

Additional evidence obtained during the extraordinary review

**Princess Elizabeth Hospital,
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Table of Contents

SUMMARY OF ADDITIONAL EVIDENCE	1
1. THE CARE ENVIRONMENT	1
WOMEN'S EXPERIENCES OF MATERNITY CARE	1
OUT OF DATE BIRTHING ENVIRONMENT.....	2
DECISION TO DELIVERY TIME OF WOMEN REQUIRING EMERGENCY CAESAREAN SECTION	3
LACK OF PRIVACY AND DIGNITY FOR WOMEN WHO REQUIRE EMERGENCY TRANSFER TO AND FROM THEATRE FROM THE DELIVERY SUITE	3
MANAGEMENT OF EPIDURAL ANAESTHESIA.....	4
MATERNITY STAFFING LEVELS	4
HEALTH AND SAFETY ISSUES	4
2. POLICIES AND PROCEDURES	5
EMERGENCY PROCEDURE/GUIDELINES FOR MATERNITY CASES ON SARK	5
ESCALATING CONCERNS POLICY NOT ALWAYS INITIATED	6
3. GOVERNANCE	6
INCIDENT REPORTING.....	6
UNSECURE STORAGE OF RECORDS.....	7
SENIOR MEMBERS OF THE ORGANISATION LACK AWARENESS OF GOVERNANCE ISSUES.....	7
RISK ASSESSMENT E.G. ROOT CAUSE ANALYSIS TRAINING	8
UNDATED REPORTS, PROCEDURES AND INCONSISTENT MINUTE TAKING	8
DISSEMINATION OF UPDATED INFORMATION IS NOT TRANSPARENT.....	8
EDUCATION AND TRAINING NEEDS.....	8
4. LEADERSHIP AND MANAGEMENT	8
5. ORGANISATIONAL CULTURE	9
THE 'GUERNSEY WAY'.....	9
MATERNITY SERVICES HAVE BEEN ORGANISED AROUND MEDICAL STAFF.	9
ROLE BOUNDARIES	9

Summary of additional evidence obtained during the extraordinary review

The Nursing and Midwifery Council exist to protect the public. We do this by ensuring that only those who meet our requirements are allowed to practise as a nurse or midwife in the UK. We take action if concerns are raised about whether a nurse or midwife is fit to practise.

The review team were advised by the Nursing and Midwifery Council (NMC) that should we identify, uncover or experience any issues or concerns that fall outside the terms of reference for the Local Supervising Authority (LSA) extraordinary review, there is a responsibility to identify and advise those in authority, in order for them to investigate. These could include issues or concerns for the governance of the States of Guernsey Health and Social Services Department (HSSD) or other professional regulators, including the NMC.

During the NMC extraordinary review of NHS England (NHSE) LSA South West (SW) in the Princess Elizabeth Hospital (PEH), HSSD, Guernsey, the QA review team identified additional evidence of concerns that we cannot report against the Midwives rules and standards (NMC, 2012) and the quality assurance of the NHS England LSA SW.

As is stated in the report of the extraordinary LSA review report, 21 midwives who are currently working in Guernsey, six senior representatives of HSSD, Guernsey, two Institute of Health and Social Care, Guernsey staff, five student nurses, seven midwives who are currently working in Jersey and seven senior LSA representatives were interviewed.

The additional concerns reported fall within the following themes:

1. The care environment
2. Policies and procedures
3. Governance
4. Leadership and management
5. Organisational culture

1. The care environment

Women's experiences of maternity care

The service users interviewed and the chair of the Maternity Services Liaison Committee (MSLC) reported that women have low expectations of the maternity services. They told us that there are many stories about poor maternity care and experiences of women in PEH. Women were afraid to complain because they would have to use the service in another pregnancy. They reported concerns about a small number of midwives whose care was discussed widely among service users. They stated that they would have considered asking for another midwife if they had those

particular midwives to look after them during labour. One service user stated that she would consider staying at home in her next labour rather than go into the PEH to ensure she received the birth she wanted. Some of the service users indicating that they had more confidence when being cared for by community midwives. One service user did acknowledge however that the care she was given second time around had improved from her first experience.

Although there are standard charges in Guernsey for the provision of the GP service, service users questioned having to pay a GP to 'sign them off' on the ward as it would be half the price if they visited the GP surgery when they went home from the ward.

One mother reported being refused a shower after giving birth in the delivery room and being made to walk back to the open ward "dripping in blood" and then "being told off for dripping blood". This potentially puts members of the public at risk of infection and does not provide assurances around support for privacy and dignity of women.

Another mother reported being very concerned about her baby not receiving appropriate liquids and rapidly decreasing in weight when she was coerced into breastfeeding her baby.

Service users told us water births were not always available when mothers wanted them, especially at night.

One service user reported that the aftercare services are not good. She reported one midwife did not have the level of English language necessary to complete the records and discharge form required. She also reported that a midwife did not assess her appropriately and tried to give her a diamorphine injection when she was too advanced in labour.

Student nurses who undertake a short maternity learning experience told us that some midwives were judgmental and lacked empathy towards women. They spoke of the midwives' insensitivity to women. One student recalled how a baby had been born 'flat' (non- responsive).

Another student reported a woman coming to the ward as her baby had not moved and she was concerned and the mother was told she should not have come and she was wasting everyone's time. One student said she had not been orientated to the maternity area and did not know what to do when a midwife was shouting at her to get assistance during a critical period. She told us that she went into the corridor to call for help. The student said she did not receive any debrief following the incident.

Out of date birthing environment

We observed an out of date birthing environment which is very 'clinical' and in need of modernisation to reflect contemporary maternity services. We observed a room which we were informed was for bereaved parents or parents who had sick babies. The room had two bed settees but was not a welcoming environment. This was the only place fathers could go for a rest period.

The community office, ultrasound facility, admissions area, delivery ward, ante and postnatal care are all positioned from two corridors. It is a compact area and service users stated that the ward is very noisy making rest and sleep difficult. Labouring women and postnatal women with their respective relatives could be in the same room.

Decision to delivery time of women requiring emergency caesarean section

We heard from midwives about the delay in undertaking emergency caesarean sections because of the location of theatre suite and its distance from the labour suite and delays in arrival of medical and theatre staff (sometimes up to 60–80 minutes). Midwives informed us that the obstetricians often have to ring theatre staff to discuss which cases should be prioritised. There are two theatre nurses on call for a twenty-four hours a day period, however other staff members required to provide emergency care in theatre would have to be called in from home for emergency cases. The midwives reported that consultant anaesthetists took the longest time to arrive in the hospital. The midwives claimed that they felt that mothers and babies were frequently at risk from the subsequent delayed procedures. Midwives also confirmed that midwives were not trained to assist in theatre.

The midwives stated that they were very anxious for the woman and baby during these situations, particularly as they had to await the arrival of consultants from home. This was a concern as many women were considered as high risk and the midwives reported “looking at the women thinking is this baby going to be alive or dead?”

We were told that the week prior to our arrival midwifery staff were taking women to theatre through the public corridors and the midwife would have to leave the women with theatre staff or unattended to change into theatre scrubs. This was reported to take at least seven minutes. This meant that for the period in which the midwife was away from the woman there was no continuous auscultation of the fetal heart if they did not take the cardiotocograph (CTG) machine with them. We observed a small changing area behind the delivery room where staff now change into theatre scrubs to take women to theatre. We were told PEH are in the process of purchasing a CTG machine for theatre.

Lack of privacy and dignity for women who require emergency transfer to and from theatre from the delivery suite

We walked the distance from the labour ward to the operating theatre which takes approximately seven minutes and includes the use of a lift and walking along a public corridor. Midwives told us women were normally distressed and in pain when they were escorted to theatre and they tried their best to maintain women’s dignity. We were told that if time allowed a porter would close the main corridor to the public to provide some privacy for the woman. A senior member of staff told us that there was a ward area which would be ideal as a labour suite in those situations which

was located in the vicinity of the theatre suite, however, it had been found to contain asbestos.

Management of epidural anaesthesia

Midwives told us that there is no on-site anaesthetist 24 hours a day, seven days a week. They informed us that it is normal practice for the consultant anaesthetist to leave women to go home at night sometimes within 30 minutes of completing the epidural procedure. The only consultant doctors that stay overnight are the accident and emergency consultant doctors and they sometimes had to be called by midwives for assistance. Relationships with consultant obstetricians were described as generally good however relationships with consultant anaesthetists were described as problematic.

Maternity staffing levels

Midwives told us they had late notice of their duty rotas and annual leave requests often took months to be confirmed. They told us it was difficult to cover the on-call rota for home births and accepted that they attended home births in their own time as a gesture of good will. They all agreed that it was difficult to have a work–life balance. We were informed that there was no clear process for increasing capacity during a shift when a woman required transfer to theatre, when support for a home birth was needed or if a woman in labour needed to be retrieved on arrival via the lifeboats from Alderney or Sark to Guernsey

Midwives stated that at one time they had informed the senior manager of maternity services that they were unable to provide cover for home births. As a result the midwives were told to cancel the home births over the weekend until the Monday.

We were informed that currently the maternity services staffing numbers are under established. There is an increased number of agency staff being used due to existing vacancies for midwives. Midwives reported that staff turnover was high and during a period of five weeks during 2013/14 five midwives left employment. The appointment of an acting head of midwifery is for a six months period and there is no deputy head of midwifery to support this individual or administrative officer support. Midwives are supportive of the post holder but there are insecurities about the longer term position of the clinical leader.

Health and safety issues

We observed a number of health and safety issues when visiting the maternity department which we reported to senior staff at the time for action to be taken. These included:

- **A fire hose in Loveridge ward**

We found a 'not working notice' on the fire hose on a wall in Loveridge ward. We reported this and were informed the hose had been removed some time ago and there was only the reel left behind. This was removed and we were informed that Estates would look at putting a suitable door over the space left behind. We were informed that the reel and hose had already been removed from Frossard ward. The remaining fire hose reels outside of the ward were to be managed as part of the Legionella Risk Assessment and Action Plan which was being formulated.

- **A risk to babies via open access balconies**

We were informed that there is not a baby tagging system in operation and maternity staff rely on the ward entry doors to avoid any potential baby abduction. We observed one room that had a door that was unalarmed and could have easily assisted someone who wanted to abduct a baby from the ward area. The senior manager was informed who alluded to "this is Guernsey, it's laid back...we don't lock things". The senior manager we discussed this with later informed us (03.10.14) that a quote of fifteen thousand pounds had been obtained for a baby tagging system but HSSD would continue to review this in order to obtain the best price.

Coincidentally service users had reported that mould growing on the balcony had been removed, indicating improvements to environmental conditions.

2. Policies and procedures

We observed the safe and secure handling of medicines procedure dated 1 April 2014 which refers to community midwives storage and disposal of medicines.

We were informed about the previous widespread use of verbal orders despite it being clear in the guidelines that verbal orders are not within the midwives scope of practice; not supported by the NMC and should only be used in extremis. We were assured that this practice was no longer happening.

We found that many processes for policy and procedures are either under review e.g. policy for the management of a serious untoward incident or are at an early stage of implementation, having recently been agreed.

Emergency procedure/ guidelines for maternity cases on Sark

We were provided with information about Guernsey and Alderney however there was no documented information about maternity services for the island of Sark. HSSD is not mandated to provide healthcare services for Sark residents (Sark is a separate jurisdiction), however they will generally be covered by personal insurance and treated at the PEH if required. We were told about the necessity to go out to the island at 3am to bring a woman in labour to PEH. We did not observe any emergency procedures or guidelines when women from Alderney or Sark need to be transferred to Guernsey for maternity care.

Escalating concerns policy not always initiated

We asked midwives about the escalating concerns policy and were informed that not everybody could access the policies on the N-Drive. Midwives described the Polyplus system where all policies were located but identified that the intranet was slow; policies and guidelines are difficult to access as the system is reliant on the right key words being used to undertake a search. For example, in order to find the policy on hypertension the midwife would need to enter “the management of...”

On further discussion we noted that agency and bank midwives at PEH do not have email accounts and therefore were not able to access information communicated by e-mail. As agency and bank midwives are often used in the maternity ward this presents a significant risk.

We were informed that there are two specific policies that maternity does not have, one pertaining to DNAs (Did not attend) and another regarding maternity mental health issues. We were told that there had been a case where a mother exhibited mental health problems but there was no-one with specialist expertise to refer her to for care. This case was identified in earlier this year but midwives were not aware of any action or guidelines, which had been taken as a result of this experience.

Midwives reported that guidelines were not written by the multi-professional team but were written by the senior governance team and then put out for consultation via email. Bank and agency midwives were unable to respond to these consultations as they do not have email access.

We were also told by midwives that there is no robust induction programme in place for new staff; some indicated they had received no induction and some indicated that their induction had lasted for only two – four weeks. We observed a draft copy of a preceptorship programme booklet that is being developed. Midwives were told they had to complete induction tasks in one month and have a follow up meeting but this meeting rarely took place to check midwifery competencies.

3. Governance

Incident reporting

A number of midwives were unfamiliar with the practice of incident reporting and were not able to talk with any confidence about the process. A senior manager informed us that they had informed all staff in 2013 about the incident reporting system ULYSSES (the company name, but midwives, including those with a risk management role, claimed not to know about this system and referred to a system called Safeguard, this is in fact the programme name. Regardless, confusion regarding the incident reporting system remains. We were informed of delays in investigations because of lack of scrutiny and rigour in risk management processes. We reviewed eight sets of minutes of obstetrics and gynaecology clinical governance committee meetings which demonstrated a lack of scrutiny and challenge to standards of clinical practice and/or issues raised. Limited follow up to these issues were documented.

For example: Minutes of obstetrics and gynaecology clinical governance committee meeting 21 July 2014, page 2, 'Baby notes are still being put into the community drawer, when this happens the GPs do not get a discharge summary which has to be done within 2 weeks' The action was for managers to remind the community midwives about this.

We observed apologies from a former senior manager for all eight meetings. We enquired about the non-attendance at these meetings and were informed that attendance was not necessary because the meetings were well managed and that they did not have a clinical background.

Unsecure storage of records

In the same set of minutes Obstetrics and gynaecology clinical governance committee meeting 21 July 2014, page 4, it was noted that 40 sets of medical notes had 'gone missing'. The governance lead was asked about this and suggested that the notes had not actually 'gone missing.' Instead they explained that this had occurred because an auxiliary nurse had gone on holiday which had delayed the process and steps were being taken to overcome the situation.

We observed a number of examples of poor and unsecure storage of records which are reported in the LSA report and demonstrate a risk to public protection. We had no evidence of HSSD governance processes which audited the secure storage of records. We also alerted the senior manager to open doors and open filing cabinets where confidential records were stored that had no obvious available keys to lock them. We were informed that the keys had been missing for a long time. In one area of the ward doors had been removed for ease of staff traffic and flow. Temporary action to secure records was taken at the time of escalating this problem to senior managers (3.10.2014)

We observed and heard that information and data provided to and discussed with individuals, audit teams and committees was accepted at face value; lacked scrutiny and rigour and was not challenged.

Senior members of the organisation lack awareness of governance issues

We observed that governance was not perceived to be the business of individuals at a senior level. The previous senior officer informed us that he had no interface with the maternity services and risk management until after a serious untoward incident involving a neonatal death. The senior officer described himself as a "generalist" at the interface between the staff and the executive board as they needed someone 'who knew how things worked'. He had no involvement with the clinical governance meetings and described the frequency of his meetings with the governance team as "ad hoc". He stated that he would be informed of any issues by the senior manager whom he met once per month.

He did not know anything about the Local supervising authority (LSA), the LSA Midwifery Officer, supervisors of midwives, or their statutory requirements or the LSA

contract. He was unaware of the gap between the suspension of the senior clinical manager and the new senior clinical manager being appointed and had never physically been on the maternity ward.

The former senior manager reported assuming that when there was a budget underspend on midwifery CPD and training that basic training was occurring and had an expectation that the former senior clinical manager would raise any concerns in midwifery practice with her and that any concerns would be raised with her at governance meetings.

Risk assessment e.g. root cause analysis training

We heard that the governance senior team received root cause analysis training but that other individuals involved in risk management at an operational level had not. There was no evidence that those who undertook the training disseminated their learning to staff involved in frontline care.

Undated reports, procedures and inconsistent minute taking

We observed a number of undated reports and procedures and unidentified authors was common practice. We found the style of minute taking was inconsistent across different groups/ committees, and clear time scales for actions are not identified, for example the notes of Obstetrics and gynaecology clinical governance meetings.

Dissemination of updated information is not transparent.

The process for dissemination of updated procedures and policies was not clear. We were informed that they are disseminated by global email however as bank and agency midwives do not have individual e-mail access this meant they were unable to view these so were reliant on reading them through the intranet system Polyplus.

Education and training needs

Midwives told us they attended mandatory training but the opportunity to attend other continuing professional development education and training updates was not always possible because of staff shortages. This was confirmed in the maternity services significant underspend in the education and training needs budget in 2012 and 2013. Student nurses felt unsupported and unwelcome on Loveridge ward.

4. Leadership and management

We observed that strong leadership and management were not demonstrated at a number of levels in the organisation. We heard inconclusive responses to a number

of our questions from senior personnel. Midwives reported a lack of clinical leadership and management within the maternity services.

We heard there is a lack of responsibility to appropriately prepare and support new staff, for example, new midwives, including agency and bank midwives.

We observed limited evidence of a robust induction or any preceptorship of new staff. Whilst some staff told us they had an individualised induction programme we heard they could not achieve all outcomes in the short length of the induction period. In addition, no one takes responsibility to confirm the new starter has achieved the outcomes.

5. Organisational culture

The ‘Guernsey way’

The term the “Guernsey way” was frequently referred to by midwifery staff to describe behaviours and/or practices. We heard midwives, service users and senior personnel make the comment “this is Guernsey..... not the mainland” or this is “the Guernsey way.” We observed this when discussing some areas of concern e.g. the safety of babies “this is Guernsey...”

We heard about midwives who challenged working practices and raised concerns but were unsupported and eventually left the island. Midwives reported that they were disciplined if they raised concerns indicating that there would be consequences if they raised or escalated concerns. We have heard a number of individuals and senior management saying that they had previously accepted things at face value and did not challenge. As the extraordinary review progressed senior personnel indicated that they now know “not to believe everything you are told”.

Maternity services have been organised around medical staff.

We heard from midwives that midwives were considered good co-ordinators if they don’t call consultants or keep calls to a minimum. We heard that midwives were discouraged from calling consultants, particularly after 17.00 and out of hours. PEH was described by some midwives as hierarchical, medically dominated, management focused and led rather than woman centred.

Role boundaries

We observed and heard about staff having more than job title and role which led to potential blurring of roles and conflict of boundaries. It has never been explicit that a risk midwife or a Head of midwifery cannot be a supervisor of midwives. However they need to be very clear about the possible conflicts or overlap of role boundaries which we found may not have been the case for the former post holders.

