maternity Hospital Services Review

DECEMBER 2019

PROFESSOR ALAN CAMERON

Dr Gray's Hospital Maternity Services Review

This version of the report into the findings of the externally-led review into maternity services at Doctor Gray's Hospital, Elgin, is one of two versions of the report provided to the Board of NHS Grampian by the review team.

The second version of the report includes additional narrative sections concerning the meetings held with small teams at the hospital. That version of the report will not be disclosed.

Some small redactions have been made below to reduce the likelihood of the inappropriate release of personal data. These are marked in black. A small number of insertions, marked with square brackets, have also been made alongside some of the redactions to assist the reader.

2 December 2019

Dr Gray's Hospital Maternity Services Review

Commissioning

The NHS Grampian (NHSG) Acute Sector Triumvirate, consisting Paul Bachoo, Acute Sector Medical Director, and Fiona Francey, Acute Sector General Manager, commissioned an independent review of the Maternity Services at Dr Gray's Hospital (DGH).

The Commissioning Managers developed a terms of reference for the review which noted the time-bound nature of the review.

The Review Team consisted:

Professor Alan Cameron, Obstetrician, Glasgow, and former Vice President of Clinical Quality Royal College of Obstetricians and Gynaecologists

Ms Aileen Lawrie, Head of Midwifery/Nursing in the Women and Children's Directorate, NHS Fife

Dr Kevin Sim, ICU Consultant, Aberdeen Royal Infirmary, NHSG

Mr Philip Shipman, HR Manager, NHSG

Executive Summary

As a result of their review, the Review Team have found the following:

- There is no evidence of a trend in adverse outcomes for patients of the DGH Maternity Service.
- Clinical Governance in the DGH Maternity Service is not fully functional and presents a risk to patient safety.
- Working relationships in the DGH Maternity Service are dysfunctional and damaged to the extent that they may impact upon patient safety.
- There are increasing concerns regarding safety with the current hybrid model within the DGH Maternity Service.
- Circumstances have changed such that it is now not possible to revert back to the previous model of care.
- There are a number of significant concerns regarding the proposed enhanced MDT model of care.
- A Best Start Hub Model of Midwifery Led care could provide a safe and sustainable Maternity Service for the population of Moray.

Methodology

2.1. Upon receipt of the commissioning letter, the Review Team met to plan their review.

2.2. The Review Team considered the Terms of Reference and sought additional information from a number of sources including:

NHSG Feedback and Complaints Team

NHSG Quality Informatics Team

2.3. In order to identify the key issues within the Maternity Services the Review Team decided to focus their limited resources on reviewing the information from the sources above and meeting with a variety of staff employed in or involved with the DGH Maternity Services.

2.4. The Review Team had 2 visits to DGH, totalling 5 days on site, and met personally, video conferenced or conducted telephone meetings with [redacted] members of staff from the following staff groups (in alphabetical order):

Acute Sector Divisional Management Team (ASDMT)

DGH Anaesthetists

DGH Clinical Management (DGH CM)

DGH Maternity Service Consultants (DGH MSC)

DGH Midwifery

DGH Paediatric Consultants

Moray Clinical Governance

NHSG Patient Services

2.5. Each member of staff was afforded the opportunity to be accompanied to their meeting with the Review Team.

2.6. The Review Team aimed to provide each member of staff with a forum for them to explain their experiences of the DGH Maternity Service and for the Review Team to ask specific questions as they deemed relevant.

2.7. The Review Team sought to ensure each member of staff was given ample time to describe their experiences and, where time ran over, a follow up meeting was arranged.

2.8. The Review Team are of the view that all members of staff were open and candid in explaining their experiences of the service.

2.9. The Review Team observed that staff within each group had similar experiences of the service, although the experiences of the staff groups varied markedly.

2.10. A number of staff commented on the extent to which this Review had been anticipated and the Review Team therefore anticipate that the report will be circulated to a wider audience than the Commissioning Managers. The Review Team have therefore sought to avoid any person identifiable information or comments that could readily be attributable to individuals.

2.11. The Review Team are grateful for Administrative Support provided throughout by Phillipa Dowley, HR Administrator.

Information Review

3.1. The Review Team reviewed the information supplied by the NHSG Feedback and Complaints Team in relation to Ombudsman Findings and Patient Complaints.

3.2. The Review Team noted there had been 1 Ombudsman Report in the period under review. The Review Team found that, although the case would have been distressing for the patient involved, it did not indicate to the Review Team that there were any specific learning outcomes that would warrant consideration as part of this review.

3.3. The Review Team noted there had been 29 Complaints/Compliments recorded by the NHSG Feedback and Complaints Service in relation to the DGH Maternity Service in the period under review. The Review Team found that of the 29 Complaints/Compliments:

4 were compliments which were to be welcomed by the service

14 related to the changes underway in the service, often referred to as the 'downgrading' of the service or the requirement to transfer to either Raigmore or Aberdeen

1 related to a potential breach of confidentiality [redacted] which was outwith the scope of this review

Of the remaining 10 complaints, the Review Team did not find any complaints that would indicate evidence of negligence within the service nor specific themes that would warrant further consideration as part of this review.

3.4. The Review Team noted the outlier scores within the NMPA Report.

3.5. The Review Team noted that the babies who had low Apgar scores within the NMPA Report had not had any adverse outcomes. The Review Team were of the view that low Apgar scores weren't a complete indicator of the safety of the service, and that they should be considered one among a number of indicators of the safety of the service. The Review Team explored those indicators during their meetings with staff from the DGH Maternity Service.

3.6. The Review Team reviewed the information supplied by the NHSG Quality Informatics Team.

3.7. The Review Team noted there had been 278 incidents reported through Datix in the period under review. Due to the number of incident reports, the Review Team concluded that they would be unable to undertake a detailed investigation of all of the incidents within the time available.

3.8. The Review Team took an overview of the incidents and did not identify a trend of adverse patient outcomes.

Key Themes and Findings

4.1. From their review of documentation provided and meetings with staff, the Review Team identified the following key themes:

- Clinical Governance
- Working relationship
- Consultant Behaviours
- Organisational Structure
- Alternative Models of Care
- Morecambe Bay comparisons
- Impact upon Staff

Clinical Governance

4.2. The Review Team found that there are two models of clinical governance within the DGH Maternity Service. One model is a DGH wide model within which each Clinical Service at DGH presents a self-selected range of cases to the wider hospital group on a 3 monthly rotation. The other model is a specific NHS Grampian Maternity Service governance structure within which representatives from the Maternity Service review cases from across Grampian for Maternity Service specific learning.

4.3. The Review Team found that DGH MSCs were committed to the monthly DGH clinical governance meetings.

4.4. The Review Team found that DGH MSCs were not committed to the NHSG Maternity Service Governance Structure.

4.5. The Review Team acknowledge that there may be a number of barriers to DGH MSCs attendance at the NHSG Maternity Service Governance structure. However, the Review Team are of the view that none of these barriers would be insurmountable if the DGH MSCs had a desire to engage with the structure.

4.6. The Review Team considered the veracity of the DGH Maternity Service in conforming to broader clinical governance requirements. The Review Team compared their observations of clinical governance within the DGH Maternity Service with the five key principles of Clinical and Care Governance as defined within the Clinical and Care Governance Framework[1]:

- *Clearly defined governance functions and roles are performed effectively*. The Review Team are of the view that the overriding principle of the clinical governance function is that of external, independent review. The Review Team noted that there is a clearly defined Risk Management Midwife from the DGH Maternity Service who reports to the wider NHSG Maternity Service Clinical Governance Structure and this provides the mechanism for some external review of

[1] https://www.gov.scot/publications/clinical-care-governance-framework/pages/4/

the DGH Maternity Service. The Review Team also noted that this was in response to the failure of the DGH MSCs to engage in the NHS Grampian structure. The Review Team noted that DGH MSCs actively engage in the DGH Hospital Wide Meeting and that the DGH MSCs cited this as an exemplar of clinical governance. The Review Team are of the opinion that, whilst this meeting provides a valuable function for shared learning, it does not provide sufficient assurance nor Maternity Service specific professional accountability. For example, the proposed new model for the DGH Maternity Service described by the DGH Clinical Management seeks to reintroduce an Advanced Midwife model. The Review Team are of the opinion that the DGH Hospital wide Meeting would not have sufficient knowledge or background awareness of that model to come to an informed decision as to whether or not the proposal was safe – only a Maternity Service specific clinical governance structure would be in a position to determine this. The failure of the DGH MSCs to engage with the NHSG Maternity Services structure therefore significantly limits clinical governance within the DGH Maternity Service. The Review Team are of the view that clinical governance within the DGH Maternity Service requires both the hospital-wide and Maternity Service specific elements to be in place and operating effectively. The Review Team did not find this to be the case and therefore found that the clinical governance function within the DGH Maternity Service was incomplete and unable to perform fully effectively.

- *Values of openness and accountability are promoted and demonstrated through actions*. The Review Team acknowledge the value that the DGH hospital wide meeting has for shared learning in a hospital context. However, the Review Team are of the view that the meeting does not fulfil all of the requirements for accountability and transparency – specifically in relation to the accountability to the NHS Grampian Maternity Service which has overall responsibility for the provision of maternity services in DGH. Furthermore, the Review Team found that cases submitted to the DGH Hospital Wide meeting were self-selected which, in the view of the Review Team, does not promote openness or accountability. The Review Team heard evidence that requests from ASDMT for clinical governance information about poor clinical outcomes had not been complied with, and the root causes of those clinical outcomes were therefore not fully explained. The Review Team therefore found that the values of openness and accountability are not promoted through action.

- *Informed and transparent decisions are taken to ensure continuous quality improvement*. The Review Team are of the view that high risk cases should be escalated within the wider NHSG Maternity Service to allow for continuous improvement. The Review Team heard evidence that high risk cases were not always escalated, and that requests for information from the ASDMT to the DGH MSCs about high risk cases had not always been complied with. The Review Team are of the view that this had reduced the opportunities for learning and improving patient outcomes. The Review Team heard from a number of sources

that the engagement with the public about the future model for the DGH Maternity Service had not fully considered patient safety nor all possible options within its remit. The Review Team acknowledge that this may have been the result of a political imperative, but are of the view that the public engagement did not seem as informed nor transparent as would be hoped. The Review Team are therefore of the view that decisions did not always seem to have been taken in an informed or transparent manner nor were opportunities always taken to ensure continuous quality improvement.

- *Staff are supported and developed*. The Review Team heard numerous examples of staff within the DGH Maternity Service not supporting each other. Those examples included, but were not limited to, [redacted] [DGH MSCs] blaming [redacted] [midwifery] for a poor clinical outcome, midwives being reluctant to contact on-call Consultants, concerns about possible bullying behaviours and reluctance on the part of some staff to attend development days specifically intended to help support and develop the service. The Review Team are therefore of the view that staff within the service were not always supported or developed.

- *All actions are focused on the provision of high quality, safe, effective and person-centred services*. The Review Team heard examples of the services within the DGH Maternity Service not being person-centred. Those exampled included, but were not limited to, a paternalistic and medicalised model of consultant care, a dismissive attitude towards women who may want an epidural, and a degree of bravado and/or complacency towards the skill levels at which clinicians were safe to practice. The Review Team are therefore of the view that not all actions were focussed on the provision of high quality, safe, effective and person-centred services.

4.7. The Review Team concluded that good clinical governance in the DGH Maternity Service needs to encompass both hospital-wide and Maternity Service specific elements and that there were significant improvements needed in both of these. Furthermore, the Review Team found that there were significant gaps between the clinical government arrangements in the DGH Maternity Service compared to the five key principles of clinical and care governance. As a result, the Review Team are of the view that **Clinical Governance in the DGH Maternity Service is not fully functional and presents a risk to patient safety.**

4.8. The Review Team then considered to what extent were working relationships a contributory factor in clinical governance arrangements not being fully functional.

Working Relationships in the Multi-Disciplinary Team

4.9. The Review Team found damaged relationships within the DGH Maternity Service between the DGH MSCs and the ASDMT, between the DGH MSCs and 'Aberdeen' and between the DGH MSCs and the DGH Midwives.

4.10. The Review Team found that the working relationships between the DGH MSCs and the ASDMT were particularly damaged, and that they had been for a significant period of time.

4.11. The Review Team observed that the DGH MSCs tended to **demonise** the ASDMT and blame- for a significant s. However, the Review ed that the same cohort of DGH MSCs had ex lained that a number of those same issues had existed for longer than [redacted]. The Review Team further observed that the majority of the DGH MSCs concerns about [redacted] the ASDMT were in relation to the style of communication, rather than what was being communicated, The Review Team are therefore of the view that, whilst there may be personality conflicts between the DGH MSCs and the ASDMT [redacted] However, the Review Team are of the view that the working relationship between the DGH MSCs and the ASDMT is almost certainly damaged beyond repair.

4.12. The Review Team observed that the working relationship between the DGH MSCs and 'Aberdeen' was also damaged. The Review Team noted that the use of the terminology 'Aberdeen' was widespread within DGH and was predominantly used in a derogatory sense. Whilst it is not always clear exactly whom 'Aberdeen' refers to, the Review Team are of the view that it is most frequently a reference to the more senior management team within the NHSG Maternity Service, the NHSG Acute Sector Management Team or the NHSG Medical Directorate. Irrespective of whom the exact reference is to, the fact that 'Aberdeen' was referred to as 'the enemy' can only lead to the conclusion that the working relationship between the DGH MSCs and 'Aberdeen' has broken down.

4.13. The Review Team found that the working relationships between some of the DGH MSCs and some of the DGH Midwives were also damaged and that damage had led to patterns of behaviour which could lead to patient safety concerns. The Review Team were specifically concerned that the response that the DGH Midwives may receive from the on-call Consultant had led to a reluctance on the part of some the DGH Midwives to contact some of the DGH MSCs when they were on-call. The Review Team noted the lack of insight on the part of some of the DGH MSCs who considered the DGH Maternity Service to be a family and that the midwives considered the DGH MSCs to 'be one of them'. The Review Team did not find any evidence of direct patient harm that had resulted from a reluctance to contact on-call DGH MSCs, however the extent of the damage to those working relationships is such that there is the potential for patient harm.

4.14. With regard to working relationships, the Review Team are of the view that **working relationships in the DGH Maternity Service are dysfunctional and damaged to the extent that they may impact upon patient safety.**

4.15. The Review Team also noted that the one consistent factor in the damaged relationship was the DGH MSCs as, for example, there did not appear to

be a damaged working relationship between the ASDMT and the DGH Midwives. In relation to damaged working relationships, the Review Team are of the view that **the current cohort of DGH Maternity Service Consultants are the consistent factor in the damaged working relationships in the DGH Maternity Service.**

4.16. The Review Team therefore considered whether the DGH MSCs behaviours were a contributory factor in those damaged relationships.

Consultant Behaviours

4.17. The Review Team were informed of a number of instances of alleged unprofessional behaviour by some of the DGH MSCs. The Review Team were especially concerned about the allegations **that** [DGH MSCs] had spoken inappropriately about Midwifery colleagues, that the DGH MSCs had refused to attend when contacted when on-call, and that some of the DGH MSCs had displayed bullying behaviours. The Review Team noted that these allegations were historical.

4.18. The Review Team were also informed that these instances had been escalated by the ASDMT and that there did not appear to have been any subsequent action.

4.19. The Review Team were unable to come to any findings in relation to these alleged behaviours as they were outwith their remit and would require more specific investigation than an overall service review.

4.20. The Review Team are of the view that any such serious allegations should have either been addressed informally, or formally investigated in accordance with the NHS Grampian Framework for Support, and that any interventions needed to have been enacted as quickly as is reasonably practicable. The Review Team are concerned that, as the reliability of witness evidence deteriorates over time, the veracity of any formal investigations may be compromised due to the passage of time since the alleged incidents.

4.21. In relation to consultant behaviours, the Review Team are of the view that **there are serious concerns about the professional behaviour of DGH MSCs which should have been investigated in accordance with the NHS Grampian Framework for Support.**

4.22. In relation to consultant behaviours, the Review Team are of the view that **the ASDMT should have been provided with feedback on the issues that they had escalated.**

4.23. The Review Team then considered whether there were structural problems which contributed to both the damaged relationships and the consultant behaviours.

Organisational Structure

4.24. The Review Team found that there were shared matrix management arrangements in place for the DGH Maternity Service where professional accountability was shared between the NHSG Acute Sector and the local DGH Clinical Management. Similarly the Review Team found that overall strategic leadership was shared between Moray H&SCP and the NHSG Acute Sector.

4.25. The Review Team found that, in practice, these matrix management arrangements were complex and not clear for those employed within the Maternity Service.

4.26. The Review Team found that the matrix management arrangements had partly developed due to the geographic distance between DGH and Aberdeen, and required local management to implement NHSG's operational and strategic requirements.

4.27. The Review Team did not find that there was any shared vision of the future for DGH, nor where DGH fitted within the wider NHSG system.

4.28. The Review Team did find that everyone was committed to providing a safe service, but also found very differing views of who should define and oversee what a safe service was.

4.29. The Review Team are of the view that matrix management arrangements can work effectively, but to do so they require collaboration amongst the parties involved. The Review Team did not find that there was sufficient collaboration within the matrix management arrangements in place in DGH for those arrangements to succeed. Instead, the Review Team found the different parties had very strongly held, and very differing, views on almost all the issues currently facing the DGH Maternity Service. The Review Team noted that the holding of different views is not unusual and, in many instances, can be extremely effective in resolving complex issues. However, the Review Team are of the view that the absence of any clearly accepted lines of accountability within the DGH Maternity Service or any shared vision for the future has led, at best, to an inability to resolve those issues.

4.30. In relation to the organisational structure, the Review Team are of the view that **the current matrix management arrangements have created to an environment where disharmony can arise but not be resolved.**

4.31. The Review Team are also of the view that **there is a need for a clearly defined vision for DGH and the DGH Maternity Service**.

4.32. Having ascertained that there was not currently a vision for the future of the DGH Maternity Service that all had ascribed to, the Review Team then considered the veracity of a number of possible models of care.

Models of Care and the Best Start[2]

4.33. Following concerns regarding safety, quality and outcomes with regards to maternity service provision at DGH, changes were made to service provision in August 2018. Following on from these service changes the CMO commissioned a report to further explore quality and safety governance within the unit.

4.34. The CMO Advisory Group from October 2018 reported on six key priorities for the DGH Maternity Service and advised on;

- Reinstating elective caesarean sections within DGH
- Increasing the number of women booked for birth at the unit (as a community midwifery unit)
- Reducing unnecessary transfers to AMH
- Increasing antenatal care delivered at DGH through review of what specialist antenatal services are currently provided at Aberdeen that could be delivered locally
- Working with NHS Highland to increase capacity at Raigmore Hospital
- Improving poor experience of trainees at DGH

4.35. The content of the CMO document will be known to the commissioning managers of this review. In summary, of the six recommendations outlined, the CMO Advisory Group recommended the reinstatement of elective caesarean sections at DGH, discussed the challenge and possible safety concerns of increasing the numbers of women booked for birth at DGH whilst the unit was practicing a "life and limb" hybrid model of care (intrapartum midwifery led care with obstetric on call cover overnight for life and limb emergencies), recognised the possible safety concerns of this model in terms of confusion concerning transfer criteria, recommended increasing triage and assessment clinics along with introducing transitional care pathways for babies within the postnatal area as opposed to SCBU and to further negotiation with NHS Highland regarding sharing care of women from Moray.

4.36. The review team was asked to inform commissioners: *If there are lessons to be learned for the service to secure the delivery of high quality care as recommended in "The Best Start" (Scottish Government 2017).*

4.37. The Best Start report sets out the vision for the delivery of high quality, safe maternity and neonatal services across Scotland, to be implemented by December 2020. The report describes how women, babies and families will get the type of care they want and how staff will be supported to deliver that care.

4.38. The Best Start report makes a number of recommendations that will change the way that maternity services are organised. It describes the

[2] *https://www.gov.scot/publications/best-start-five-year-forward-plan-maternity-neonatal-care-scotland/*

future vision of maternity and neonatal services across Scotland that will be one where:

1. All mothers and babies are offered a truly family-centred, safe and compassionate approach to their care, recognising their own unique circumstances and preferences
2. Fathers, partners and other family members are actively encouraged and supported to become an integral part of all aspects of maternal and newborn care.
3. Women experience real continuity of care and carer, across the whole maternity journey, with vulnerable families being offered any additional tailored support they may require.
4. Services are redesigned using the best available evidence, to ensure optimal outcomes and sustainability, and maximise the opportunity to support normal birth processes and avoid unnecessary interventions.
5. All staff are empathetic, skilled and well supported to deliver high quality, safe services, every time.
6. Multi-professional team working is the norm within an open and honest team culture, with everyone's contribution being equally valued.
7. A new model of neonatal intensive care services

4.39. One of the key strengths of the Best Start report is that it acknowledges the importance of organisations enabling positive workplace cultures through a focus on improving inter-professional working with a focus on communication, escalation and interdisciplinary professional education, organising care around community hubs and promoting collaboration across professional and organisational boundaries. The report stresses the importance and benefits of continuity of midwifery care, while highlighting the need for careful, supportive leadership of midwives practising this way. The report also advocates for choice in place of birth: at home, in a midwifery unit or within a hospital environment.

Alternative Models of Care: Current Hybrid Model

4.40. With specific reference to the overarching principles 1, 3, 4, 5 and 6 within the Best Start report the review team found the following within the current DGH Maternity Service.

4.41. *Principle 1: Are all mothers and babies offered a truly family-centred, safe and compassionate approach to their care, recognising their own unique circumstances and preferences?* The Review Team are of the view that the current hybrid model of maternity care being practiced within DGH poses a significant safety risk for women, clinicians and NHS Grampian. This is due to the unintended consequences of the introduction of the “life and limb” on call obstetric cover/CMU hybrid model of care. These unintended consequences are highlighted more fully within the body of this report and are characterised by staff highlighting confusion and uncertainty over referral, transfer and escalation of care criteria. An example of this is

anecdotal evidence being reported to the review team that women are being cared for at DGH during antenatal episodes who fit the criteria for transfer to AMH and that women are being discouraged from transferring their care to AMH by some clinicians in order to birth their babies at DGH.

4.42. *Principle 3*: *Do Women experience real continuity of care and carer, across the whole maternity journey, with vulnerable families being offered any additional tailored support they may require?* Due to the constraints of time it was not possible for the review team to undertake a deep dive into continuity of carer data for the unit. The review team heard information from the DGH MSCs regarding being overloaded with work and due to this overload that the team were unable to participate in multidisciplinary review and education sessions with AMH. There are one thousand women in Moray annually who will require maternity care, not all of these women will require the care of a Consultant Obstetrician. The recommendations within the Best Start report have the potential to streamline Consultant Obstetric time which could enable continuity of carer to be delivered to women with increased obstetric risk during the antenatal and postnatal period within Moray by the Consultant Obstetric team. Due to time constraints the review team were unable to ascertain whether women were receiving Consultant Led antenatal care inappropriately, this is an area that NHSG could review in order to assist with Consultant Obstetrician job planning.

4.43. *Principle 4: Has the Services been redesigned using the best available evidence, to ensure optimal outcomes and sustainability, and maximise the opportunity to support normal birth processes and avoid unnecessary interventions?* There is the expectation that the recommendations within the report will be fully implemented within NHSG by December 2020. Maximising the opportunity to support normal birth processes could be achieved by reconfiguration of the maternity service provision at DGH as a community midwifery unit (CMU). There was continual reference to the unit's previous status as a "Consultant Unit" when in reality the unit did not have the service provision of a Consultant Unit, for example, there was no option of epidural as an analgesic of choice for women during their labour. This miscommunication carried into public consultations with women regarding the options of maternity care provision to be considered for DGH and the communications with the public could be thought to be disingenuous in this respect. There was no communication regarding both the advantages and disadvantages of a CMU or the advantages of women assessed as having low risk receiving midwife led care in line with Best Start recommendations. The safety concerns regarding care provision in a unit where women with increased risk were being cared for without adequate recourse to analgesia was not highlighted in public consultations, for example the care of women with twins or women undergoing induction of labour not being provided with an epidural for the duration of their labour, the need for increased use of opiate analgesia for these women and the possible subsequent effects of this on the newborn (lower APGAR scores and challenges with establishing feeding leading to a decrease in breast feeding and possible increasing neonatal hypoglycaemia and jaundice).

4.44. *Principle 5: Are all staff are empathetic, skilled and well supported to deliver high quality, safe services, every time?* Staff from all disciplines are self-reporting to the review team a reduction in their exposure to complex clinical care episodes which is leading to a reduction in staff competency and confidence in certain aspects of clinical care provision and decision making skills. There is particular concern from the MDT regarding the maintenance of skills required for undertaking caesarean section. This reduction in skill set and confidence is increasing the longer the hybrid model is in place. From interviews with the MDT there are incidences of staff displaying paternalism in respect of compassionate discussions regarding the options for analgesia/anaesthesia, with women variously referred to as "stoic "and "different" and staff reporting "we don't want it [epidural service], we don't need it" and that "the women don't want it, they [women] don't seem bothered about it [epidural service]. The current culture within the unit appears to be one where the medical model was dominant with communication to the review team of a paternalistic culture and a current hybrid model of care that does not fully meet the needs of anyone, women or staff.

4.45. *Principle 6: Is Multi-professional team working the norm within an open and honest team culture, with everyone's contribution being equally valued?* The review team was interested to note that the paternalistic culture dominant within the unit was evident when discussing Midwife Led Care as an option of care delivery. All professions within the multidisciplinary team referred to midwife led care as a "downgrade" of the service. The midwifery team also reported destructive behaviours from the DGH MSCs when the midwives had previously attempted to introduce "Midwife led Care" rooms onto the intrapartum area, with the midwives describing various Consultants "ripping the [midwife led care] sign off the door" and stating "we don't do that here". The use of language when communicating options of care for women needs to be consistent and reflect the safety and quality of differing models of care, midwife care for women of low risk is not a downgrade of service. Recent research highlights that midwifery continuity of care models show increased perception of higher quality level of care across every antenatal measure (Allen et al 2019)[3].

4.46. The Review Team are of the view that **the current hybrid model of care being practiced within DGH is not sustainable in the short or long term** and that **there are increasing concerns regarding safety with the current hybrid model**. There is dissatisfaction voiced from all professions regarding this model of service provision. There is an ageing profile within the current midwifery establishments nationally along with challenges of recruitment due to the historical reduction in midwifery training numbers. The midwifery team have voiced that they are dissatisfied with the organisation of midwifery care and dissatisfied with their role within the current model.

[3] Allen J, Kildea S, Tracy MB at al (2019) The impact of caseload midwifery, compared with standard care, on women's perceptions of antenatal care quality: Survey results from the M@NGO randomized controlled trial for any women at risk. BIRTH: Issues in Perinatal Care

4.47. The Review Team are of the view that **NHS Grampian needs to consider how to re-orientate the maternity service at DGH to enable safe, satisfying and sustainable models and pathways of care for both women and staff**.

Alternative Models of Care: Model of Expanded MDT

4.48. The Review Team noted that the model of care being developed by the DGH Maternity Service was an expanded MDT which required an increase the number of MSCs [redacted] an increase in the number of Advanced Nurse Practitioners (ANPs), and to further bolster the MDT with Physicians Associates, Prescribing Pharmacists and Midwives trained in Advanced Practice, although there was no outline as to what the advanced midwife model would be.

4.49. With specific reference to the overarching principles 1, 3, 4, 5 and 6 within the Best Start report the review team considered the following in relation to the developing model of an expanded MDT.

4.50. *Principle 1: Would all mothers and babies be offered a truly family-centred, safe and compassionate approach to their care, recognising their own unique circumstances and preferences?* The Review Team are of the view that an expanded MDT would have the potential to provide this approach as the limitations placed on the current DGH Maternity Service caused by workforce shortages would no longer be in place. However, the Review Team are concerned that the current cohort of DGH MSCs do not have the potential to offer a truly family-centred approach. The Review Team's concerns are based upon the opinions expressed by the DGH MSCs in relation to such approaches.

4.51. *Principle 3*: *Would Women experience real continuity of care and carer, across the whole maternity journey, with vulnerable families being offered any additional tailored support they may require?* As noted previously, it has not been possible for the Review Team to undertake a deep dive into the continuity of carer data for the current DGH Maternity Service. However, the Review Team are of the view that an expanded MDT would have the potential to enable continuity of carer to be delivered to all women. The Review Team are also of the view that an increase in the Consultant Obstetric team would have the potential to enable continuity of carer to be delivered to women with increased obstetric risk who require the care of a consultant. However, the Review Team are concerned with the extent to which the current medicalised model of care is embedded in the current DGH Maternity Service and whether it will be possible to move away from that medicalised model towards a model of tailored support.

4.52. *Principle 4: Will the Service be redesigned using the best available evidence, to ensure optimal outcomes and sustainability, and maximise the opportunity to support normal birth processes and avoid unnecessary interventions?* The Review Team are of the view that an expanded MDT has the potential to support normal birth processes and avoid unnecessary intervention, and is undoubtedly a redesign of the current service.

However, the MDT are concerned about the sustainability of the proposed MDT. The Review Team heard about the historical challenges of recruiting to DGH, and are concerned about the likelihood of recruitin and retaining additional Consultants. [redacted] The Review Team are of the view that this is unlikely given the historical challenges of recruiting to DGH and the NHS wide shortage of such consultants. The Review Team also noted that DGH Clinical Management had explained that there was no blueprint for the proposed model, and the Review Team are therefore concerned that the paucity of evidence is contrary to the Best Start requirement for evidence-based re-design. The Review Team noted the references to the Nuffield Trust Report on Smaller Hospitals, but are of the view that, whilst the report may provide a useful blueprint for Smaller Hospitals, it did not meet the requirement for evidence-based redesign of Maternity Services. The Review Team did however note the strong recommendation within the Report for Smaller Hospitals to create wider networks that function well and have strong clinical governance.

4.53. *Principle 5: Would all staff be empathetic, skilled and well supported to deliver high quality, safe services, every time?* The Review Team are of the view that an expanded MDT should have the potential to deliver safe services due to the expansion in consultant numbers and enhanced support to those consultants. However, the Review Team are concerned that, with a relatively limited number of births in a year, an expanded consultant team may not may not gain sufficient exposure to high risk cases to maintain their skills. The Review Team would be concerned if this was the only change being proposed, however, when combined with the requirement for the service to become less medicalised, then the consultant exposure to cases would consequently decrease even further. The Review Team are therefore of the view that the proposed model may not provide the opportunity for consultants to maintain their skills. The Review Team also noted DGH Clinical Management's reference to midwives developing advanced practice skills as part of the enhanced MDT. The Review Team are concerned that the lack of governance surrounding the previous advanced midwife practice role, which led to that role being discontinued in June 2017, would not appear to have been taken into account when the DGH Maternity Service was developing its thinking about the proposed enhanced MDT. The Review Team also noted the difference in views amongst staff about how well progressed the enhanced MDT was in practice.

4.54. *Principle 6: Would Multi-professional team working be the norm within an open and honest team culture, with everyone's contribution being equally valued?* The Review Team are of the view that this presents one of the biggest hurdles in the development of the enhanced MDT model that is being proposed by the DGH Maternity Service. The Review Team heard

examples of blame, alleged bullying, unprofessional behaviour and the desire for DGH to be 'left alone' – none of these are conducive to a multi-disciplinary team working in an open and honest culture, where everyone's contribution, irrespective of role or location, is equally valued.

4.55. The Review Team acknowledge and applaud the 'blue-sky' thinking that has gone into the proposed model of an enhanced MDT. The Review Team also acknowledge that the proposals are intended to maintain a safe service and are driven by a passionate desire to maintain local services. The Review Team are concerned by a number of aspects of the enhanced MDT model. The Review Team are, however, also of the view that some of these could be overcome by, for example, more detailed workforce planning and improved consultant job planning. The Review Team are concerned about the likelihood of recruiting [redacted] additional consultants and the timescale for doing so. Furthermore, the Review Team are concerned about the lack of insight on the part of those developing the model of the extent to which working relationships within the Maternity Service have broken down, and the reliance that the proposed model has upon those relationships and wider networks.

4.56. Of all their concerns, the Review Team were most concerned by the timescale for implementing the proposed enhanced MDT when set against a backdrop of the current hybrid model becoming less safe on an almost daily basis. The Review Team heard a number of dates in relation to some component parts of the proposed enhanced MDT model but did not gain clarity on exact timescales for when the proposed MDT model would be in place.

4.57. The Review Team are therefore of the view that **there are a number of significant concerns regarding the proposed enhanced MDT that need to be addressed with some urgency for NHSG to be fully assured that it is a safe and sustainable model for future Maternity Services in Moray**. The Review are also of the view that some of the concerns, such as the ability to recruit, may not be able to be addressed and **an alternative model for future Maternity Services in Moray needs to be considered**.

4.58. The Review Team acknowledge that consideration of future models of care is usually impacted by many influences. Unencumbered by such influences, the Review Team considered whether there were alternative models that could provide safe and sustainable Maternity Services for the population of Moray.

Alternative Models of Care: Revert to Current Model

4.59. The Review Team noted that DGH Clinical Management were confident that the junior doctor rota, which had been the catalyst for the introduction of the current hybrid model, was likely to be recruited to for the forthcoming rotation.

4.60. The Review Team therefore considered whether reverting to the initial model of care was an option for the DGH Maternity Service.

4.61. The Review Team noted the reference from the DGH Anaesthetists to the new guidance from the Royal College of Anaesthetists which indicated that, in order to support the previous model of Maternity Service within DGH, the DGH Anaesthetists would need to implement a model of resident on-call Anaesthetic support. The Review Team noted that this was currently not in place and would require significant further recruitment.

4.62. The Review Team further noted the findings that they had made in relation to clinical governance, working relationships and organisational structure and concluded that the issues within the DGH Maternity Service were such that the service required re-design rather than a retrograde step backwards

4.63. The Review Team are therefore of the view that circumstances have changed such that it is now not possible to revert back to the previous model of care.

Alternative Models of Care: Best Start Hub

4.64. The Review Team noted the key findings of the Birthplace in England Research Programme[4] which found that 'midwifery units appear to be safe for the baby and offer benefits for the mother'; that 'for planned births in freestanding midwifery units and alongside midwifery there were no significant difference in adverse perinatal outcomes compared with planned birth in an obstetric unit'; and that 'women who planned birth in a midwifery unit (AMU or FMU) had significantly fewer interventions, including substantially fewer intrapartum caesarean sections, and more 'normal births' than women who planned birth in an obstetric unit'.

4.65. The Review Team noted the concerns that had been expressed by DGH Clinical Management about the efficacy of locating a midwifery-led unit within a District General Hospital. However, the Review Team noted that this is a model of care currently in place in Perth Royal Infirmary[5], a 260 bedded District General Hospital serving a population of approximately 180,000.

4.66. The Review Team therefore considered whether a Best Start Hub model of midwifery led care would be possible within DGH.

4.67. The provision of choice for women within the current maternity services could be viewed positively when reviewing the publication of government maternity care strategies which aim to highlight and enable women's choices and decision making through the promotion of midwifery care (DOH, 2007b[6]; DOH, 2010[7]; MSAG, 2011, Best Start 2017). Within these

[4] https://www.npeu.ox.ac.uk/birthplace/results
[5] www.birthinperth.scot.nhs.uk
[6] Department of Health, (2007b) *Maternity Matters: Choice, access and continuity of care in safe service.* London: Department of Health.
[7] Department of Health, (2010) *Midwifery 2020 delivering expectations.* London: Department of Health.

strategies there is a focus on the depiction of maternity care as a commodity, with women identified as consumers. The consumer focus suggests that the provision of choice is embedded within practice, with a concomitant improvement in the quality of maternity care provision. This does not appear to be the reality for the midwives and obstetricians interviewed for this review who have identified difficulties, misunderstandings and challenges regarding the provision of choice for women. There is disparity between the care advocated by government and research evidence, and the implementation of this evidence into clinical practice. An example of this relates to the most current evidence base regarding care provision for women who have had one or more baby. The evidence confirms that home birth or birth in a Standalone Midwifery Unit, is the most beneficial for both the woman and the baby. This type of care shows a statistically significant decrease in adverse perinatal outcomes along with a decrease in caesarean section, instrumental delivery, episiotomy rates and an increase in normal birth rates (Birthplace in England Collaborative Group, 2011[8]). It is necessary to question why this disparity between strategy, evidence and implementation into practice exists at DGH.

4.68. The development and provision of maternity care at DGH has been increasingly focused on the medical model of care. This focus has resulted in a divergence of service provision. The midwifery model of care, which views pregnancy and birth as an inherently normal physiological process, emphasising the social and experiential aspects of birth, has been viewed almost as inferior to the medical model. However, the predominance of the medical model is not necessarily supported by evidence regarding its efficacy. This medical model of care is embedded within the maternity system in Moray today and is now considered consensually constructed by the staff and the public and is consequently difficult to challenge. This consensus has resulted in a situation where normal pregnancy is seen by the population of Moray as routinely medically managed.

4.69. The use of risk assessment and risk discourse to determine the choices, which are made available to women, appeared endemic within the discussions with the midwives and obstetricians and subsequently the public. The identification of risk was a priority for the multidisciplinary team and the experiential aspects of pregnancy and birth appeared more of a minor consideration. Midwife led care is seen as a downgrade of service provision and a risk in itself.

4.70. The predominant medical model had influenced the midwives at DGH and they demonstrate a preoccupation with the need to optimise safety and limit choice accordingly. The midwives constantly discussed risk and normality as defined as the absence of risk rather than the presence of normality. This is despite the evidence that the increasing medicalisation of

[8] Birthplace in England Collaborative Group, (2011) 'Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: The Birthplace in England national prospective cohort study'. *British Medical Journal.* 343 (7840). Available at: d7400.doi: 10.1136/bmj.d7400 9

birth has had less effect on the reduction of adverse outcomes in pregnancy and birth compared to wider social and environmental issues for example the use of contraception and pregnancy spacing, increased standards of living and vaccination programs[9].

4.71. In order to choose or consent to care a woman needs to understand the nature of the choice that is being suggested. In this review there is an implication by the midwives and obstetricians that knowledge is an entity in itself and is able to be transferred from one person to the other, its efficacy measured in the amount of information that is transferred and not necessarily how the information is understood. The fact that women comply with the care pathways recommended by midwives and obstetricians at DGH does not mean that women have given consent that would be thought legally valid. This issue of understanding and informed consent in maternity has recently come under scrutiny following the case of *Montgomery v Lanarkshire Health Board* (2015)[10]*.* This case highlights that the standard by which information sharing will be assessed is not by reference to the medical professional, instead the relevant standard is whether the woman would attach significance to the risk. The case highlights the importance of considering *material* risk. This will be individual for each woman and it could be argued that limiting information regarding available options compromises the concept of choice (Prochaska, 2015)[11]. To provide the care that women need and is best practice it is imperative that the maternity team practice collaboratively. The findings from this review show that multidisciplinary working can be difficult to achieve and it is suggested that multidisciplinary education could improve this. A multidisciplinary education programme could enhance distinct professional autonomy by improving the recognition and respect of differing philosophies of care.

4.72. *Best Start* has particular recommendations regarding the provision of maternity services (SG, 2017). Within the key objectives outlined it is highlighted that pathways of care should be person centred and that assessments of women should be holistic. The maternity team at DGH provided information that showed that there were difficulties in providing this type of care with particular reference to midwife led care. This disparity between government guidance and its implementation requires senior management within NHSG to support the implementation of the recommendations within Best Start with particular focus on support for a stand-alone midwifery unit and the preparedness of the midwifery team to provide that service.

4.73. The midwives who were interviewed in this review reported benefits to their professional practice through their involvement in the provision of a midwife

[9] Renfrew, M. J., Homer, C. S. E., Downe, S., McFadden, A., Muir, N., Prentice, T., ten Hoope-Bender, P. (2014) Midwifery: An Executive Summary for The Lancet's Series, *The Lancet*, June 2014

[10] *Montgomery (Appellant) v Lanarkshire Health Board (Respondent), (2015) Judgement.* Available at: https://www.supremecourt.uk/decided.../uksc_2013_0136_judgment.pdf UKSC11

[11] Prochaska, E. (2015) 'UK Supreme Court upholds woman's autonomy in childbirth: Montgomery v Lanarkshire Health Board'. Available at: http://www.birthrights.org.uk/2015/03.

led service. They aimed to provide this service within a system aligned to providing the medical model of maternity care. The midwives described the negative impact on themselves as professionals when trying to provide a social model of care within an unsupportive system. This review has highlighted the importance of recognising the effects that the predominant medical model has upon midwives and how this ultimately affects women's choices. This review has also highlighted that midwives themselves recognise the interventions that would best improve the provision of a sustainable maternity service at DGH.

4.74. The Review Team are of the view that **a Best Start Hub Model of Midwifery Led care could provide a safe and sustainable Maternity Service for the population of Moray**.

Comparison with Morecambe Bay

4.75. The Review Team noted the reference to and/or comparison with 'Morecambe Bay' was made on more than one occasion during their meetings with members of the DGH Maternity Service. The Review Team therefore considered certain aspects of their findings in relation to the findings of the Morecambe Bay Investigation[12].

4.76. The Review Team noted the Morecambe Bay report headline findings which highlighted that 'the origin of the problems we describe lay in the seriously dysfunctional nature of the maternity service at Furness General Hospital (FGH). Clinical competence was substandard, with deficient skills and knowledge; working relationships were extremely poor, particularly between different staff groups, such as obstetricians, paediatricians and midwives; there was a growing move amongst midwives to pursue normal childbirth 'at any cost'; there were failures of risk assessment and care planning that resulted in inappropriate and unsafe care; and the response to adverse incidents was grossly deficient, with repeated failure to investigate properly and learn lessons.'

4.77. The Review Team are concerned by the similarity between their own findings and the headline findings of the Morecambe Bay Investigation in relation to the poor working relationships between staff groups, the inadequacy of clinical governance, the poor response to adverse outcomes and services acknowledgement that there is a high normal childbirth rate at DGH. This concern is heightened by the knowledge that the current hybrid model within the DGH Maternity Service is leading to a de-skilled consultant workforce. However, these concerns are, to a certain extent, tempered by there being no evidence of unnecessary deaths of mothers or babies.

4.78. The Review Team are however also aware of the limitations of their own findings which are necessarily less comprehensive than those of the Morecambe Bay Investigation. The Review Team are of the view that

[12] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment data/file/408480/47487_MBI_Accessible_v0.1.pdf

NHSG may need to consider undertaking a full and detailed review of clinical cases to draw more detailed conclusions regarding historical patient outcomes within the DGH Maternity Service.

Impact on People

4.79. During their meetings with members of staff from the DGH Maternity Service, the Review Team noted that almost all of those staff had been adversely affected by the current issues within the service.

4.80. The Review Team would characterise some of those affects as apprehension, anger, fear, burn out and, in those most severely affected, as 'broken'. The Review Team are of the view that a package of support is needed to assist those staff who have been adversely affected by the current issues in the service.

4.81. The Review Team noted the desire on the part of the ASDMT to share the outcomes of this review with the DGH Maternity Service in an open and transparent manner. The Review Team are concerned that some of the conclusions that have been drawn will further adversely affect some staff within the service. However, the Review Team are of the view that this should not prevent the outcomes being shared.

4.82. The Review Team are of the view **that staff have been adversely affected by the current issues in the DGH Maternity Service and a package of support is needed to assist those staff**.

Findings

5.1 As a result of their review, the Review Team have found the following:

- From the information review undertaken, there is no evidence of a trend in adverse outcomes for patients of the DGH Maternity Service.

- Adverse patient outcomes are not the only indicators of the safety, or otherwise, of a service. There are other indicators of potential risks to patient safety including clinical governance systems, working relationships, and clinical competence.

- There is a disconcerting similarity between the DGH Maternity Service and the headline findings of the Morecambe Bay Investigation in respect of the poor working relationships between staff groups, the inadequacy of clinical governance, the poor response to adverse outcomes, the increasingly deskilled consultant workforce and the service's acknowledgement that there is a high vaginal birth rate at DGH. These concerns are, to a certain extent, tempered by there being no evidence of unnecessary deaths of mothers or babies, and no evidence of trends in adverse patient outcomes.

- Clinical Governance in the DGH Maternity Service is not fully functional and presents a risk to patient safety.

- As Clinical Governance in not fully functional, NHSG may need to consider undertaking a full and detailed review of clinical cases to be completely assured about historical outcomes for individual patients within the DGH Maternity Service.

- Working relationships in the DGH Maternity Service are dysfunctional and damaged to the extent that they may impact upon patient safety.

- The current cohort of DGH Maternity Service Consultants are the consistent factor in the damaged working relationships in the DGH Maternity Service.

- There are serious concerns about the professional behaviour of DGH Maternity Service Consultants which should have been investigated in accordance with the NHS Grampian Framework for Support.

- The Acute Sector Divisional Management Team should have been provided with feedback on the issues that they had escalated.

- The current matrix management arrangements have created an environment where disharmony can arise but not be resolved.

- There is a need for a clearly defined vision for DGH and the DGH Maternity Service.

- The current hybrid model of care being practiced within DGH is not sustainable in the short or long term.
- There are increasing concerns regarding safety with the current hybrid model.
- Circumstances have changed such that it is now not possible to revert back to the previous model of care.
- There are a number of significant concerns regarding the proposed enhanced MDT that need to be addressed with some urgency for NHSG to be fully assured that it is a safe and sustainable model for future Maternity Services in Moray.
- An alternative model for future Maternity Services in Moray needs to be considered.
- A Best Start Hub Model of Midwifery Led care could provide a safe and sustainable Maternity Service for the population of Moray.
- Staff have been adversely affected by the current issues in the DGH Maternity Service and a package of support is needed to assist those staff.

5.2 In response to the specific terms of reference, the Review Team have concluded the following:

- *Review the outcomes for mothers and babies occurring during this time and determine if there is evidence that the standard of care was different from other NHS services on indicators derived from routine data*

  From the information review undertaken, there is no evidence of a trend in adverse outcomes for mothers and babies in the period of the review. The Review Team found anecdotal evidence that standards of care are different from other NHS services and these are described in detail in the body of the report. The time constraints placed on the review prevented the detailed review of cases that would be required to definitively determine whether that anecdotal evidence has resulted in poor outcomes for individual patients.

- *Assess and make findings as to the ability of the service to deliver consultant led maternity care in line with current maternity and neonatal best practice, and considering essential support services, such as anaesthetics, in this process.*

  The Review Team are of the view that there is the potential for DGH to deliver consultant led maternity care, but that service would require a much enhanced multi-disciplinary team. The Review Team have significant concerns about the likelihood of that potential being realised within the time available which is limited due to the increasingly deskilled workforce within the service. The Review Team are of the view that the challenges of developing an enhanced MDT are compounded by a lack of

supply of the required workforce, with particular concern about the nationwide shortage of Consultant Obstetricians/Gynaecologists. The Review Team are also concerned about the ability of the current consultant workforce to adapt to current maternity practice as described within Best Start.

- *Review the scope of practice of medical and midwifery staff within the unit and comment on any structural or cultural factors influencing this. Specifically, is there evidence to suggest that the Midwifery team inappropriately undertook or were encouraged to undertake high risk intrapartum care without appropriate medical review and input regarding decision making*

  The Review Team have found evidence that midwifery staff had historically undertaken care which was outwith their scope of practice, but that practice has now stopped. The Review Team have found that, due to the constraints of the current hybrid model, the current consultant cohort are becoming deskilled which is leading to an increased risk to patient safety. The Review Team did not find evidence of midwifery staff specifically being encouraged to undertake high risk care, but the Review Team did find anecdotal evidence of a culture of complacency towards maintaining skill levels within the service and reluctance to escalate care to the consultant group.

- *Review the service's adherence to agreed NHSG governance processes both within DGH and the wider context of the W&C service in AMH in response to investigating complaints and critical incidents. This should include the process for responding to national reporting frameworks such as MBRACCE and EBC*

  The Review Team have found that clinical governance within the DGH Maternity Service is not fully functional and presents a risk to patient safety.

- *Review the service's responses, and any subsequent actions taken, following receipt of the outcomes of level 1 and level 2 reviews of significant incidents, and national outcome data, such as NMPA and MBRACCE reports. Specifically, were the recommendations of any adverse event review process shared with the wider multi professional team and implemented in a supportive manner without discrimination*

  The Review Team have found that outcomes and learning from national outcome data such as the NMPA Report had not been shared with the wider multi professional team. The Review Team found that, historically, the process for sharing any learning from significant incidents had been for a consultant to distribute that learning in writing. The Review Team found that process was not conducive to supportive learning.

- *Review complaints received and Ombudsman cases during this period, and identify any themes, and the communication of learning from complaints within the service*

  The Review Team have found that there had been one Ombudsman case within the period under review and, although the case would have been distressing for the patient involved, did not indicate to the Review Team that there were any specific learning outcomes. The Review Team did not find evidence of any negligence based complaints in the period in question. As with above, the Review Team found that, historically, the process for sharing any learning from significant incidents had been for a consultant to distribute that learning in writing. The Review Team found that process was not conducive to supportive learning.

- *Review the multidisciplinary service contribution to the maternity patient safety agenda, the identified quality priorities and the progress achieved*

  The Review Team found that some of the initiatives that may be expected within a unit of this size were not progressing, such as MCQIC drivers for improvement including stillbirth reduction, post-partum haemorrhage management improvement strategies, nor the neonatal initiatives such as audits of term newborn admissions or neonatal assessment bundle.

  The Review Team would expect that this type of activity to be jointly led by the clinical lead and lead midwife.

  The Review Team are of the view that the lack of progress in such initiatives is most likely to be due to the lack of designated clinical leadership, combined with the dysfunctional working relationships within the DGH Maternity Service.

- *If there are lessons to be learned for the service to secure the delivery of high quality care as recommended in 'The Best Start'*

  The Review Team have found that the current hybrid model of care is not consistent with the Best Start, and that there are significant concerns with the likelihood of the enhanced MDT model of care being able to be implemented within the time necessary or by the current cohort of consultants. The Review Team are of the view that the alternative model of care of a Best Start Hub of Midwifery Led care could provide a safe and sustainable maternity service as recommended in the Best Start.

- *If there are lessons to be learned regarding whether specific changes to structure or practice are required to achieve outcomes compliant with modern standards.*

  The Review Team found that the structure and practice most likely to achieve outcomes compliant with modern standards is to introduce a Best Start Hub Model within the DGH Maternity Service.

- *If any further investigation is required and whether such an investigation should focus on professional conduct or capability or both*

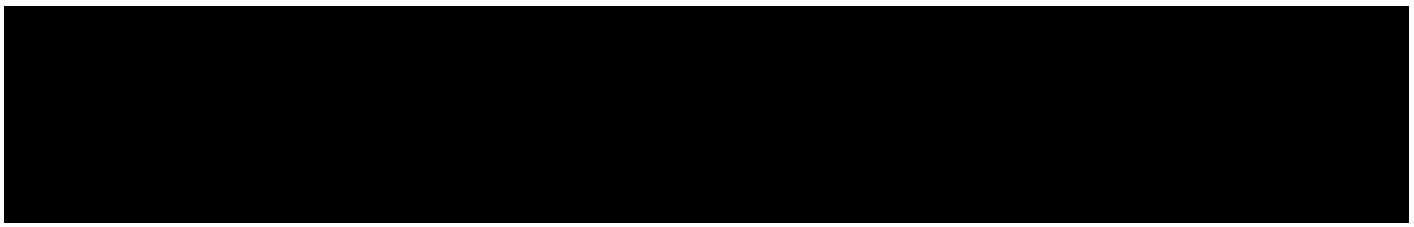
  The Review Team have found that there are serious concerns about the professional behaviour of the DGH MSCs which should have been investigated as allegations of misconduct under the NHSG Framework for Support.

  The Review Team have not found any evidence of concerns that would warrant investigation in relation to professional capability. However, to be fully assured that there are no issues regarding professional capability, the Review Team are of the view that, as has been noted previously, it would be necessary to undertake a full review of cases, which time constraints did not allow for in this review.

Recommendations

6.1 As a result of their review, the Review Team make the following recommendations:

- NHSG transitions from the current hybrid model of care to a Best Start Hub Model of Midwifery Led care as soon as it is safe to do so.
- NHSG undertakes a full and detailed review of clinical cases to assure themselves of the historical outcomes for individual patients within the DGH Maternity Service.
- NHSG timeously utilises appropriate employment policies in relation to any findings that result from the detailed case review referred to above.
- NHSG adopts robust clinical governance arrangements within the Maternity Service that fulfil the requirements of the Clinical and Care Governance Framework.
- NHSG clarifies the management arrangements for DGH.
- NHSG develops a clear vision for DGH and the DGH Maternity Service.
- NHSG develops a full package of support for all staff who have been adversely affected by the issues within the DGH Maternity Service.



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Chapter 9: Guidelines for the Provision of Anaesthesia Services for an Obstetric Population 2020

Published: 31/01/2020

In this section

Introduction

Pregnancy and the time around the birth of a baby is usually an exciting time in the life of a family, but it also brings with it potential risks to mother and baby. We are fortunate in the United Kingdom to have a low maternal mortality rate (MMR) but we have seen a plateau in the UK's MMR in the last triennium.[4,7,6] Our continued national learning from the confidential review of every maternal death over the last seven decades has allowed us to determine where deficiencies in service provision have led to substandard or poor care and to identify areas where improvements to care can be made to reduce the risk for mothers and babies. It is vital that we use this shared learning and the currently available evidence to shape our provision of care to pregnant and recently delivered women, both here in the UK and with the wider population globally.

Working on delivery units can be incredibly rewarding for obstetric anaesthetists and the wider multidisciplinary team, but it can also be highly challenging and rapidly changing. It is not possible to identify all women or babies who are at risk of rapid deterioration, but we need to be able to respond appropriately and safely in the event of an emergency. Obstetrics accounts for a large proportion of the emergency surgery performed in hospitals.[9,10] We have emphasised in these recommendations the importance of training and working as a team when delivering care in maternity units. This is truly a multidisciplinary workforce, where obstetricians, anaesthetists, neonatologists, midwives, theatre staff, anaesthetic assistants, and many others

work closely alongside each other in situations that can be stressful. To ensure that teams can function effectively in this environment, they need to train together and have the appropriate infrastructure and necessary resources to meet these expectations.

The anaesthetist is now a well recognised and busy member of the delivery unit team. Approximately 60 per cent of women require anaesthetic intervention around the time of delivery of their baby, but the total anaesthetic involvement is higher. It is currently difficult to quantify other non-anaesthetic procedures that anaesthetists carry out on the delivery suite.[11] Approximately 1 in 4 women deliver by caesarean section, and many more require anaesthetic care for operative/assisted deliveries and procedures during pregnancy or around the time of delivery. Anaesthetists are also involved in planning the care of high-risk women during the antenatal period. While most women are considered low risk at the start of their pregnancies, the obstetric population is changing. In 2015, the largest percentage increase in fertility rates was for women aged 40 and over (a group whom have been identified as at high risk of mortality in the recent MBRRACE report) and the incidence of obesity in this country continues to rise.[4,13,14] The number or women who have had a previous caesarean delivery has risen, and with that comes the risks of complications related to placental adhesion and uterine rupture. More women with significant pre-existing conditions, e.g. congenital cardiac disease, are proceeding with their pregnancies, and they require specialised services to support them during this time. These recommendations outline areas where tertiary units are expected to take a lead role, but, as a pregnant woman may present to any unit, they should all be ready to recognise and manage the acutely deteriorating woman with pathways in place to obtain expert guidance when required.

Maternity services are subject to considerable patient expectation; through media, internet and educational resources, women and their families are often well informed about what to expect at delivery, and many are keen for a particular mode of delivery or type of analgesia. We have to deliver an anaesthetic service that is safe and effective, and that also aims to meet these expectations where appropriate.

We are expecting further National Institute for Health and Care Excellence guidelines on intrapartum care for the high risk maternity population to be published in 2019, along with Royal College of Anaesthetists' guidance on managing critically ill women (updating recommendations made in 'Providing equity of critical and maternity care for the critically ill pregnant or recently pregnant woman').[15,16] These are likely to influence the provision of care for high risk and acutely unwell women in the year to come after publication of this year's Guidelines.

1. Staffing Requirements

The duty anaesthetist's focus is the provision of care to women in labour or who, in the antenatal or postpartum period, require medical or surgical attention. The duty anaesthetist will be a consultant, an anaesthetic trainee or a staff grade, associate specialist and specialty (SAS) doctor.

1.1

To act as duty anaesthetist without direct supervision from a consultant, the anaesthetist should meet the basic training specifications and have attained the RCoA's Initial Assessment of Competency in Obstetric Anaesthesia.[22]

C | Strong

1.2

There should be a duty anaesthetist immediately available for the obstetric unit 24/7. This person's focus is the provision of care to women in labour or who, in the antenatal or postpartum period, require medical or surgical attention. The role should not include undertaking elective work during the duty period.[23]

C | Strong

1.3

Busier units should consider having two duty anaesthetists available 24/7, in addition to the supervising consultant.[24]

C | Moderate

1.4

In units offering a 24-hour neuraxial analgesia service, the duty anaesthetist should be resident on the hospital site where neuraxial analgesia is provided (not at a nearby hospital).

GPP | Strong

1.5

The duty anaesthetist should have a clear line of communication to the supervising consultant at all times.

GPP | Strong

1.6

It is recognised that in smaller units, it may be difficult to have a duty anaesthetist exclusively dedicated to the delivery unit. If the duty anaesthetist has other responsibilities, these should be of a nature that would allow the activity to be immediately delayed or interrupted should obstetric work arise. Under these circumstances, the duty anaesthetist should be able to delegate care of their non-obstetric patient immediately to be able to respond to a request for care of obstetric patients. Therefore, for example, they would not simultaneously be able to be a member of the on-call resuscitation team. If the duty anaesthetist covers general theatres, there should be another anaesthetist ready to take over immediately should they be needed to care for obstetric patients.

GPP | Strong

1.7

Adequate time for formal handover between shifts should be built into the timetable.

GPP | Strong

1.8

A structured tool should be considered to facilitate handover.[25]

C | Moderate

1.9

The duty anaesthetist should participate in delivery suite ward rounds.[26]

B | Strong

The lead obstetric anaesthetist

1.10

Every obstetric unit should have a designated lead anaesthetist (see glossary) with specific programmed activities allocated for this role.

C | Strong

1.11

The lead obstetric anaesthetist should be responsible for the overall delivery of the service, which includes ensuring that evidence-based guidelines and protocols are in use and are up to date; monitoring staff training, workforce planning, and service risk management; and ensuring that national specifications are met, and auditing the service against these agreed standards, including anaesthetic complication rates.

GPP | Strong

1.12

The lead obstetric anaesthetist should ensure representation of the anaesthetic department at multidisciplinary meetings for service planning, e.g. labour ward forum.[24]

GPP | Strong

1.13

The lead obstetric anaesthetist should ensure that there are ongoing quality improvement projects in place to maintain and improve the care in their units.[27]

C | Strong

Consultant responsibilities

1.14

As a basic minimum for any obstetric unit, a consultant anaesthetist should be allocated to ensure consultant cover for the full daytime working week (that is, ensuring that mon-fri, morning and afternoon sessions are staffed).[24] This is to provide urgent and emergency care, not to undertake elective work.

C | Strong

1.15

In busier units, increased levels of consultant cover should be considered, reflecting the level of consultant obstetrician staffing in the unit.[28] This may involve extending the working day to include consultant presence into the evening session and/or increasing consultant numbers.

C | Strong

1.16

Additional consultant programmed activities should be allocated for:

- elective caesarean deliveries
- antenatal anaesthetic clinics (or to review referrals if no formal clinic is in place).[24]

C | Moderate

1.17

In units where trainee anaesthetists work a full or partial shift system, and/or rotate through the department every three months (or more frequently), provision of additional consultant programmed activities should be considered, to allow training and supervision into the evening.[29]

GPP | Strong

1.18

There should be a named consultant anaesthetist responsible for every elective caesarean delivery operating list. This consultant should be immediately available. The named consultant should have no other clinical responsibilities.

C | Moderate

1.19

Consultant support should be available at all times with a response time of not more than half an hour to attend the delivery suite, and maternity operating theatre. The supervising consultant should not therefore be responsible for two or more geographically separate obstetric units.

B | Strong

1.20

In busy units, consideration should given to extending resident consultant cover into the evening.

GPP | Moderate

1.21

Staff working in the maternity unit should be aware of their supervisor's identity, location and how to contact them.[30] The name(s) of the consultant(s) covering the delivery suite should be clearly displayed and easily visible to all staff, and contact numbers readily available.

GPP | Strong

1.22

The anaesthetist caring for the woman should not be responsible for neonatal resuscitation and the care of the newborn baby.[21]

GPP | Strong

Anaesthetic assistance

1.23

Women requiring anaesthesia in the peripartum period should have at least the same standards of perioperative care as for any surgical patient.[31]

C | Strong

1.24

The anaesthetist should have a competent trained assistant immediately available for the duration of any anaesthetic intervention and this practitioner should not have any other duties.[31]

C | Strong

1.25

All theatre staff acting as anaesthetic assistants should comply fully with current national qualification standards, and be required to have attained and maintained the relevant competencies to perform the role (an example of these competencies is referenced).[32,33]

C | Strong

1.26

Anaesthetic assistants who cover obstetrics should demonstrate additional knowledge and skills specific to the care of pregnant women.[32]

C | Strong

1.27

Anaesthetists and anaesthetic assistants working without direct supervision in obstetric theatres and on the delivery suite should be familiar with the environment and working practices of that unit, and work there on a frequent basis to maintain that familiarity.

C | Strong

Post-anaesthetic recovery staff

1.28

All women requiring postoperative recovery care should receive the same standard of care as the non-obstetric postoperative population.[33,34,35,36]

GPP | Strong

1.29

All theatre and post-anaesthetic recovery staff looking after the obstetric population should be familiar with the area for recovery of obstetric patients and be experienced in the use of the different early warning scoring systems for obstetric patients. They should have been trained to the same standard as for all recovery nurses, have maintained these skills through regular work on the theatre recovery unit, and have undergone a supernumerary preceptorship in this environment before undertaking unsupervised work.[33,36]

C | Strong

Other members of the team

1.30

An adult resuscitation team trained in resuscitation of the pregnant patient should be immediately available.[37]

GPP | Strong

1.31

There should be secretarial support for the department of anaesthesia, including the obstetric anaesthetic service.

C | Strong

1.32

Provision should be made to ensure access to appropriate healthcare professionals to support women who require their services, such as clinical pharmacists, dietitians, outreach nurses and physiotherapists.[16]

GPP | Strong

1.33

Locum anaesthetists should be assessed to ensure their competence prior to undertaking work without direct supervision.[24]

C | Strong

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2. Equipment, services and facilities

Equipment

2.1

Blood gas analysis (with the facility to measure serum lactate and the facility for rapid estimation of haemoglobin and blood sugar) should be available on the delivery suite.

GPP | Strong

2.2

Delivery suite rooms should be equipped with monitoring equipment for the measurement of non-invasive blood pressure, oxygen saturation and heart rate.

GPP | Strong

2.3

Delivery suite rooms should have oxygen, suction equipment and access to resuscitation equipment. Equipment should be checked daily in accordance with the Association of Anaesthetists published guidelines.[38]

GPP | Strong

2.4

Delivery suite rooms must comply with Control of Substances Hazardous to Health (COSHH) Regulations 2002 and guidelines on workplace exposure limits on waste gas pollution.[39,40]

M | Mandatory

2.5

The standard of monitoring in the obstetric theatre should allow the conduct of safe anaesthesia for surgery as detailed by the Association of Anaesthetists standards of monitoring.[41]

C | Strong

2.6

A fluid warmer device allowing rapid transfusion of blood products and intravenous fluids should be available.[42]

GPP | Strong

2.7

A rapid infusion device should be available for the management of major haemorrhage.[41]

GPP | Strong

2.8

In tertiary units, with a high risk population, it is recommended that there should be equipment to enable near patient estimation of coagulation such as thromboelastography (TEG) or thromboelastometry.[57]

M | Strong

2.9

Cell salvage may be considered for women who refuse blood products or where massive obstetric haemorrhage (MOH) is anticipated but it should not be used routinely for caesarean delivery. Women should be informed of the risks and benefits of its use and staff who operate this equipment should receive training in how to operate it, and use it frequently to maintain their skills.[43,44]

C | Strong

2.10

Devices, such as forced air warmers, to prevent and/or treat hypothermia should be available.[45]

C | Strong

2.11

A difficult intubation trolley with a variety of laryngoscopes, including video laryngoscopes; tracheal tubes (size 7 and smaller); laryngeal masks, including second generation supraglottic airway devices; and other aids for airway management, should be available in theatre. The difficult intubation trolley should have a standard layout which is identical to trolleys in other parts of the hospital so that users will find the same equipment and layout in all sites.[46,47]

C | Strong

2.12

Patient controlled analgesia (PCA) equipment should be available for postoperative pain relief, and staff operating it should be trained in its use and how to look after women with PCA.[48]

C | Strong

2.13

The maximum weight that the operating table can support should be known, and alternative provision made for women who exceed this.

GPP | Strong

2.14

Equipment to facilitate the care of morbidly obese women (including specialised electrically operated beds, and positioning aids such as commercially produced ramping pillows, weighing scales, sliding sheets, and hover mattresses or hoists) should be readily available and staff should receive training on how to use the specialised equipment.[49]

C | Strong

2.15

Ultrasound imaging equipment should be available for invasive procedures such as central vascular access, transversus abdominis plane (TAP) blocks and the provision of central neuraxial blockade.[50,51]

C | Strong

2.16

Ultrasound equipment should be available for use by trained staff for transversus abdominis plane (TAP) blocks, central neuraxial blockade, placing lines and transthoracic echocardiography. Other tasks, such as airway and gastric volume assessment, may also benefit from the availability of ultrasound.[52,53]

C | Strong

2.17

Synchronised clocks should be present in all delivery rooms and theatres to facilitate the accurate recording of events and to comply with medicolegal requirements.[54]

C | Strong

2.18

Resuscitation equipment, including an automated defibrillator, should be available on the delivery suite and should be checked regularly.[55] A perimortem caesarean section pack containing a scalpel, surgical gloves and cord clamp should be available on all resuscitation trolleys in the Maternity Unit and areas admitting pregnant women e.g. emergency departments.[56] A range of various sizes of tracheal tubes of no >7 mm internal diameter should also be kept on the resuscitation trolleys.[4]

C | Strong

Support services

2.19

There should be arrangements or standing orders in place for agreed preoperative laboratory investigations. There should be a standard prescription or a local Patient Group Directive for preoperative antacid prophylaxis.

GPP | Strong

2.20

Haematology and biochemistry services to provide analysis of blood and other body fluids should be available 24/7.

GPP | Strong

2.21

A local policy should be established with the haematology department to ensure blood and blood products once available are able to be transferred to the delivery suite rapidly for the management of major haemorrhage.[57,58]

C | Strong

2.22

O negative blood should be immediately available, and ideally stored on the delivery suite.

GPP | Strong

2.23

There should be rapid availability of radiology services.

C | Strong

2.24

In tertiary referral centres, there should be 24-hour access to interventional radiology services.[55]

C | Aspirational

2.25

Echocardiography should be available at all times in units that routinely deal with cardiac patients.[6]

C | Strong

2.26

Robust and reliable local arrangements should be in place to ensure the supply and maintenance of all medicines required in obstetric anaesthesia. There must be a system for ordering, storage, recording and auditing of controlled drugs, in accordance with legislation.[59,60,61]

C | Strong

2.27

There should be access to a clinical pharmacist of an appropriate competency level and with appropriate experience in obstetrics, to advise on day-to-day medication or prescribing issues in the obstetric population, and to provide input in local policies and procedures pertaining to any aspects of medicines management.[62]

C | Strong

2.28

Sterile prefilled syringes or bags of low dose local anaesthetic combined with opioid solutions for regional analgesia should be available.

C | Strong

2.29

Prefilled syringes of commonly used emergency drugs, e.g. suxamethonium and phenylephrine, should be used where available.[63]

GPP | Aspirational

2.30

Local anaesthetic solutions intended for epidural infusion should be stored separately from intravenous infusion solutions to minimise the risk of accidental intravenous administration of such drugs.[64]

C | Strong

2.31

Medication for rare but life threatening anaesthetic emergencies, in particular Intralipid, sugammadex and dantrolene, should be immediately available to the delivery suite, and their location should be clearly identified. There should be a clear local agreement on the responsibility for maintenance of these emergency medicines, i.e. regular checks of stock levels, integrity, and expiry dates.

GPP | Strong

2.32

Physiotherapy services should be available 24/7 for patients requiring high dependency care.

GPP | Strong

Facilities

2.33

There should be easy and safe access to the delivery suite from the main hospital at all times.

GPP | Strong

2.34

An emergency call system should be provided.

GPP | Strong

2.35

There should be at least one fully equipped obstetric theatre within the delivery suite, or immediately adjacent to it. Appropriately trained staff should be available to allow emergency operative deliveries to be undertaken without delay.[21] The number of operating theatres available for obstetric procedures will depend on the number of deliveries and the operative risk

profile of the women delivering in the unit.

GPP | Strong

2.36

There should be medication storage facilities within maternity theatres which provide timely access to medicines when clinically required, while maintaining integrity of the medicinal product and allowing the organisation to comply with safe and secure storage of medicines regulations.[62,65]

C | Strong

2.37

Adequate recovery room facilities, including the ability to monitor blood pressure, ECG, oxygen saturation, end-tidal carbon dioxide and temperature, should be available within the delivery suite theatre complex.[41]

C | Strong

2.38

Anaesthetic machines, monitoring and infusion equipment and near patient testing devices should be maintained, repaired and calibrated by medical physics technicians.

GPP | Strong

2.39

All units should have facilities, equipment and appropriately trained staff to provide care for acutely ill obstetric patients. If this is unavailable, women should be transferred to the general critical care area in the same hospital with staff trained to provide care to obstetric patients.[16]

C | Strong

2.40

All patients should be able to access level 3 critical care if required; units without such provision on site should have an arrangement with a nominated level 3 critical care unit and an agreed policy for the stabilisation and safe transfer of patients to this unit when required.[16,55] Portable monitoring with the facility for invasive monitoring should be available to facilitate safe transfer of obstetric patients to the ICU.[66]

C | Strong

2.41

An anaesthetic office, within five minutes from the delivery suite, should be available to the duty anaesthetic team. The room should have a computer with intra/internet access for access to specialist reference material and local multidisciplinary evidence based guidelines and policies. The office space, facilities and furniture should comply with the standards recommended by the Association of Anaesthetists guidelines.[67] This office could also be used to allow teaching, assessment and appraisal.[67]

C | Strong

2.42

A communal rest room in the delivery suite should be provided to enable staff of all specialties to meet.

GPP | Strong

2.43

A seminar room should be accessible for training, teaching and multidisciplinary meetings.

GPP | Strong

2.44

All hospitals should ensure the availability of areas that allow those doctors working night shifts to take rest breaks essential for the reduction of fatigue and improve safety.[26] These areas should not be used by more than one person at a time and allow the doctor to fully recline.

C | Strong

2.45

Standards of accommodation for doctors in training should be adhered to.[25] Where a consultant is required to be resident, on-call accommodation should be provided.

C | Strong

2.46

Hotel services should provide suitable on-call facilities, including housekeeping services for resident and non-resident anaesthetic staff. Refreshments should be available 24/7.

GPP | Strong

Guidelines

2.47

C | Strong

2.48

All obstetric departments should provide and regularly update multidisciplinary guidelines. A comprehensive list of recommended guidelines can be found in the Obstetric Anaesthetists' Association (OAA)/Association of Anaesthetists guidelines for obstetric anaesthesia services.[55]

C | Strong

2.49

Guidelines for the management of pregnant women receiving anticoagulation should be available.[68]

C | Strong

3. Areas of special requirement

Care for the acutely ill obstetric patient

3.1

NICE guidance on the recognition of and response to acute illness in adults in hospitals should be implemented.[70]

C | Strong

3.2

An early warning score system, modified for use in obstetrics, with a graded response system should be used for all obstetric patients to aid early recognition and treatment of the acutely ill woman.[71,72]

C | Strong

3.3

All units should be able to escalate care to an appropriate level, and critical care support should be provided as soon as required, regardless of location.[57]

GPP | Strong

3.4

Whenever possible, escalation in care should not lead to the separation of mother and baby.[4,16]

C | Strong

3.5

When midwives provide a level of care beyond their routine scope of practice, they should be appropriately trained.

GPP | Strong

3.6

There should be a named consultant anaesthetist and obstetrician responsible 24/7 for all women requiring a higher level of care.[16]

GPP | Strong

3.7

Women requiring critical care in a non-obstetric facility should be reviewed daily by a maternity team including an anaesthetist.[4]

C | Strong

Care for the obese woman

The incidence of obesity is rising in the obstetric population. Obesity is associated with increased incidence of both obstetric and medical complications.[73]

3.8

There should be a system in place for antenatal anaesthetic review of obese women with a body mass index (BMI) >40 kg/m^2.[2,74] Assessment should be arranged to ensure timely delivery planning can take place.[75]

GPP | Strong

3.9

The duty anaesthetist should be informed as soon as a woman with a BMI above a locally agreed threshold is admitted.

GPP | Strong

3.10

There should be appropriate equipment to care for obese women.[76]

C | Strong

Care for women under the age of eighteen

The following recommendations apply to units that admit young women and girls under the age of eighteen years for obstetric services.

3.11

There should be a multidisciplinary protocol governing care of these patients that includes: consent, the environment in which these patients are cared for, and the staff responsible for caring for these young people.

C | Strong

3.12

Anaesthetists should be aware of legislation and good practice guidance[77,78,79] relevant to children and according to the location in the UK.[80,81,82,83] These documents refer to the rights

of the child, child protection processes and consent.

M | Mandatory

3.13

Anaesthetists must undertake at least level 2 training in safeguarding/child protection,[84] and must maintain this level of competence by regular annual updates on current policy and practice and case discussion.[85]

C | Strong

3.14

At least one anaesthetist in each anaesthetic department, not necessarily an obstetric anaesthetist, should take the lead in safeguarding/child protection[86] and undertake training and maintain core level 3 competencies. The lead anaesthetist for safeguarding/child protection should liaise with their multidisciplinary counterparts within the obstetric unit.

C | Strong

Care for women requiring specialist services

3.15

There should be policies defining how women are referred to and access specialist or tertiary services (e.g. neurosurgery, acute stroke services).[4]

C | Strong

4. Training and education

4.1

All anaesthetists involved in the care of pregnant women should be competent to deliver high quality, safe care that takes into account the physiological changes in and other requirements of pregnant women.[87]

C | Strong

4.2

There should be a nominated consultant responsible for training in obstetric anaesthesia, with adequate programmed activities allocated for these responsibilities.[55]

C | Strong

4.3

Elective caesarean deliveries should be utilised for training purposes.[88]

B | Strong

4.4

The successful completion of the initial assessment of competence in obstetric anaesthesia should be obtained by all core trainees before they are allowed to work in an obstetric unit without direct supervision.[89,90]

C | Strong

4.5

A process should be in place for the formal assessment of anaesthetists prior to allowing them to join the on-call rota for obstetric anaesthesia with distant supervision.[89,91]

C | Strong

4.6

In situ simulation training can help to identify system process gaps.[92] Simulation-based learning techniques should be used to assist anaesthetists to resolve these issues and develop the necessary technical and non-technical skills.[93,94,95,96,97,98,99,100,101,102,103]

B | Strong

4.7

There should be induction programmes for all new members of staff, including locums. Induction for a locum doctor should include familiarisation with the layout of the labour ward, the location of emergency equipment and drugs (e.g. MOH trolley/intralipid/dantrolene), access to guidelines and protocols, information on how to summon support/assistance, and assurance that the locum is capable of using the equipment in that obstetric unit. All inductions should be

documented.

GPP | Strong

4.8

Anaesthetists with a job plan that includes obstetric anaesthesia must demonstrate ongoing continuing education in obstetric anaesthesia, and continuing professional development as needed for this aspect of their work.[104] Hospitals have a responsibility to enable this with local teaching where appropriate, and by facilitating access to other education and training.[96,105,106]

M | Mandatory

4.9

Any non-trainee anaesthetist who undertakes anaesthetic duties in the labour ward should have been assessed as competent to perform these duties in accordance with OAA and RCoA guidelines.[31,55,89] Such a doctor should work regularly in the labour ward but should also regularly undertake non-obstetric anaesthetic work to ensure maintenance of a broad range of anaesthetic skills.

C | Strong

4.10

All staff working on the delivery suite should have annual resuscitation training, including the specific challenges of pregnant women.[107]

B | Strong

4.11

Anaesthetists should contribute to the education and updating of midwives, anaesthetic assistants and obstetricians.

GPP | Strong

4.12

Anaesthetists should help organise and participate in regular multidisciplinary courses and ‘skills drills’ for emergency situations.[8,99,100,101,108]

C | Strong

5. Organisation and administration

Organisation

5.1

A system should be in place to ensure that women requiring antenatal referral to an anaesthetist are seen and assessed by an anaesthetist, normally a consultant, within a suitable time frame. Ideally, this should be in the form of multidisciplinary team management of these high risk women. Where the workload is high consideration should be given to risk stratification so that not all women are required to attend in person, by using targeted telemedicine / distribution of relevant literature.[109]

GPP | Strong

5.2

An anaesthetist should be included in the multidisciplinary team (MDT) antenatal planning of management for women with complex medical needs.[4] Planning should include consideration of the woman's wishes and preferences.

GPP | Strong

5.3

All women requiring caesarean section should, except in extreme emergency, be visited and assessed by an anaesthetist before arrival in the operating theatre. This should be timed to allow women sufficient time to weigh up the information they have been given, in order to give informed consent for anaesthesia.

GPP | Strong

5.4

There should be a local guideline on the monitoring of women after regional anaesthesia and the management of post anaesthetic neurological complications.[110]

C | Strong

5.5

All women who have received regional analgesia/anaesthesia or general anaesthesia for labour and delivery should be reviewed following delivery. Locally agreed discharge criteria should be met before women go home with written information provided.[111] There should be local guidelines on preoperative, intraoperative and postoperative care for those cases where the enhanced recovery process is appropriate.[112]

GPP | Strong

Consent

5.6

Women must be assumed to have capacity unless there is evidence to the contrary, as per the Mental Capacity Act.[113]

GPP | Strong

5.7

There should be documentation of any discussions informing consent for any procedures undertaken by the anaesthetist.[113]

C | Strong

5.8

Written consent should be obtained prior to undertaking an epidural blood patch.[113]

GPP | Strong

Neuraxial and opioid analgesia

5.9

Obstetric units should be able to provide neuraxial analgesia on request. Smaller units may be unable to provide a 24-hour service; women booking at such units should be made aware that neuraxial analgesia may not always be available.[55]

GPP | Strong

5.10

Midwifery care of a woman receiving neuraxial analgesia in labour should comply with local guidelines that have been agreed with the anaesthetic department. Local guidelines should include required competencies, maintenance of those competencies and frequency of training. If the level of midwifery staffing is considered inadequate, neuraxial analgesia block should not be provided.

C | Strong

5.11

Units should have local guidelines on the recognition and management of complications of neuraxial analgesia that include training on the recognition of complications and access to appropriate imaging facilities when neurological injury is suspected.

C | Strong

5.12

Units should provide low-dose neuraxial analgesia.[19,114]

GPP | Strong

5.13

Neuraxial analgesia should not be used in labour unless the obstetric team is immediately available.

GPP | Strong

5.14

There should be a locally agreed neuraxial analgesia record and a protocol for the prescription and administration of drugs.

C | Strong

5.15

When the anaesthetist is informed of a request for neuraxial analgesia (and the circumstances would be suitable for this type of analgesia) the anaesthetist should attend within 30 minutes of being informed. Only in exceptional circumstances should this period be longer, and in all

cases attendance should be within one hour. This should be the subject of regular audits.[27,115]

B | Strong

5.16

When remifentanil PCA is provided as an alternative to neuraxial analgesia, there should be local multidisciplinary guidelines.[116]

C | Strong

5.17

Midwives caring for women receiving remifentanil PCA should be trained specifically in the use of the technique, and stay with the woman continuously without any break in observation. Remifentanil PCA should only be provided in units where it is frequently used. Rapid reversal of respiratory depression/arrest and airway resuscitation equipment should be immediately available.

B | Strong

Emergency caesarean delivery

5.18

There should be a clear line of communication between the duty anaesthetist, theatre staff and anaesthetic assistant once a decision is made to undertake an emergency caesarean delivery.

GPP | Strong

5.19

The anaesthetist should be informed about the category of urgency of caesarean delivery at the earliest opportunity.[117]

GPP | Strong

5.20

A World Health Organization (WHO) checklist adapted for maternity should be used in theatre.[118]

B | Strong

5.21

Before induction of general anaesthesia, there should be a multidisciplinary discussion about whether to wake the woman or to continue with anaesthesia in the event of failed tracheal intubation.[119]

B | Strong

5.22

Women should be informed of the risks of accidental awareness under general anaesthesia during emergency caesarean delivery. Precautions should be taken to minimise these risks.[10,117,118,120]

C | Strong

5.23

There should be clear arrangements in contingency plans and an escalation policy for use should two emergencies occur simultaneously, including whom to call.

C | Strong

5.24

Hospitals should have approved documentation defining safe staffing levels for anaesthetists and anaesthetic assistants, including contingency arrangements for managing staffing shortfalls, and annual reviews of compliance with these should be performed.

C | Strong

The multidisciplinary team

Care of the pregnant woman is delivered by teams rather than individuals. Effective teamwork has been shown to increase safety, while poor teamwork has the opposite effect.[71,96] It is, therefore, important that obstetric anaesthetists develop effective leadership and team membership skills, with good working relationships and lines of communication with all other professionals, including those whose care may be needed for difficult cases. This includes midwives, obstetricians and neonatologists, as well as professionals from other disciplines such

as intensive care, obstetric physicians, neurology, cardiology, haematology, radiology, general practitioners and other physicians and surgeons.

5.25

Team briefing and the WHO checklist should be in routine use on the labour ward to promote good communication and team working and reduce adverse incidents.[117,118,121,122]

C | Strong

5.26

The use of handover tools, which reduce critical omissions during handovers in obstetric anaesthesia, should be promoted.[25,123]

GPP | Strong

5.27

Units with high numbers of caesarean delivery should have elective caesarean delivery lists to minimise disruption due to emergency work.[87,124] Any elective caesarean delivery list should have dedicated obstetric, anaesthetic and theatre staff.

GPP | Strong

5.28

If any major restructuring of the provision of local maternity services are planned, the lead obstetric anaesthetist should be involved in that process.[24]

C | Strong

5.29

Anaesthesia should be represented on all committees responsible for maternity services (e.g. the Maternity Services Liaison Committee, Delivery Suite Forum, Obstetric Multidisciplinary Guidelines Committee, Obstetric Risk Management Committee).[24,55]

C | Strong

5.30

Hospitals should have systems in place to facilitate multidisciplinary morbidity and mortality

meetings.[125]

C | Strong

5.31

The route of escalation to critical care services should be clearly defined.[126]

C | Strong

Serious incidents

5.32

When members of the healthcare team are involved in a critical incident, they can be profoundly affected. A team debriefing should take place after a significant critical incident. Critical incident stress debriefing by trained facilitators, with further psychological support, may assist individuals to recover from a traumatic event. After a significant critical incident, the lead clinician should review the clinical commitments of the staff concerned promptly.

GPP | Strong

5.33

There should be systematic measures in place to respond to serious incidents. These measures should protect patients and ensure that robust investigations are carried out by trained safety leads. When an incident occurs, it should be reported to all relevant bodies within and beyond the hospital. A system of peer review or external evaluation of serious incident reports should be in place.[120,121]

GPP | Strong

5.34

An anaesthetist should be involved in all case reviews where the case includes anaesthetic input.

C | Strong

6. Financial considerations

There is a paucity of evidence regarding the financial implications of many of the recommendations we make here. Many of them are not new however and, although we do not have data about the compliance of every unit with previous versions of these guidelines, the vast majority of units will already adhere to most of the standards outlined here. Many of the recommendations represent a financial impact on workforce and time allowance and this should be dealt with in robust job planning and specification in each anaesthetic department and, in the case of hospital managers, at trust or board level.

Where we have made recommendations about specific equipment, this may have implications for capital and operational expenditure in terms of acquisition of the equipment and its ongoing use and maintenance. Where these recommendations are made, it is based on evidence that there is benefit to patients in terms of outcome and/or improved safety, or that it offers a cost-effective alternative to other treatment options available. Local business cases and action plans may need to be developed. The cost of implementing any of these evidence-based recommendations should always be considered in relation to the financial risks of providing substandard care. Apart from the human costs of this, litigation in maternity services is an expensive issue.

Any service implications will have to be considered against the background of the need for all NHS trusts in England and Wales to reduce expenditure, and in the context of the proposed changes to the budgetary structure of maternity services.[122] We recognise that staff in some units, particularly those with smaller delivery rates, may feel it is burdensome to implement some of these service specifications. It is not the purpose of this guidance to dictate how these recommendations are met – that is to be decided locally. Individual trusts/boards and their executives will need to consider the ongoing viability of any maternity unit that continues to fail to meet these standards. The amalgamation or formalised intertrust/board partnerships of smaller consultant-led units, for example, which are an effort to pool resources more efficiently, may require consideration if service provision consistently falls short of the expected standards.

7. Research, audit and quality improvement

7.1

The lead obstetric anaesthetist should audit and monitor the duty anaesthetist workload to ensure that there is sufficient provision for the busyness of the unit.

GPP | Strong

7.2

There should be regular audits of the quality of clinical governance, with particular attention being paid to provision and updating of local guidelines, reviews of adverse events, and record keeping.[24]

C | Strong

7.3

There should be regular audits relating to the provision of neuraxial analgesia, with particular attention paid to midwifery staffing levels and delays between request for and delivery of pain relief, maternal satisfaction rates and recognised complications.[130,131]

C | Strong

7.4

There should be a regular audit of delays to elective caesarean deliveries.[55]

C | Strong

7.5

The use of an obstetric appropriate WHO style checklist before all surgical obstetric interventions should be the subject of regular audit and observational study.[118]

B | Strong

7.6

All cases of maternal death, significant permanent neurological deficit, failed intubation or awareness during general anaesthesia should undergo case review, with learning from this shared locally and/or nationally.[27]

C | Strong

7.7

Provision of supernumerary training sessions for non-specialist anaesthetists expected to provide out-of-hours or emergency care on the maternity unit should be the subject of review.[132]

C | Strong

7.8

In units providing a programme of enhanced recovery from caesarean delivery, there should be regular audits of readmission rates for these women.[133]

C | Strong

7.9

As well as the specific topics detailed above, a regular audit programme should encompass national audit recipes and standards.[27]

C | Strong

7.10

Care should be taken to ensure that all audit, standards and guidelines documents carry clear definitions of terms such as ‘neuraxial analgesia rate’.[17]

C | Strong

7.11

Research in obstetric anaesthesia and analgesia should be encouraged. Research must follow strict ethical standards as stated by the General Medical Council (GMC).[134]

M | Mandatory

8. Implementation support

The Anaesthesia Clinical Services Accreditation (ACSA) scheme, run by the RCoA, aims to provide support for departments of anaesthesia to implement the recommendations contained in the GPAS chapters. The scheme provides a set of standards, and asks departments of anaesthesia to benchmark themselves against these using a self-assessment form available on the RCoA website. Every standard in ACSA is based on recommendation(s) contained in GPAS. The ACSA standards are reviewed annually and republished approximately four months

after GPAS review and republication to ensure that they reflect current GPAS recommendations. ACSA standards include links to the relevant GPAS recommendations so that departments can refer to them while working through their gap analyses.

Departments of anaesthesia can subscribe to the ACSA process on payment of an appropriate fee. Once subscribed, they are provided with a 'College guide' (a member of the RCoA working group that oversees the process), or an experienced reviewer to assist them with identifying actions required to meet the standards. Departments must demonstrate adherence to all 'priority one' standards listed in the standards document to receive accreditation from the RCoA. This is confirmed during a visit to the department by a group of four ACSA reviewers (two clinical reviewers, a lay reviewer and an administrator), who submit a report back to the ACSA committee.

The ACSA committee has committed to building a 'good practice library', which will be used to collect and share documentation such as policies and checklists, as well as case studies of how departments have overcome barriers to implementation of the standards, or have implemented the standards in innovative ways.

One of the outcomes of the ACSA process is to test the standards (and by doing so to test the GPAS recommendations) to ensure that they can be implemented by departments of anaesthesia and to consider any difficulties that may result from implementation. The ACSA committee has committed to measuring and reporting feedback of this type from departments engaging in the scheme back to the CDGs updating the guidance via the GPAS technical team.

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9. Patient communication and information

9.1

Information should be made available to commissioners and to women in the early antenatal period about availability of neuraxial analgesia and anaesthetic services in their chosen location for delivery.[55]

C | Strong

9.2

Every unit should provide, in early pregnancy, advice about pain relief and anaesthesia during labour and delivery. An anaesthetist should be involved in preparing this information and approve the final version.[113]

M | Mandatory

9.3

Information must be made available to women in the antenatal period about possible deviations from normal delivery and of emergencies that might arise in the peripartum period, in anticipation of constraints imposed by time and circumstances in the event of such situations arising.[113,135,136,137]

C | Strong

9.4

Information should be made available to non-English speaking women in their native languages.[131,132]

GPP | Strong

9.5

Units should consider local demographics, such as the prevalence of particular languages, when designing information or commissioning interpreting services.

GPP | Strong

9.6

Hospitals should ensure that the mother's need for information in other languages should be assessed and recorded during antenatal care so that interpreting services can be planned for.

GPP | Strong

9.7

Interpreting services should be made available for non-English speaking women, with particular attention paid to how quickly such services can be mobilised and their availability out of hours.

GPP | Strong

9.8

Face to face interpreting services should be considered as most suitable, given the practical requirements for women in labour. However, telephone based services may be able to serve a

greater number of languages and be more quickly mobilised, particularly out of hours.

C | Strong

9.9

The use of family members to interpret or translate should be avoided unless absolutely necessary or the woman specifically declines an independent interpreter. It should be a rare occurrence that there is no alternative translation method available.[140,141]

C | Strong

9.10

Women who refuse transfusion of blood or blood products, whether because of adherence to the Jehovah's Witness faith or for other reasons, should be identified early in the antenatal period. They should meet with an anaesthetist to discuss their specific restrictions, and should receive information about the potential risks associated with their decision.[142,143] Their decision should be documented as part of the informed consent process. Such conversations should be conducted with appropriate privacy to avoid the risk of coercion.

M | Mandatory

9.11

Women with potential capacity to consent issues should be identified early in the antenatal period, and arrangements made to both maximise their competency and to ensure that they are adequately represented and advocated for, in keeping with current legislation.[144]

GPP | Strong

9.12

All explanations given to women should be clearly documented in their records.

GPP | Strong

Complaints

9.13

If complaints are made about aspects of care, a consultant anaesthetist should review and

assess the patient's complaint, discussing her concerns and examining her where appropriate. This should be documented. Referral for further investigations may be required.

GPP | Strong

9.14

Complaints should be handled according to local policies.

GPP | Strong

9.15

The lead obstetric anaesthetist should be made aware of all complaints.

GPP | Strong

Areas for future development

Areas of research currently identified as deficient by the GPAS CDG include:[4,145,146]

- efficacy of obstetric early-warning systems
- risks and benefits of 'natural' caesarean delivery
- oral intake in labour
- defining the 'busyness' of an obstetric unit.

Glossary

Busy units – The busyness of a unit cannot be defined solely by the number of births. For the anaesthetic department, the number of anaesthetic interventions, (defined as the number of regional anaesthetics e.g. epidural, spinal, combined spinal-epidural, where the indication was 'labour', the number of caesarean sections, instrumental deliveries and any other procedure performed in the operating theatre, the number of critically ill women requiring anaesthetic input and the number of women seen in the anaesthetic antenatal clinics) may provide the best proxy measure to judge the busyness of the unit.[17] In this document, the term 'busier units' is used to denote those units that, due to the number of anaesthetic interventions and/or other

local factors, require higher levels of resources in order to deliver the necessary anaesthetic service.

Duty anaesthetist – The term 'duty anaesthetist' is used here to denote the anaesthetist who is the doctor immediately responsible for the provision of obstetric anaesthetic services during the duty period.

Lead anaesthetist – Staff grade, associate specialist and specialty (SAS) anaesthetists undertaking lead roles should be autonomously practicing doctors who have competence, experience and communication skills in the specialist area equivalent to consultant colleagues. They should usually have experience in teaching and education relevant to the role and they should participate in Quality Improvement and CPD activities. Individuals should be fully supported by their Clinical Director and be provided with adequate time and resources to allow them to effectively undertake the lead role.

Immediately – Unless otherwise defined, 'immediately' means within five minutes.

Obstetric unit – an NHS clinical location in which care is provided by a team, with obstetricians taking primary professional responsibility for women at high risk of complications during labour and birth. Midwives offer care to all women in an obstetric unit, whether or not they are considered at high or low risk, and take primary responsibility for women with straightforward pregnancies during labour and birth. Diagnostic and treatment medical services, including obstetric, neonatal and anaesthetic care, are available on site 24 hours a day.[18]

Obstetrician-led care – Care in labour where the obstetrician is responsible for the woman's care. This should only be provided in an obstetric-led unit in a hospital. Much of the woman's care will still be provided by a midwife.[19,20]

Obstetric team – The term 'obstetric team' is used here to denote all the members of the multidisciplinary team that work in the maternity unit[21]

Supervising consultant – The term 'supervising consultant' is used here to denote the consultant anaesthetist with responsibility for the delivery of obstetric anaesthetic services during the duty period.

Supervision – Trainees should be supervised in accordance with the curriculum.[91] The diverse nature of SAS posts means that the standards of education, training and experience that can be expected from post holders can vary quite widely. The degree of supervision a doctor requires should be agreed via a robust, local governance process and follow the RCoA guidance on 'Supervision of SAS and other non-consultant anaesthetists'.[22] More experienced SAS doctors may have the expertise and ability to take responsibility for patients themselves, without consultant supervision, under certain circumstances.

Guidelines for the Provision of Anaesthesia Services for an Obstetric Population 2020

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