Royal College of Obstetricians & Gynaecologists

Invited Review Service

How the RCOG has made a difference

The RCOG receives invitations from healthcare organisations where there is a wish to improve women's health care. Each request is unique and we provide a tailored approach to meet the needs of the service. Some examples of how the RCOG has facilitated improvement include:

- Assessing individual clinical performance
- Reviewing clinical risks and patient safety
- Improving teamwork and collaboration
- Managing service demands effectively
- Identifying solutions for workforce issues
- Assessment of service capacity and safety
- Compliance with recognised standards and national guidance
- Reviewing governance structures and procedures

"Helpful in terms of a general review and providing assurance for the department and Trust board."

The following examples illustrate the variety and scope of reviews that the RCOG have delivered.

ONE Configuring local maternity services

The RCOG undertook a major options appraisal across Cumbria and North Lancashire on behalf of two CCGs, to provide independent advice on the provision of high quality, safe and sustainable maternity services for the future.

During a three-day site visit, our assessors spoke to almost 100 people involved with or having an interest in local maternity services. Most meetings were with clinical staff working in maternity and related services such as paediatrics, surgery, anaesthetics and intensive care. Our assessors also met GPs, ambulance service representatives, local commissioners, NHS Trusts, local MP's, patient group members, the Health Scrutiny Committee and HealthWatch Cumbria.

Our report outlined six options for change, recognising that the geography, pockets of deprivation and poor transport infrastructure made decisions about service configuration very challenging and stressed the importance of engaging the local community in the development of future plans, increasing investment and the active recruitment of doctors. Our assessors also recommended:

- Establishing a project team to develop a detailed feasibility report on the cost, viability and risks of proceeding with any of the options
- Integrating smaller units with community-based services
- Establishing new and variable ways of working so consultants working across sites can comply with evidence-based standards and maintain core competencies and knowledge
- Gradually developing midwifery led unit to enhance the choice of birth for women
- Nurturing leadership and management qualities in consultants across the maternity service and strengthening professional unity between medical staff across all sites

"Very valuable and would not hesitate to involve the College again."

TWO Governance

Following receipt of an anonymous letter to the GMC regarding patient safety, poor practice and flawed investigations within a Trust, we were invited to examine the obstetric and gynaecology services. Our assessors reviewed reports and documents available within the Trust's clinical guidance framework and specific cases involving surgical practice in gynaecology, and antenatal and intrapartum care. We also looked into issues that may have been preventing staff from raising patient safety concerns. On completion of the two-day site visit our assessors made the following recommendations to improve safety:

- Named Executive Director to increase awareness and compliance with the Whistleblowing Policy
- Improve record keeping through staff training and special checks
- Develop effective procedures to ensure incidents are reported and action taken to share lessons learned
- Improve the rigour of their root cause analysis investigations

THREE Training across two hospital sites

A review was commissioned by a Trust to evaluate the clinical training programmes and opportunities in obstetrics and gynaecology and to review the supervision provided to trainee junior medical staff and student midwives across two sites following concerns about patient safety and aspects of training raised during a Deanery visit.

There was clearly much work already underway at the Trust to address these concerns and our assessors were able to support the Trust further with the following additional recommendations:

- Formation of a trainees group with regular meetings and dedicated Newsletter to improve communications
- The development of new Training Needs Analysis Guidance and increasing attendance by all levels of staff at mandatory training courses
- Freeing up trainees' time with nursing and midwifery staff undertaking roles such as phlebotomy
- Increasing the presence of senior personnel in obstetric triage to develop junior trainees
- Identifying a trainee representative to work with the rota coordinator to allocate sufficient training sessions to maintain consultant continuity

FOUR Better partnership working

A trust asked RCOG to help improve joint working and the interpersonal relationships between a wide range of staff including Trust executives, obstetricians and midwives. Following a site visit and interviews with all grades of staff, the assessors were reassured by the Medical and Nursing Directors' insight into these issues. However, they confirmed that poor inter-professional relationships and the lack of effective working between teams was indeed a significant weakness in the working of the unit. The assessors recommended that the Trust:

- Create a vision and plan for immediate change and long-term service redesign
- Create a structure to allow for multidisciplinary input into the management of the unit and to provide assurance on good governance to the Board
- Seek external facilitation to overcome the barriers between groups of staff and silo working

FIVE Workforce numbers and national standards

A review commissioned by a Trust with concerns about staffing levels, looked at the medical and midwifery workforce numbers in the context of national standards. We undertook a review of the workforce plan, consultant job plans and the staffing establishment for trainees and non-consultant career grade doctors. The assessors were encouraged that staff at all levels appeared highly motivated, proud of their service and accepting of the need for change.

However, the review confirmed that there was a shortfall in the number of consultant obstetricians to meet the national standards for consultant cover on labour ward. Midwifery staffing levels were unanimously cited as the main concern, which was compounded, by high staff sickness rates and problems with recruitment and retention of midwifery staff. Improvement actions recommended by the assessors included:

- An immediate increase in consultant obstetrician numbers to allow for improved service delivery, training, good governance and the ability to plan the future direction of the service
- Support greater collaboration amongst relevant staff to ensure the midwifery and support workforce is optimally deployed to provide safe staffing of core clinical areas at all times
- Undertake and complete a Birthrate plus® exercise and implement the recommendations for midwifery staffing

SIX Gynaecology surgery services

The RCOG undertook a review against national standards of the current work profile and gynaecology laparoscopy service across two sites.

Our assessors found that the Trust had a high workload, with a larger proportion of gynaecology to obstetric practice, compared to many other similar sized units. The staff interviewed were passionate and impressive in their commitment to the service. However, there was a lack of team cohesion among the consultant body during the interviews. Adherence to department clinical policies appeared slightly 'ad hoc' and the current membership and structure of the Gynaecology Forum did not seem to have the authority or seniority of membership to deliver. The assessors found that clinicians and managers were lacking in a shared, unified strategic agenda and there was no reassurance that these problems were understood. Our assessors made recommendations including:

- Immediate development of an emergency gynaecology assessment unit
- Immediate job plan analysis and the provision of dedicated on-call surgical services at consultant level
- Appointment of a suitable clinical director and other medical managers
- Prioritise safety and quality issues – ensuring that they are at the top of the directorate agenda
- Review of the clinical governance structure for gynaecology and the appointment of an officer accountable for safety, with access to the directorate and Trust management

"The review has been well received and a positive experience for our service."

SEVEN Delivery of Safe Care

The delivery of safe care is an overarching theme in all the reviews. During one review the RCOG team identified that although systems were in place to support clinical governance, and safe and effective practice, they were not functioning. They were difficult to use and did not support front line care.

In addition the incident reporting system was not utilised to its full potential and the range of incidents reported were mainly concerned with low level facility and process issues rather than clinical incidents. Moreover, no one was able to identify any learning which had come about from the incident reporting or complaints processes. Our recommendations included:

- A review of the use of the incident reporting system
- Development of a system to produce a reasoned response to incidents
- Using the outcomes from incidents and complaints as learning and developmental tools
- An agreed plan for governance and joint working needed to be developed and supported by all professional groups

EIGHT Compliance with guidance and standards

Adverse events and untoward incidents triggered an RCOG review of the obstetric and gynaecology services in a Trust. We were asked to assess the safety of the service using national standards, and to advise on the implementation of the 'Tomorrow's Specialist' paper (RCOG 2012).

Our assessors concluded that, although the women's services had improved over time, there were still aspects that fell below the expected standard and needed attention and recommended that the following areas were addressed immediately:

- Review clinical practice on the management of miscarriage against NICE Guidelines
- Set up a prospective audit of hysterectomy and laparoscopic surgery
- Develop the 'Lead for the Early Pregnancy Unit' role to ensure more consistent decision-making and identify a colleague to be responsible for infertility services
- Develop one-stop clinics as outlined in the 'Standards for Gynaecology' (RCOG 2008)

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"The review met our expectations fully, the supportive approach helped us achieve our quality improvements and has resulted in a safer service and reduced incidents/SIRIs."

"Our dashboard has now been green for post partum haemorrhage for the past 12 months signifying that our outcomes have improved. We have also only had one (planned) Caesarean hysterectomy."

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