



Royal College of
Obstetricians &
Gynaecologists

Shared Learning from the Invited Reviews Undertaken in 2013-2014

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“The review has contributed to increased focus on addressing areas for improvement.”

Executive Summary



The RCOG receives invitations from healthcare organisations where there is a wish to improve women's health care. Each request is unique and the RCOG provides a tailored approach to meet the needs of the service. However, once a review has been completed, the recommendations and the learning from that review are rarely shared outside of the organisation.

The main goal of an Invited Review is to support employers, commissioners and managers to work with clinical colleagues to design safe and sustainable services that will provide improved outcomes for women's health.

In accordance with the recent guidance 'A framework of operating principles for managing invited reviews within healthcare'¹, the dissemination of findings and good practice from reviews is a significant resource for improving clinical practice and an important way of sharing more widely examples of situations that are probably affecting many healthcare organisations. This may help them to benefit from the experience of others and encourage them to review their own service to improve care for women and working conditions for their staff.

This document highlights the findings, recommendations and some examples of good practice gathered from various Invited Reviews between 2013 and 2014. They have been grouped together for reporting only, and are not to be viewed as isolated themes. Common to the majority of the reviews, issues were found with medical leadership, collecting data and reporting outcomes, interpersonal relationships, multidisciplinary team working, workforce issues and incident reporting processes.

Professor Alan Cameron, Vice President Clinical Quality 2016

ONE

Learning from the Invited Reviews

1.1 Serious untoward incidents (SUI)

The RCOG is regularly invited to provide an external perspective of the process of an 'internal' serious incident report. This is to provide assurance that the Trusts mechanism for serious incident management is robust and effective.

The Invited Review of one SUI concluded that a maternal death followed a clear failure to manage a severe septic miscarriage. The causal factors of this were a lack of assessment of fetal well-being during the patient's prior visits to A&E, which would have allowed earlier diagnosis and treatment.

There was poor communication and co-ordination of care at all levels from admission to the ICU until the time of the hysterectomy on the day the patient died (delaying life-saving treatment) and the absence of a multidisciplinary team approach to manage this complex case.

There were also several contributory factors which included an emergency gynaecology rota that relied on a truncated rota system, reducing the likelihood of the woman having continuity of care.

Good Practice Point:

The Trust undertook a review of the senior cover for gynaecology and the early pregnancy unit and recruited two Clinical Fellows. The Trust also developed and ratified the 'Communication and Handover of Care between Professionals Maternity Guideline' and revised the 'Obstetric Haemorrhage Guideline' to include the necessity for the presence of another consultant O&G when a hysterectomy is being considered.

“It brought gravitas to a situation that was not being taken seriously enough. It was triggered by the CEO and has greatly improved processes in obstetric theatres. It has also helped the individuals concerned.”

1.2 Governance structures and arrangements

Clinical governance arrangements were another major theme in the terms of reference and identified as an incidental finding during Invited Reviews. The fundamental purpose of serious incident management is to learn from events, to prevent the same thing happening again in the future. This relies on organisations having effective systems for open-reporting, structured investigation and timely implementation of lessons learned. An open culture of 'fair blame' and learning is key.

One Invited Review, reported that the clinical risk policy and governance structure within the obstetric department appeared to be robust and in line with common practice in other NHS Foundation Trusts. Nevertheless, obstetricians and midwives were generally very negative about the clinical governance processes, as they perceived them to create a "blame culture". Serious Incident (SI) reports were described as "ambiguous" and without clear outcomes, which was unhelpful to learning and prevention of recurrence. The quality of the Root Cause Analysis (RCA) investigations, analysed during the visit, were below the standard expected.

Good Practice Point:

By strengthening the Clinical Governance Team, this Trust was able to buddy with a neighbouring unit to improve their clinical risk processes, investigations into clinical incidents and dissemination of lessons learned. The Trust also undertook debriefing sessions of serious incidents.

Another review highlighted that although there were systems in place to support clinical governance and safe and effective practice, the systems were not functioning well, as they were difficult to use and did not support front line care. There was insufficient time for clinical staff to use the systems. The organisation did not utilise the incident reporting system to its full potential, so there was a low level of reporting, and the range of incidents reported were mainly concerned with facility and process issues, rather than clinical incidents.

Staff described a lack of feedback from reporting systems and unfair responses to reports. Learning lessons from reports is a crucial element to change practice but staff were unable to identify any learning from the incident reporting or complaints processes. Staff groups described great difficulty in releasing time to attend meetings and were frustrated that there was no central forum for discussing clinical matters.

The recommendations included reviewing the use of the incident reporting system and developing a system to produce a reasoned response to incidents. Using the outcomes from incidents and complaints is a good learning and developmental tool.

Good Practice Point:

A new clinical governance lead was appointed who ran quarterly academic half days to share learning from complaints and clinical incidents. The lead also implemented a daily review of all clinical incidents by a multi-disciplinary team.

In another unit, new serious incident reporting policies were put in place, which required the need for medical input and round table discussions with those involved, including feedback before submission of any final report. This allowed staff to not feel isolated or blamed when a serious incident occurred. It allowed for openness and transparency within the trust.

RCOG:

The RCOG frequently receives requests to nominate a clinician for an external opinion of an internal SUI report, to offer quality assurance that the report was rigorously investigated.

The Invited Reviews service includes lay assessors as part of the review team. Working alongside the clinical assessors, the lay assessor can offer a non-clinical viewpoint, focusing particularly on the patient and public perspective when reviewing the service. This can help to bring the patient journey and overall experience of a service into the heart of a review, alongside the safety and quality elements the clinical perspective brings. Lay co-assessors will be asked to review patient complaints, patient experience surveys and feedback as well as interview MSLC representatives or advocates, and ascertain the process by which these feed into the governance structures within a Trust.

Recommendations from NHS England's National Maternity Review (Better Births)² have recommended that the health care safety investigation branch of NHS Improvement develop a national standardised investigation process.

“The review met our expectations. It allowed the Executive board to feel confident that our in-house process was robust.”

I.3 Multidisciplinary team (MDT) working

Multidisciplinary care is defined as a team of professionals from a range of disciplines working together to plan and deliver comprehensive care that addresses as many of the patient's needs as possible. If the patient's circumstances change over time, the composition of the team may change to reflect the needs of the patient.

There was clear evidence from the Invited Reviews that achieving a functioning multidisciplinary team (MDT) can be a problem for some services. Four of the Invited Reviews had specific terms of reference related to investigating the MDT culture and how practices could be strengthened.

In one Invited Review, a delay in the management of a woman with endometrial cancer showed weak links between the gynaecology diagnostic clinician and the gynaecology oncology MDT.

The review recommendations included developing a clear written pathway with milestones for referrals and investigations, prompt attendance to patients admitted with suspected or confirmed gynaecological cancer and expediting investigations and not waiting until after the MDT discussion.

Good Practice Point:

This unit integrated the gynaecology review meeting into a bi-monthly clinical governance day.

Multi professional teams that train together have shown to improve outcomes for women and babies. Real 'team working' share common practices such as socialising together, training together, communicating well in a variety of situations, having respect for colleagues input and working in partnership with women wherever possible.²

“The review has been very helpful in clarifying our thoughts about the relevant issues and how these might be addressed.”

Each individual recommendation was discussed and actions agreed with the multi-disciplinary team over a series of 5 workshops.

This in itself proved to be a valuable exercise as it allowed structured discussion between the teams from both sites and challenged them to identify together how these recommendations could be translated into action.”

1.4 Interpersonal relationships

Working collaboratively with colleagues to maintain or improve patient care is a core duty, which is clearly stated in the General Medical Council (GMC) document Good Medical Practice.³ Patients have the right to expect that different professional groups will work together.

Poor interpersonal relationships between medical and midwifery staff was a common theme in most of the Invited Reviews, with eight reviews specifically highlighting these in the terms of reference or as findings.

One service review recommended a department-wide discussion about the importance of positive interpersonal behaviours and how to support one another in the development of professionalism, using an agreed code of conduct.

Another Invited Review, triggered by a cluster of perinatal deaths of babies of low risk women, caused considerable concern. The Clinical Director believed the deaths would have been avoided if electronic fetal monitoring had been carried out. The healthcare organisation recommended to undertake continuous CTG monitoring on all women, which was met with significant opposition from midwives. Midwives in the unit felt that they were then practicing defensively and were extremely anxious that any clinical decisions or actions not in line with this recommendation would be criticised. The recommendations suggested that a multidisciplinary team should be set up to enable senior managers, clinicians and midwives to discuss ways in which professionals could work more collaboratively and move away from 'silo working'.

Good Practice Point:

This unit undertook an audit of 'The Care of Low Risk Women in Labour' and reported their findings, which included the fact that midwives were taking responsibility for undertaking risk assessment of women in labour and recognising and reacting when labour deviated from normal. There were improvements in the number of women who had been risk assessed in labour and had a management plan documented in their notes. Midwives felt confident to refer for an obstetric opinion and communicate when deviations in labour were identified. Where concerns about fetal wellbeing or progress of labour were identified, midwives commenced continuous electronic monitoring of the fetal heart. Further work is being developed, that will help ensure midwives are clear on the reasons for performing continuous monitoring and when the woman should exit the low risk pathway.

Educational establishments have a duty to promote inter-professional working during undergraduate level training. Respecting colleagues and working in partnership across professional barriers will help achieve integrated person centred care.

1.5 Adherence to guidance and national standards

Many of the Invited Reviews identified an urgent need for organisations to revise their own local guidelines and train staff in their use. Many requests asked that the review focus on the function and performance of a unit in the context of national standards and guidelines.

In one unit, although the guidelines were well constructed and up-to-date, it was the unit's policy to hold them on the organisation's intranet. This made them difficult to access and they had no search facility or index, which made them useless in most circumstances.

In another unit, the use of guidelines varied between staff and this was a major source of discontent and disruption. This led to confusion among staff and, in particular, trainees. It had also led to planned care, which had been agreed with patients, being changed by another consultant, against unit guidelines. It was recommended that the adoption of clinical protocols and guidance should be endorsed by all consultants to reduce the variation in practice. National standards and guidance are not only valuable in standardising practice but also in providing supporting evidence for clinical practice.

For example one review recommended the setting up of 'one-stop clinics' as stated in the RCOG's report 'Standards for Gynaecology', and universal application of NICE guidelines across all professional groups.

Good Practice Point:

In one unit, updating guidelines as part of a multi-disciplinary team allowed for all staff to work in collaboration and take ownership. This helped to reduce variations in practice. When doctors did deviate from guidance due to individual patients circumstances, there was an agreed process, including justifications.



1.6 Trainees' supervision

Trainee doctors are the future generation of the workforce. Clinical and educational supervisors have a duty to oversee the clinical performance and education of trainees, act as mentors, monitor progress and ensure each trainee receives appropriate career guidance and planning. This duty requires time and resources, which should be recognised within consultants' job plans.

Two healthcare organisations asked the Invited Review to focus on trainee supervision. In one organisation, the 2014 GMC National Training Survey had identified poor clinical supervision of trainees by some consultants. Interviews with trainee doctors are extremely valuable in ascertaining if the department is well managed, whether trainees feel they are fully supported and encouraged to undertake further development. The recommendations included evaluating the supervision provided to trainee staff and to progress the plans from the GMC survey.

Good Practice Point:

In one unit (across two sites) the trainees had formed a trainees group, with an identified leader at each hospital. They had regular meetings and the leader of the groups met with the College Tutor on a formal basis. The trainees had representation at the departmental business meetings which also had a developmental leadership role function. The trainees also produced a monthly newsletter to help improve communication between them and other staff.

RCOG:

On request, the RCOG Education Team can analyse the GMC National Trainee survey results from organisations that have commissioned a review. Any issues pertaining to patient safety or undermining are shared with the assessors before the review. Where appropriate the assessors will also interview the Head of School of the LETB and trainees at the organisations to input into the RCOG review.

1.7 Leadership, management and accountability

Medical leadership roles require setting direction, leading, engaging and managing others. Individuals should be trained, have the appropriate skills, have adequate time to fulfil their roles and work within systems that allow them to function effectively.

In one Invited Review, almost all staff identified poor inter-professional relationships and a lack of team working as significant weaknesses in the running of the unit. The healthcare organisation had undergone a period of structural change into a system of 'divisions'. As a result, staff felt that the maternity service had lost its voice in the new structure, particularly as it no longer had a clear route for influencing the Trust Board, due to the lack of direct reporting. There was an obvious divide between medical and midwifery staff, and no unified vision on the future development of the service. Staff were frustrated, which led to a clearly expressed passive acceptance that change could not occur. Both the previous and current Clinical Directors were not involved in the decision-making process for running the maternity services and felt that decisions were made without them. The review recommended a fundamental assessment of the management structure of the maternity services and reporting arrangements in the healthcare organisation, to overcome traditional professional boundaries and sensitivities, and to allow the service to be planned around the needs of its patients. It also recommended training in leadership skills for medical staff.

Good Practice Point:

The obstetric consultants in one unit had been under the spotlight for quite some time for their alleged inability to work as a team. This had been identified in previous external reviews. When interviewed, the consultant staff had expressed almost universally some self-awareness of this. There was also a general agreement that appointment of the new and current Divisional Lead had brought about a 'wind of change' from the situation where the previous lead was seen to be leading a faction, to one where most of the consultant staff seem to be prepared to make a fresh start and try to work as a team. This seemed to be further corroborated by the comments from virtually all staff groups that, in an emergency, all medical staff pull together and are eager to help each other at any time of the day or night.

RCOG Peer2Peer Support service:

The Peer2Peer Support service is an online directory that enables members to connect with other RCOG members to aid their professional development. The aim of the Peer2Peer Support service is to provide non-clinical guidance on topics such as people management, leadership, professional development and job planning. Members can register as a mentor and/or a mentee, giving everyone the opportunity to support their peers at whatever career stage they are at.

I.8 Workforce issues

The need for greater attention to workforce planning is evident in many of the Invited Reviews.

Ensuring adequate staffing for safe provision of care is paramount. However, the RCOG recognises that it is also essential for the future that consultants continue to develop, both in terms of clinical and non-clinical skills. This is particularly important for those resident consultants to ensure a balanced and rewarding career which will aid staff retention.⁴

The terms of reference for one Invited Review included assessing medical and midwifery work force numbers. The review found that the number of consultant obstetricians was inadequate to safely support a labour ward at the current birth rate or provide enough consultant time for effective management and development of the service. This had led to frustration as new posts had not been supported because they were not cost neutral.

Consultant job plans were also found to be very complex and quite rigid, and despite attempts to change the job planning process, little had changed. The service relied heavily on non-consultant career grade doctors to support the tiered way of working, but there was no evidence that the department had considered the likely impact of future work force availability on their way of working.

The recommendations included reviewing the future workforce, particularly in respect of the likely difficulty in recruiting to obstetric-only jobs in the future and the likely impact of reducing trainee numbers, undertaking a Birthrate® Plus exercise, or similar, and implementing its recommendations and reviewing specialist and project midwife roles against defined required outcomes.

RCOG:

“Women need a specialist workforce that is able to work in integrated clinical teams, providing care locally where possible. The increasing trend towards specialist-delivered care over the past decade must expand so that more trained doctors (specialists) are employed to provide care for women with complex obstetric needs and gynaecological emergencies 24 hours a day, 7 days a week. To do this effectively within a rapidly changing health system requires highly skilled, adaptable doctors. These professionals must be able to work in multidisciplinary teams and provide a range of leadership skills. They must have many professional attributes and be fully committed to lifelong learning, closer team working and working across different environments. The specialist of tomorrow will increasingly work within multidisciplinary teams with close links to primary care.”⁴

RCOG:

The report entitled 'Providing Quality Patient Care' is the first of three Safer Women's Healthcare reports to be produced, and addresses the immediate difficulties in providing sufficient medical workforce in obstetrics and gynaecology to safely staff UK units and provides a number of solutions especially around consultant working out of hours. This report provides the opportunity to update previous guidance within the College's Safer Childbirth Report (2008) in light of subsequently published evidence.

RCOG:

The RCOG carries out an annual census to assist with assessing workforce numbers to get an overview of workforce deployment and planning.⁵ This looks at the number of deliveries, consultant presence on labour wards, rota types and posts in the unit. This census helps the RCOG to look at trend analysis and has recently shown that consultant job descriptions increasingly include resident on call and consultant presence on the labour ward.

Good Practice Point:

This unit implemented a daily meeting between the midwifery coordinator and the senior team, together with an obstetric consultant to determine the unit's priorities and clinical workload and agree an optimal workforce deployment. The Birthrate® plus exercise was completed. A business case was submitted and an agreement to increase the midwifery establishment up to 1:27. Two locum consultant posts were agreed and put in place. This allowed consultant cover on the ward to be increased to 91 hours per week. The Trust were working towards further increases in consultant presence with the pending gynaecology merger.



1.9 Delivery of safe care

Providing safe care is an overarching theme in all the Invited Reviews as any compromise to patient safety is not acceptable. One report stated that the healthcare organisation had produced an abundance of data, some conflicting, but had no system for quality assuring this data or the ability to act on outputs. It was recommended that the clinical governance structure needed immediate and urgent attention, with a regular review of clinical practice based on reliable and supported information. It was also recommended that some supporting professional activity time should be dedicated to investing in data collection.

Another review of an organisation, also subject to external review by a regulatory body, found that the unit's incident reporting system had no guidance on what to report. Reporting standards and indicator values should be in line with, and comparable to, national standards. Poor data collection systems and a lack of data sharing were highlighted. Audits for the medical staff were not integrated with the rest of the hospital. It was suggested that a joint midwifery, obstetric, paediatric and anaesthetic audit programme be established with a clear system for how results and recommendations would be presented to enhance multi-professional learning. Sharing an agreed set of data both professionally and publicly and investing in a data collection system was also recommended.



“Very useful review, our caesarean section figures last fiscal year have been reduced by 2.3%”

Good Practice Point:

Within this unit, a maternity software package was rolled out, and an agreement was made between public health, medical and midwifery colleagues on what data needed to be measured for the dashboard, to bring it in line with national guidance. The dashboard was shared at governance meetings, maternity incident review meetings and with the local buddying Trust.

Once data has been collected and analysed, a process has to be in place to allow the outcome data to serve as evidence to assist any change in clinical practice. The impact of this change must also be measured. Using national data allows Trusts to benchmark themselves against similar sized Trusts across the country. The RCOG Clinical Indicators Project⁶ aims to develop clinically relevant, methodologically robust performance indicators for obstetric and gynaecological care using currently available data. This information will be used to inform quality improvement initiatives and enable comparative benchmarking of women's health services across the UK. The second report from the Clinical Indicators Project presents 18 indicators that can be used to compare the performance of English NHS trusts.

The report uses Hospital Episode Statistics (HES) data from 2013/2014 (data routinely submitted by NHS hospitals). The researchers have risk-adjusted for factors that are beyond the hospital's control (e.g. mother's age and medical history) to enable fairer comparisons to be made between trusts.

The recently published NHS England National Maternity Review² makes a series of key recommendations for how services should change over the next five years to ensure that safer, personalised maternity services are available to all. One of the key recommendations was to develop a national set of indicators to help local maternity systems to track, benchmark and improve the quality of maternity services.

By routinely collecting data on outcomes and mandating standardised perinatal morbidity and mortality reviews, Trusts across the country will be able to benchmark their performance against others' and aim to reduce variation and improve outcomes.

1.10 Raising concerns

There has been much debate which has concluded that legislative drivers and guidance will only go so far and that taking local action quickly and effectively is absolutely crucial. Protecting patients from harm and ensuring dignity of care requires an open and transparent culture at all levels of the system⁸. Healthcare organisations must be supported to implement and embed frameworks that lead to a change in culture and raise awareness of the different approaches to raising concerns.

One Invited Review investigated the issues that prevented staff raising patient safety concerns and not following the channels described in the healthcare organisation's Whistleblowing Policy and Guidance. An example of the latter was an anonymous letter about poor clinical practice in obstetrics and gynaecology sent to the GMC. A newer version of the healthcare organisation's Whistleblowing Policy was issued and the following measures were taken: a personal letter was sent to individual clinical staff members to encourage them to come forward should they have any concerns about patient safety, a confidential email address for raising concerns was established and the Executive Team planned awareness and feedback events.

The recommendations included identifying a named Executive Director in the current Whistleblowing Policy so that staff who felt unable to raise concerns to their line manager were aware of whom to contact.

Alongside this improving awareness amongst nursing, midwifery and medical staff of the Whistleblowing Policy by discussing the policy at the obstetric and gynaecology specialty meetings, senior midwives' meeting and supervisors of midwives' forum and finally addressing the fear of blame for whistleblowing amongst staff with awareness and feedback events organised by the Executive Team across specialties.

Good Practice Point:

The unit appointed a named executive and set up a generic confidential email inbox. All staff were provided with a 'speaking up' credit card attached to their pay slips. The Trust executive undertook road shows for staff to attend.

All doctors have a duty to act when they believe patients' safety is at risk, or that patients' care or dignity are being compromised. The GMC's guidance on 'Raising and acting on concerns about patient safety (2012)⁷ sets out the expectation that all doctors will, whatever their role, take appropriate action to raise and act on concerns about patient care, dignity and safety.



Configuration/options appraisal review

The RCOG was approached to undertake a review of maternity services across Cumbria and North Lancashire, to provide independent and expert advice on the best way to arrange high quality, safe and sustainable maternity services for the future.

The review team met and spoke to almost 100 people with an interest in the provision of local maternity services. The majority were clinical staff working in maternity and related services such as paediatrics, surgery, anaesthetics and intensive care. The review team also met a number of GPs, representatives from the ambulance service, key people from the CCGs, North Cumbria University Hospitals NHS Trust, University of Morecambe Bay NHS Foundation Trust, members of patient groups, Cumbria County Council Health Scrutiny Committee and Healthwatch Cumbria. There was also an opportunity for conversations with local MPs.

The report⁹ outlined six options that could only be supported on 'safety and sustainability grounds' if steps were taken to reform the approach to staffing, improve antenatal, labour and delivery and postnatal care, address anaesthetic issues and agree sufficient paediatric cover for a special care neonatal unit. It also recognised that the geography, pockets of deprivation and poor transport infrastructure made decisions about service changes very difficult. It stressed the importance of engaging the community in the development of future arrangements.

These changes will require increased investment and active medical recruitment.

The review recommended a project team be established to develop a detailed feasibility report on the cost, viability and risks of proceeding with the preferred option. The following specific actions to be taken into urgent consideration included strengthening of the professional unity between medical staff across all sites, nurturing leadership and management roles in new and existing consultants across whole aspects of the maternity service and cross site 'hands on' working for staff in smaller units with bigger tertiary units to help them maintain core competencies and knowledge.

Good Practice Point:

A project team was established swiftly and led by a senior manager, with an external advisory obstetrician, local HoM and a patient advocate. The team reported to a Non-executive Director on the CCG, appointed to lead the project. Significant time was spent ensuring that the interface between the RCOG and Morecambe Bay investigation recommendations were fully understood and utilised to best effect in improving service safety and sustainability. The group was tasked with reporting on the viabilities of the various options. The reports included updates on staffing and activity projections for each unit, modelling of future demand for services

and 10 year activity, an assessment of deprivation and impact on transport issues, antenatal, normal births and neonatal transport modelling, paediatric availability or alternative for special care unit provision. The CCG also agreed to invest in a communications strategy, including the community, political leaders, and professional stakeholders in all aspects of this work. The communications and engagement work will result in a detailed implementation plan which is formulated by key stakeholders. The level of public interest remains very high particularly in North Cumbria and work continues to improve this relationship.

THREE

Concluding comments

“This report shows the wide variety of ways by which an Invited Review process can begin. Each one is different and the review is tailored to the needs of the requesting organisation. However, they all provide a valuable external objective view, where services and clinical performance are judged against national standards. The range of the report findings demonstrates the important role that this process can fulfil to support Fellows, Members, providers and commissioners of services in providing high quality care in Obstetrics and Gynaecology.”

Mr David Evans FRCOG, CEO Northumbria Trust and Past Invited Reviewer

1. A framework of operating principles for managing invited reviews within healthcare
Academy of Royal Colleges, January 2016
2. National Maternity Review (Better Births)
NHS England 2016
3. Good Medical Practice
General Medical Council (GMC) document 2013
4. Becoming Tomorrow's Specialist
RCOG 2014
5. Census Planning RCOG 2013
RCOG 2015
6. Patterns of Maternity Care in English NHS trusts 2013/14
RCOG March 2016
7. Raising and acting on concerns about patient safety
General Medical Council (GMC) 2012
8. Report of the Mid Staffordshire NHS Foundation Trust
Public Inquiry 2013
9. Options Appraisal Reconfiguration of Obstetrics and Maternity Services in Cumbria
RCOG 2014



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