States of Guernsey

Access to Public Information Response

December 24th 2016

REQUEST UNDER THE CODE OF PRACTICE FOR ACCESS TO PUBLIC INFORMATION

Request sent on December 24th 2016:

I am making a request under the Code of Practise for access to Public Information for certain information from the Royal College of Obstetrician and Gynaecologists Performance Review (published 2015).

I request any excerpts from the report related to review, analysis or findings pertaining to; overnight obstetrician /gynaecology cover to Loveridge Ward; the obstetrician /gynaecologist on-call system in Loveridge Ward and related patient safety findings and recommendations.

States of Guernsey response sent January 17th 2017:

The relevant extracts from the review as requested in your email are listed below. These extracts are specifically concerning the analysis or findings pertaining to:

- Overnight obstetrician/gynaecology cover to Loveridge Ward;
- The obstetrician/gynaecologist on-call system in Loveridge ward; and
- Related patient safety findings and recommendations

Beginning of extract:

The Royal College of Obstetricians and Gynaecologists were asked to review the Maternity and Neonatal services in Guernsey and Alderney in October 2014. A team including two obstetricians, a senior midwife, an anaesthetist, a paediatrician and a lay representative visited Guernsey on the 24/25th November 2014.

There are between 600 and 650 deliveries annually with care provided by 39 midwives employed by HSSD, four obstetricians, four paediatricians and nine anaesthetists (all doctors employed by MSG). At the time of the visit one of the obstetricians was on sick leave and there were three locums working, taking the total to six. The Head of midwifery was employed in an interim capacity and the Director of Nursing was on sick leave.

There had been a number of external reviews including one from both the Nursing and Midwifery council NMC (2014) and from the local midwifery supervising authority LSA

(October 2014). In previous years there had been reviews from the Royal College of Obstetricians and Gynaecologists, Royal College of Anaesthetists and the Royal College of Paediatrics and Child Health.

Summary Recommendations:

1. Culture
   The Culture of the unit must change and become woman focused with an open learning environment.

2. Leadership
   Leadership is crucial to progress. A dedicated head of a service needs to develop the short and long term strategy in collaboration with the senior team and colleagues and set out action plans to take the team to the next level.

3. Midwifery
   A permanent head of midwifery needs to be appointed with suitable support (both from senior midwives and development support from HSC)

4. Obstetrics
   A resident Obstetrician is required for all women in labour with risk factors that would lead them to need to be delivered in a consultant-led unit (as defined by NICE and not suitable for midwifery-lead intrapartum care).

5. Neonatal
   The neonatal resuscitation team needs to be led by an experienced neonatal nurse (with the A & E doctor no longer part of the team).

6. Training
   Strengthening of training links with Southampton will help ensure that the unit does not 'drift' into inappropriate ways of working. Staff (doctors, nurses and midwives) from Southampton could come to Guernsey as a rotation for a week or two. Thus allowing local staff to go off Island without affecting staffing levels and allow for an external pair of eyes on local practices.

7. Environment
   The labour ward needs modernisation and there needs to be a dedicated obstetric theatre in close proximity to the labour ward.

CONTEXT

PEH is the only inpatient until on the Island of Guernsey. Maternity care is provided by four Consultant Obstetricians (who work from the MSG) and 39 midwives (2014) employed by HSC. There are approximately 600-650 deliveries a

year. There have been a number of external reviews over the last 10 years including those by the Royal College of Obstetricians and Gynaecologists in 2006 and 2011, an anaesthetic review in 2008, one by the Royal College of Midwives in 2009, and Royal College of Paediatrics and Child health review in 2013. In 2014 there have been reviews by the Local Supervising Authority and the Nursing and Midwifery Council. Previous reviews have not always been followed up with clear action plans.

Due to the local political and legal arrangements there are no “non-specialist” medical staff employed to obstetric, anaesthetics or paediatric services and thus all is provided by the consultant staff with no “middle-tier” to support this service. This pattern of care is unique among Crown dependencies. Professional regulation comes under the jurisdiction of the general medical council for the medical staff (with some ongoing discussion with regard to revalidation and lines of responsibility) and the NMC for nursing and midwifery staff. The LSA has provided support for supervision and standards of midwifery care.

At the time of the review there was one local supervisor of midwives (SoM) and support from the supervisors in jersey.

Unlike in the UK where all health care is free at point of access, in Guernsey primary care had to be paid for, whilst maternity care is free (as is secondary gynaecological care). This may change referral patterns with women requesting referral to secondary care relatively early and a higher reliance on specialist rather than general practitioners.
Admission rights for midwives (to the hospital) were only approved in 2012, thus midwifery lead care is a relatively new concept for the women of Guernsey (who may have the expectation for consultant input into normal pregnancy).

OBSTETRIC STAFFING

This is a consultant unit with no junior or trainee doctors. There are four full time consultants with locums appointed to cover most holiday, sabbatical and long-term sick leave. Until September 2014 the consultants were not on site when covering the labour ward (all live within 20 minutes travelling time). Since September/October 2014 the consultants have agreed to be resident at night and weekends. The number of consultants had been temporarily increased to six (with 2-3 locum appointments to cover the increase and to cover sick leave, etc.). This has led to significantly improved medical support for women in labour but has had a knock on effect on elective work, in particular gynaecology and continuity of care.

All the consultants are on the GMC specialist register and most have previously held substantive NHS appointments.

13.2 OBESTETRICIANS

There are currently four substantive consultants (one of whom is not currently working) and three locums (thus six obstetricians currently covering the work load). They are hardworking, experienced and dedicated professionals working in a consultant provided service with no back up junior staff. The consultants have to see all their own patients, follow up on those who require plans of care (e.g. liaising directly with other medical staff, social services, radiology and pathology). All inpatient care is provided by the consultant staff including all pre and postoperative care, antenatal and postnatal ward work. The organisational burden of this care needs to be recognised.

The assessors were given the timetables for three of the four substantive posts (prior to the recent change in working practices). Each had a 24 shift on the labour ward during which they also saw emergency patients on the MSG site. The consultants all appear to have about five clinics a week (including colposcopy, urodynamic and scanning) not including the emergency clinics when on call. It is unclear how many theatre sessions there are but the timetables suggest each consultant has a list each week (the lists may include local anaesthetic colposcopy and hysteroscopy).

Each consultant has the daily “handover” from 08:00 – 09:00 on their timetable, monthly risk management meeting (Monday 12.30 – 14.30) and monthly perinatal meetings (Friday). Consultant One has a number of management meetings through the week and Consultant Two runs the monthly half-day teaching/academic session.

There is very little time allocated to governance, continuing professional development (CPD) or joint unit management.

Currently there are effectively six obstetricians working. They do 24 labour ward cover (the reviewers were uncertain if they still cover emergency clinics or stay on the site). The timetables for when not on labour ward (or a day off after a 24 hour shift) was not clear.

Obstetric Recommendations

1. The previous pattern of work (no obstetrician in the hospital) is not going to be acceptable following the reviews from the LSA and the NMC a change in local professional attitudes and the report from Professor Walker who investigated the recent neonatal death. Guernsey does not run a midwifery led unit for

managing low risk women in labour. There should be obstetrician on-site if there is a women in labour who needs to be in a consultant unit. This would include (amount others) all vaginal births after caesarean (VBACs), twins, preterm labours, hypertensive women, abnormal fetal heart rates, women with pyrexia in labour and women on syntocinon. The options would be to increase the number of obstetricians (probably six or seven) or to employ six middle grade non-training staff is highly variable (Guernsey has always managed to attract high quality consultant staff).

2. Given the low intensity of work when on call, with the provision of adequate office space on the maternity unit, (close to the labour ward), the on-call consultant will be able to undertake significant managerial, governance and teaching activities during his/her shift on the labour ward. Emergency reviews should be limited to women with early pregnancy problems and pregnancy problems such as decreased fetal movements, abdominal pain, bleeding etc. The urgent referrals from the GP should be seen in a dedicated space near the maternity unit as this will be better for the women, than waiting to be seen if the consultant is busy on the labour ward.

3. Review of clinic appointment (both obstetric and gynaecology) may reveal that a number of these reviews are not required and thus free up the consultants time.

4. The elective caesarean section rate of 14%appears to be high for a low risk unit. This may reflect a low VBAC rate which may be improved by a dedicated VBAC clinic (midwifery or medical). The assessors did not review whether external cephalic version (ECV) is offered on the island.

5. All the obstetricians needs to have time to support the running of the unit and this needs to be recognised in their job plans.

6. Although the assessors were reassured that all the consultants had been appraised in the previous 12 months, none of the appraisals shown were up to date. The Responsible Officer needs to ensure that all the consultants are actively engaged with the appraisal system.

7. With an increase in consultant numbers, consideration needs to be given to the administrative support each consultant requires. Given that the overall workload will not be increasing (i.e. the number of obstetric gynaecological patients) there should be only limited need for an increase in secretarial support (consultants can share secretaries).

8. All the consultants would benefit from dedicated time to support reflection and governance. There are a number of training courses available for both clinical governance and appraisal training. It may be that a course could be run

on the island as this may be a “need” across a number of the medical disciplines.

13.5 INTRARTUM CARE

Until recently, the midwifery team has provided care with consultant support in the form of 2-3 daily ward rounds and attendance when called (from clinic or home). Anaesthetic support is from the anaesthetist covering the ICU.

The facilities are old fashioned and in poor condition. The midwifery-led care room is situated on the inpatient ward and is cramped and unwelcoming. The rooms on the delivery suite are extremely clinical and cluttered with unnecessary equipment (including an anaesthetic machine, portable suction etc.). The assessors found it extremely difficult to navigate around the hospital. This is obviously not a problem for the staff but the signposting is less than the ideal.

There is nowhere for medical staff to work within the maternity unit. This does not encourage the obstetricians to stay on site, nor does it make good use of their time when there are no clinical duties to be done.

The intrapartum guidelines are difficult to follow and as such are unhelpful (this will be covered elsewhere).

INTRAPARTUM RECCOMENDATIONS

There are two major intrapartum recommendations. The first is regarding the medical support and is covered both here in the first recommendation and in the section on ‘Obstetrics’. The second requirement is a complete refurbishment of the maternity facilities.

1. On-site medical cover 24 hours a day is required if anything other than low risk midwifery is to be performed. That is, any women who would not be suitable for a midwifery led unit (e.g. VBAC, twins etc.). This will need to be achieved either by employing middle grade obstetric staff or increasing the consultant staff to six or seven posts. This proposal has been discussed in the section on ‘Obstetricians’.

6. The on-call consultant needs an office on the unit so that the governance work can be done when on call.

8. A clinic space within the maternity unit would enable the on-call consultant to review all emergency referrals on site (i.e. all the urgent GP and midwifery referrals which are currently seen on the MSG site).

TOP RECOMMENDATIONS

The culture of the unit must change and become women focussed with an open learning culture. The Assessment Team recommend the following as its top

recommendations to be implemented as soon as is possible in order to begin that change.

- Investment in staff of all disciplines (midwives, consultant obstetricians and paediatricians and neonatal nurses) to ensure the highest level of safe and patient-centred care is possible in this geographically isolated island.
- Resident obstetrician for all women in labour with risk factors that would lead them to need to be delivered in a “consultant” unit (i.e. not suitable for midwifery led intrapartum care).
- Office space on the labour ward or Loveridge for the on-call consultant.

End of extract