RCOG Response to the Kirkup Report of the Morecambe Bay Investigation
Introduction

The Royal College of Obstetricians and Gynaecologists (RCOG) welcomes the Kirkup Report and its recommendations. This response will address the recommendations which mention the RCOG specifically (nos. 20 and 22) and comment on other recommendations that have an impact on the running of high quality maternity services.

Specific recommendations

Recommendation 20: There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them.

The RCOG is involved as a panel member of the National Maternity Review, chaired by Baroness Julia Cumberlege, which will include a review of all maternity services including isolated and rural units which are often difficult to staff.

Separate to this, the RCOG has instigated its own review, Safer Women’s Healthcare, due to be published in early 2016. This review has multidisciplinary input and the RCOG anticipates that the working party report will complement the work of the National Maternity Review.

Recommendation 22: We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them.

The RCOG recognises that there can be good educational opportunities in units of varying sizes and agrees with the General Medical Council (GMC) that supportive educational environments are essential with all staff disciplines focusing on improving their own and trainees’ educational development.

As a craft specialty, it is essential that there is sufficient volume and diversity of clinical workload to train future consultants and therefore rotation to small units may only be applicable for short periods of time to gain the required clinical competencies as part of a seven-year training programme. Local Education and Training Boards (LETBs) are responsible for oversight of training placements and quality management of the training environment. The RCOG will continue its work with LETBs to encourage identification of high quality training environments.
Generic issues identified in the Kirkup Report

The RCOG is aware of the generic issues that dysfunctional maternity services face, as identified by our quality visits and invited reviews. These are:

1. **Patient safety**: The RCOG has played an active role in encouraging all its Fellows and Members to put patient safety first in clinical practice. The RCOG hosts and provides support for NHS England Women’s Health Patient Safety Expert Group (WHPSEG), which exists to improve safety for women and their babies receiving NHS-funded care across the UK. This initiative addresses Domain 5 of the *Outcomes Framework* which seeks to provide care for patients in a safe environment and protect them from avoidable harm.

   Essential components to ensuring high quality in patient safety are the application of the *Duty of Candour* in the NHS and the successful implementation of the CQC’s *Fundamental Standards of Care* and the corresponding guidance documents. The RCOG develops clinical guidance to aid clinicians in identifying best practice. We recognise there is variation in the implementation of these guidelines in trusts and are currently focusing on how standardisation can be encouraged.

   Patient safety is paramount to the RCOG which has an established Invited Reviews programme. Chief Executives and/or Medical Directors can approach the College to request a review if they have cause for concern. Those commissioning the reviews are responsible for implementing the review recommendations. The RCOG ensures that there is also midwifery input in these reviews and, where required, liaises with the RCM. Organisations are contacted 3-6 months after the review and asked to provide follow-up to the RCOG recommendations to satisfy the College that they have addressed the issues raised at the time of the review. The College is currently producing a document on the common issues identified in these reviews and the areas for service improvement for the NHS.

   *It is vital that these review findings, especially those of staff experience and competencies, are fed back to the service and a lessons learned document is produced by the service to demonstrate how change has taken place following receipt of the document.*

2. **National leadership support**: The College has set up a UK Board which will take responsibility for O&G issues and quality assure internal RCOG processes on revalidation, including the provision of advice to doctors, appraisers and Responsible Officers. The UK Board will also contribute to national and regional quality assurance models and processes being developed by regulatory and representative bodies.

   There are plans to strengthen the role and responsibilities of elected Council members of the RCOG so that they become the main point of contact for trained doctors seeking advice on professional issues. The RCOG sees this as an evolving function which will encourage leadership in the specialty.
3. **Local management and clinical governance:** *Each Baby Counts* is a College initiative to review all serious untoward incidents submitted by units where there has been a term intrapartum stillbirth, early neonatal death or baby harmed at the time of birth. Learning from the analysis of these investigations will be fed back to individual maternity services so they can learn from the events and act and improve patient safety. NHS England recently revised its [Serious Untoward Incident framework](#), containing the definitions of SUIs which organisations must adopt.

The *Safer Women’s Healthcare* Project will update the *Standards for Gynaecology* and *Standards for Maternity Care* documents first published in 2008. Adherence to these national standards in all maternity units should be promoted in the CQC's quality assurance process and extended to include expectations on the professional duties of clinical leads (recommendation 28) and quality measures for NHS managerial staff (recommendation 29).

The Kirkup Report noted instances of poor quality record keeping. It is crucial for all trusts to demonstrate that they have the appropriate structures and protocols in place to enable better record keeping since this helps with risk management and timely follow-up arrangements can then be made. The RCOG will consider auditing the records and record keeping policies of trusts in its invited reviews.

The RCOG’s *Clinical Performance and Governance Scorecard* (2008), also known as the ‘Maternity Dashboard’, serves as an early warning tool to alert maternity services of gaps in service provision and patterns that will raise concerns.

It has been difficult to get units to use the dashboard and, where it is used, there has been an inconsistency in the types of situations being monitored and the information collected. The RCOG believes strongly that the information contained in the dashboard will help trust boards to better monitor their services on a monthly basis and to put in place actions to address emerging issues. *The RCOG would like to see a mandate for all maternity units to use the dashboard. Standardised data should be submitted to NHS England and the CQC so that concerns are flagged up and acted upon.* The Maternity Dashboard should be updated as follows:

**Workforce:**
- Replace levels of consultant cover in the labour ward with presence
- Locum agency use/shift/week
- Numbers of GMC/NMC referrals
- Exit questionnaires of trainees

**Clinical indicators:**
- Friends and Family Test results on recommendations of the maternity unit
- Recent litigation claims
4. **Maternity Peer Review:** The RCOG understands that NHS England is developing a national peer review programme for maternity services. The previous system of Hospital Recognition Visits undertaken by the royal medical colleges was instrumental in detecting educational issues within units. A similar review programme to capture clinical performance and patient satisfaction would be welcomed.

The Maternity Peer Review will take the form of an accreditation kitemark that will embed a culture of honesty and transparency in maternity services and empower staff to speak openly and in confidence with the assessors. Likewise, these reviews must be audited for benchmarking purposes so that trusts can review whether progress has been made. The findings from these reviews should be made public and filtered down to all staff so that learning can be further disseminated and additional training following incidents planned (recommendation 12).

5. **Clinical skills and competencies:** The isolation of rural units, such as University Hospitals Morecambe Bay NHS Foundation Trust (UHMCT) is not unusual. Consultants working in a small/rural unit have fewer opportunities to learn from other colleagues or to experience different ways of working and a broader case mix. Increasing professional dialogue will increase clinical awareness and reduce the isolation.

The RCOG believes that in these small, rural units, buddying with staff from other NHS organisations and regular placements at other units would assist in helping clinicians to keep up-to-date with current working practices. Additional resources would be needed to provide backfill or supernumerary positions to facilitate off-site and/or rotational working and, although financially challenging, will be required if rural units are to continue to provide services. *Working practices and job plans need to be redesigned in these units to enable cross-cover rotation between units*

*For CPD and competency to be maintained, doctors working in small units must have access to colleagues in the neighbouring acute units and formal partnerships should be set up between hospitals within the region through the system of Strategic Clinical Networks. These approaches to joint working between hospitals, the sharing of resources and provision of mentoring schemes are also discussed in recommendations 8–10. Additional staff could be funded by Tariff Plus.*

6. **Workforce:** The NHS has a national problem with middle grade rota gaps in obstetrics and gynaecology of approximately 25–30% at any one time. The traditional backfill by locum trainees is limited and the availability of short-term posts provided by overseas doctors via the Medical Training Initiative (MTI) has been reduced. As a result, consultants are often asked to fulfil the roles of a middle grade doctor and, when resident-on-call, they are often on duty in place of middle grade trainees rather than in addition to them. *Workforce calculations in O&G conducted by the Centre for Workforce Intelligence (CfWI) must bear in mind that any sudden reduction in trainee numbers will further challenge the provision of safe care with a likely disproportionate effect on rural, more isolated units. Unless new
models of care are identified or resource provided for consultant expansion, reconfiguration is inevitable.

Rural and remote units with low levels of activity often find it difficult to recruit locum and full-time staff. Agency staff are frequently used as a temporary solution – this is unsustainable and can have a detrimental effect on staff training and morale.

At a wider-level, programmes must be put in place to help up-skill community practitioners (in this case, GPs and midwives) in areas where the recommended levels of consultant-led care are difficult to achieve.

7. **Culture and behaviour within maternity units**: The annual General Medical Council (GMC) National Training Surveys have highlighted issues of bullying and undermining in maternity units. In response, the RCOG appointed a Workplace Behaviours Advisor to work with locally appointed champions throughout the UK. In addition, an undermining toolkit and an e-learning resource to reduce undermining and bullying in the workplace have been produced in conjunction with the RCM.

Recognising trained doctors’ ongoing need for education and support to drive patient safety, the RCOG report *Becoming Tomorrow’s Specialist* (2014) promotes mentoring, coaching and buddying to support doctors. This document has been promoted to the RCOG’s entire membership, including clinical directors and new consultants. Trusts should explore which of these proposals are appropriate to the needs of their workforce and embed them into their personnel and staff engagement policies.

**RCOG recommendations: Future considerations for maternity services**

- **There is the need to support and monitor the implementation of guidance produced by the royal colleges.** Such an approach encourages consistency in clinical practice and ensures that staff are up-to-date. However, it is important that those following guidelines do not see it as a tick-box exercise.

- **There is the need for more proactive sharing of information from Invited Reviews with the regulators (CQC and Monitor).** Such an approach encourages openness and transparency on the NHS but may deter trusts and CCGs from requesting invited reviews.

- **Within maternity services, there should be greater engagement with neonatologists and anaesthetists.** The RCOG involves midwifery, paediatric and anaesthetist colleagues from the respective royal medical colleges in its invited reviews where applicable, but there is a need to work more closely with these professionals proactively on workplace and clinical issues.

- Similarly, **there is the need to consider the availability of other specialties such as medical and surgical support, imaging, interventional radiology and psychiatric services for obstetric management of unanticipated complications.**
- **Strict protocols on risk assessment and patient pathways based on agreed national standards (including the capacity to treat high-risk patients and capacity to provide for emergency transfers) are needed in all maternity units.** These must be audited to ensure compliance. Standardised clinical dashboards must be part of the governance within maternity units.

- At a broader level, **in geographically remote areas with small isolated communities, more emphasis should be placed on community-based midwifery and the development of primary care services.**

- In small units, staffing structures must ensure patient safety with innovative models of care that bear in mind and correct for the lower levels of clinical activity and lower staffing to provide full 24/7 care. **The model of strategic clinical networks organised on a ‘hub and spoke’ system where units share resources and staff rotate across sites should be considered in areas with difficult geography.** This should improve patient care and staff satisfaction and enable staff to keep up-to-date with their clinical skills.

- **The RCOG suggests that project teams consisting of a senior manager, an obstetrician, head of midwifery and patient representatives should be appointed to advise local Clinical Commissioning Groups on the population and workforce needs in catchment areas.**

**Actions for the RCOG**

1. The RCOG will develop solutions on maternity staffing issues (eg. rota gaps and recruitment/retention in rural units) via the **Safer Women’s Health Care** project.

2. The RCOG will consider developing an early warning system for maternity on a weekly/monthly schedule to include an updated version of the Maternity Dashboard – implementation and the evaluation of its use needs to be mandated.

3. We are in the process of describing the local/regional representation for engagement, sharing of information and best practice through greater responsibilities of Council Representatives. The RCOG will address the feasibility of developing confidential forums to discuss concerns.

4. Workplace Behaviours Programme – the RCOG will assess the impact and value of our local champions, use of the undermining toolkit and the e-learning resource.

5. The RCOG will examine the feasibility of encouraging attendance at the annual three-day RCOG Professional Development Conference once every three years.

**RCOG, 22 May 2015**