FOI REF: 22/642

28th November 2022

East Sussex Healthcare NHS Trust

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FREEDOM OF INFORMATION ACT

I am responding to your request for information under the Freedom of Information Act. The answers to your specific questions are as follows:

Please can you also supply us with a copy of any invited review carried out by the RCOG at the Conquest hospital in the last 10 years.

Please see the attached document for a copy of the review carried out by the RCOG in August 2013.

Please note that according to our Freedom of Information Policy we only release the names of staff on Grade 8a and above, therefore names of staff below that grade have been redacted from the attached document.

If I can be of any further assistance, please do not hesitate to contact me.

Should you be dissatisfied with the Trust's response to your request, you have the right to request an internal review. Please write to the Freedom of Information Department (esh-tr.foi@nhs.net), quoting the above reference, within 40 working days. The Trust is not obliged to accept an internal review after this date.

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The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF

Telephone: 0303 123 1113

Yours sincerely

Linda Thornhill (Mrs)
Corporate Governance Manager
esh-tr.foi@nhs.net

Royal College of Obstetricians & Gynaecologists

CONFIDENTIAL

Review of the Obstetric and Neonatal Services of East Sussex Healthcare NHS Trust at Conquest Hospital

Undertaken by:
Mr Paul L Wood MD FRCOG (Lead Assessor)
Mr Andrea Galimberti FRCOG (Co-Assessor)
Professor Stewart Forsyth OBE MD FRCPCH (Co-Assessor)

On 8 and 9 August 2013

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INTRODUCTION

This review visit took place at the same time as a separate review visit undertaken by the Royal College of Paediatrics and Child Health (RCPCH).

Terms of Reference

1. Using case note review, interviews with staff and review of policies and procedures, identify areas for development in respect of Clinical Decision Making, Clinical Risk Assessment and Clinical Risk Management.

2. To make recommendations as to how these areas for development should be addressed.

3. Review the serious incidents that have occurred in Maternity and Paediatrics over the last twelve months and assess the clinical decision making processes, the root cause analyses, the incident reporting timeliness, and in particular identify any:

- Learning points following serious incidents.
- Failures to make the correct diagnosis.
- Failures to perform an appropriate examination.
- Failures to offer or perform appropriate treatment.
- Failures to arrange an appropriate review strategy in relation to the condition for which referred.
- Failures to take appropriate action in a timely manner.
- Failures to comply with relevant Trust Clinical Guidelines.
- Failures to identify or report a serious incident in a timely manner.
- Failures to take appropriate action within a reasonable time frame to minimise the risk of a similar incident occurring and/or to address the root causes identified.

4. To make recommendations for actions that will ensure that there are robust and clinically led systems and processes in place to enable clinicians to critically appraise incidents, to identify root causes and implement actions so that learning and appropriate changes in clinical practice can be delivered and evidenced.

BACKGROUND

East Sussex Healthcare NHS Trust held an Extraordinary Trust Board Meeting in public on Friday 8 March 2013. Included in the Board papers was a document entitled 'Ensuring Safety for Obstetrics and Gynaecology and Neonatal Services'. The report provided the Board with information required to make a decision on the preferred option for improving the safety of the maternity and neonatal services. The paper sets out the reasons behind the view that for some patients some of the time the maternity and neonatal services operated by the Trust did not deliver the safety and quality standards expected and required. The paper was based on the views of the Trust's senior clinicians

and also those of the National Clinical Advisory Team (NCAT). The current dependency on mitigating actions meant that the cumulative risk of service failure was at an unacceptable level, and that the delivery of a safe service could become rapidly unsustainable, leaving the Trust with little time to implement effective mitigating actions. The preferred option presented to the meeting on 8 March 2013 was the provision of a consultant-led obstetric service, neonatal service, inpatient paediatric service and an emergency gynaecology service at the Conquest Hospital. A stand-alone Midwifery-Led Unit (MLU) with enhanced ambulatory paediatric care was to be established at Eastbourne District General Hospital.

The main risk factors identified were:

- Increased numbers of high risk pregnancies.
- Lack of 24/7 availability of medical and midwifery staff with the required competences.
- An ongoing dependency on temporary staff.
- Potential failure of the risk mitigations at short notice.
- The lack of availability of clinical leadership in a service delivered on multiple sites.

The requirement to act had been triggered by an analysis of increasing numbers of serious incidents (SIs). The NCAT attended in January 2013 and a Risk Summit had taken place in February 2013. Both concluded that the Trust was operating with unsustainable levels of risk and urgent action was deemed necessary. Prior to 2013 approximately 2000 women were delivered in each of two separate sites at Conquest Hospital and at Eastbourne District General Hospital. The Trust's number of SIs per calendar year from 2007 are summarised as follows:

Year	Obstetrics	Paediatrics
2007	1	2
2008	6	2
2009	1	0
2010	10	2
2011	7	1
2012	8	3
2013 (to 8 March)	8	1

The processes in place in relation to serious incidents were as follows:

- Root Cause Analysis (RCA).
- Discussion at weekly conference calls with the Primary Care Trust (PCT)/ Strategic Health Authority (SHA).
- Action plans for RCA discussed at the bimonthly Divisional Patient Safety and Clinical Improvement Group and at core team meetings.
- Each serious incident was also discussed at the fortnightly Trust Wide Serious Incident Review Group.

The themes identified from recent serious incidents were:

- Senior opinion not being sought in a timely manner.
- Women not being reviewed in a timely way.
- Poor care resulting in harm to babies at birth.
- Poor communication in relation to planning and communicating care plans.
- Poor liaison with senior colleagues.
- Care given by agency staff causing harm.
- Junior staff not recognising the deteriorating condition of a patient and escalating appropriately.
- Inadequate supervision of junior staff.
- Maternal risk factors.

The report referred to the Dr Foster Patient Safety Indicator Data and explained how the Trust was a significant outlier in 2010–11 and 2011–12 for obstetric trauma at caesarean section and this continued to be the case. The Trust's observed rate for 2011 was 20 against an expected level of 3.1. In 2011–12 this was 15 against an expected rate of 3.1, meaning the risk of harm to a woman undergoing caesarean section at East Sussex Healthcare NHS Trust was five-fold more than anticipated. The majority of the caesarean sections resulting in obstetric trauma were identified as having been undertaken by locum/agency doctors or more junior registrars without the presence or supervision of a consultant. Analysis demonstrated that there was a greater risk of harm at the Eastbourne site.

The Maternity Dashboard had identified:

- A consistent need to divert women in labour from one site to another.
- The birth to midwife ratio was above that expected.
- High midwifery absence rates.
- Low normal delivery rates.
- Higher than expected numbers of term babies admitted to the Neonatal Unit.

Key factors that were adversely influencing the quality and safety of service provision included the inability to provide consultant labour ward presence at levels above 40 hours per week, lack of suitable applicants to fill established posts with accompanying requirements to take unplanned action to address shortfalls, staff not always being able to operate at the skill levels required and lack of availability of experienced staff 24/7.

NCAT had concluded the following:

- A decision on the location of inpatient maternity care and paediatrics was needed as a matter of urgency.
- The manner in which the maternity and paediatric services were operating was neither safe nor sustainable.

- The siting of inpatient maternity services was dependent on appropriate arrangements with other relevant services.
- The maternity services were the main driver but separate inpatient paediatric services were felt to be too small to be sustainable.
- In the presence of two separate emergency departments the provision of emergency gynaecology needed to be managed on the remaining site in the absence of resident gynaecology staff.

NCAT's recommendations included:

- Co-location of maternity and paediatric inpatients on one site as a matter of urgency.
- A Trust-wide strategy for maternity and paediatric services to be developed.
- Consideration to the establishment of alongside and stand-alone MLUs.
- Maternity, gynaecology and paediatrics should be on the same site.
- The Trust to reconsider the overall strategy for delivering services to acutely ill patients in order to improve service delivery and reduce clinical risk.
- Need to urgently address local leadership of the paediatric team and improve cohesion.
- A paediatric group to take forward standardisation of clinical guidelines and practice within an agreed time frame.

The paper considered a risk assessment of the various options and the advantages of the preferred option was adopted. This involved the provision of a consultant-led obstetric service, neonatal service, inpatient paediatric service, an emergency gynaecology service on the Conquest site and establishing a stand-alone MLU as well as enhanced ambulatory paediatric care at Eastbourne General Hospital.

The advantages included:

- Ability to provide a minimum of 60 hours consultant labour ward presence.
- Consolidation of activity providing a wider range of experience for trainees, improving recruitment and retention.
- Improved medical cover at night.
- Improvement in staffing, flexibility of midwifery resources, improved midwifery skill mix, and provision of dedicated consultant-led teams.

NCAT referred to an external review of four cases which had taken place without the benefit of the clinical records, clinical guidelines, knowledge of the working practice and knowledge of the staff involved. However the external review concluded:

1. The Trust acted responsibly in requesting external reviews. NCAT noted that overall the reviews were well contributed and written but there were significant omissions.
2. There were delays in escalating incidents for risk review and identifying them as serious incidents.
3. There were delays in completing planned actions and a lack of robust assessment that actions had been achieved.

4. There was a lack of escalation by midwifery, neonatal nursing or theatre staff directly to the consultant when there were concerns about a middle grade doctor's actions raising concerns regarding the profile of the Labour Ward Co-ordinator and Labour Ward Lead Clinician.
5. There appeared to be significant issues around obstetric staffing including decision-making relating to delivery at full dilatation and trials of instrumental vaginal deliveries.
6. The RCAs did not demonstrate sufficient evidence of support being offered to medical staff, especially locums and paediatricians after adverse outcomes and a failure to adhere to local clinical guidance was a common theme in the incidents reviewed.
7. Poor communication within and between teams was a common feature.

Concerns raised by NCAT included:

- Delays in escalation.
- Lack of supervision of locum and middle grade staff.
- Validity of the interpretation of Serious Incident Reports.
- A very worrying culture of complacency in relation to risk within maternity and paediatrics.
- Poor record keeping.
- Poor communication.
- Lack of plan of care.
- Lack of documentation.
- Lack of appropriate level for opinion/planning.
- Inappropriate grades/level of staff undertaking or providing care.
- Where a serious incident involved a poor outcome for the baby there appeared to be a minimal review of obstetric care prior to the birth.

NCAT felt that the RCA Enquiry Team did not appear to have asked the appropriate questions and therefore they felt the conclusions were likely to be incorrect. The NCAT refer to the Edgecumbe Report which was 'truly shocking in its account of failure of clinical leadership and of the dysfunction within the Paediatric Team'. NCAT concluded that neither the maternity nor the paediatric services were safe or sustainable in their current shape and that the paediatric department especially appeared to be dysfunctional with little insight. Urgent steps were needed to address these shortcomings. This report was dated 11 February 2013.

Care Quality Commission (CQC) Inspection Reports (Maternity & Paediatric), Conquest Hospital, Eastbourne District General Hospital – Inspections (24–25 June 2013)

The assessors were provided with favourable Care Quality Commission reports (in draft) for both hospitals following inspections in June 2013. These reports were later issued in their final form by the CQC following correction of some minor factual inaccuracies.
Points to note within the reports include:

- The temporary reconfiguration of maternity and paediatric services was completed on 7 May 2013.
- There had been prior concerns registered by a team of consultant paediatricians at Eastbourne District General Hospital.
- Care and welfare, safeguarding, requirements relating to workers, staffing and assessing and monitoring the quality of service provision had been inspected and assessed as meeting the standards.

The reports noted that:

- Systems were reviewed at both the Conquest Hospital and Eastbourne District General Hospital.
- There had been a marked increase in the reporting of incidents during the second half of the financial year ending March 2013.
- Conclusions reached were that the Trust is providing a safe, effective, responsive, caring and well led maternity and paediatric service.
- Staff felt that centralisation of obstetric intrapartum care was safer.
- Staffing was obtained by the use of 'familiar' bank and agency staff.
- Colleagues had been supportive following the relocation.
- Obstetricians were now 'present' on the labour ward rather than 'available'.
- The need for locum obstetric staff at night had been removed.
- There had been a reduction in clinical incidents since amalgamation.
- The Report referred to the computerised system for reporting incidents.
- Incident forms were reviewed daily with risk meetings Monday–Friday.
- Staff received feedback about incidents on a monthly basis.
- There had not been any clinical incidents regarding neonatal resuscitation since the reconfiguration.
- The Trust's maternity services had been assessed as Level 3 at the last Clinical Negligence Scheme for Trusts (CNST) visit. (N.B. This was an incorrect typographical error and should have read Level 2).
- In the context of the paediatric concerns, if reassessed by CNST the Trust would be assessed as higher risk, but this would not make it uninsurable.

- The CQC was satisfied that, within maternity and paediatrics, the Trust had taken appropriate steps to mitigate risk and ensure that care and treatment was planned and delivered in a way that ensured people's safety and welfare.
- Maternity staff confirmed they received safeguarding training annually.
- Staff interviewed had a clear understanding of mental capacity assessments.
- Temporary staff (locums) were subject to the same level of checks and similar selection criteria to staff in substantive posts.
- The risk of employing locums was on the Risk Register and specific controls had been put in place.
- The Trust compared its SIs with others and the national mean.
- The Trust may not be able to find evidence when consultants were on the ward on the basis of the attendance diary.
- All locums were directly supervised re decision-making and instrumental and operative deliveries.
- The Maternity Dashboard had been reviewed.
- Each clinical unit had a risk register and monthly risk meeting.
- The high-level risk register was reviewed.
- Minutes of the Serious Incident Review Group had been inspected for 29 May and 12 June. Contradictions in report were questioned by the Inspectors. The controls in place for locum staff were deemed to be 'adequate'
- Escalation was to the Divisional Risk Meeting, Health and Safety Group, Patient Safety Group, Clinical Management Executive, Quality & Standards Committee and Patient Safety and Clinical Improvement Group and finally the Trust Board.
- Six SI reports and their RCAs were examined in detail and, in general, the CQC found that the reports and reviews had been completed to a high standard.
- Some staff had been made personally accountable following RCA.
- Generally the action plans were relevant and had been completed, but not all.
- There has been a South Coast Audit that had only been able to provide limited reassurance that action plans were being completed. One recommendation was that actions were implements and monitored. Auditing of the quality of case notes had been incomplete.

RCOG EXTERNAL CLINICAL ADVISORY TEAM REVIEW, 8–9 August 2013

Interviewees

- Coordinator – Ms Paula Smith, Acting Associate Director, Women and Children – Integrated Care, East Sussex Healthcare NHS Trust, who facilitated the review
- Ms Amanda Harrison – Director of Strategic Development and Assurance
- Dr David Hughes – Medical Director (Governance)
- Mr Jamal Zaidi – Divisional Director – The Divisional Director has joint accountability for governance including risk, along with the Associate Director of Nursing
- [redacted] Matron Delivery Suite
- Dr Sebastien Adamson – ST4 Obstetrics and Gynaecology
- Mr Dexter Pascall – Clinical Unit Lead, Obstetrics. The Clinical Unit Lead has responsibility for the implementation of the Maternity Risk Management Strategy, this responsibility being shared with the Head of Women's Reproductive and Sexual Health Services
- Ms Anne Watt – Divisional Clinical Governance Manager
- Dr Noka Sadete – Middle Grade Trainee in Neonatology
- Dr Graham Whincup – Paediatrican
- Ms Lindsey Stevens – Head of Midwifery and Associate Nurse for the Division
- [redacted] Neonatal Matron
- Ms Cathy O'Callaghan – Acting Clinical Services Manager

Other Information received in advance of the visit

- Maternity Risk Management Strategy
- Copy of notes and correspondence relating to serious incidents:
    - 2013/10044,
    - 2013/5108,
    - 2102/22311,
    - 2012/23709,
    - 2012/23168,
    - 2012/23709,
    - 2012/24174,
    - 2013/10830,
    - 2013/10040.

Information supplied during the visit

- Clinical records of 47 sets of notes relating to mothers and babies admitted to the Neonatal Unit by way of a random review of case notes.
- Maternity Dashboard April to July 2013.
- Risk Management Meeting Minutes dated 21 June 2013 and 26 July 2013.
- Adverse incidents by category and incident August 2012 to May 2013.
- Maternity Staffing Audit Report December 2012.

- Guidance for Maternity Unit Staffing Levels for all care settings relating to obstetrics and midwifery.
- Obstetrics and Gynaecology weekly rota.
- Daily reporting tools for Maternity Services, Gynaecology and Paediatrics.
- Complaint status as of 10 June 2013.

Site visit

The visit included a brief tour of the Neonatal and Obstetric Unit at the Conquest Hospital during which the labour ward staff were able to demonstrate familiarity with the Datix Incident Reporting System.

Clinical risk and service delivery assessments

Review of serious incidents

The documents relating to eight serious incidents during 2012–2013 were reviewed and a detailed analysis of these cases has been provided to the Trust.

The case reviews identified serious failures in clinical decision-making and service management including delays in escalation of level of care, excessive use of locum doctors, poor communication, inadequate supervision of middle grade doctors, inappropriate care, misinterpretation of CTGs, misleading documentation, and substandard clinical skills including neonatal resuscitation.

The review of the RCAs of each of the incidents revealed that they were invariably undated with no recognisable authorship. Review of the statements shows that these are not consistent in terms of their format or presentation.

These incidents predate the reconfiguration of services and it is vitally important that these serious risks to patient safety are rigorously audited in the new service configuration to ensure the quality of care provided within the new structure is at an acceptable level.

Review of case notes

Time constraints limited the number of case notes reviewed on a random basis but the Review revealed a good standard of neonatal note keeping and in particular the value of combined medical and nursing notes was observed.

Within the obstetric records the risk profiles were often not completed and the reviewers support the need for an ongoing random audit of case notes which has not been carried out within the Trust despite previous recommendations.

Staff were generally good at signing the booklets and the obstetric cases appear to have generally been well managed overall. Incomplete documentation relating to antenatal, labour and postnatal risk factors were evident despite provision of a well structured risk assessment form. Many important clinically relevant fields were not completed. It was gratifying to see that early warning scores had been acted upon appropriately. Not all medical entries were signed.

Maternity risk management strategy

The current version of the Maternity Risk Management Strategy (V1.0) was ratified in November 2012 and issued in January 2013. We were advised that this strategy was in place at the time of the SIs that have been reviewed. The previous strategy version V7 2011017 was dated January 2011.

The Strategy refers to cross-site Obstetric Risk Management and Labour Ward Leads. The document was apparently made available to all staff within the organisation, partner organisations and the public. Key objectives were to ensure that staff had an understanding of the risk management structure via mandatory training sessions and to encourage participation in the risk management process. Other objectives included undertaking audit of practice at three yearly intervals or six to nine months after a practice change, and regular review of the maternity service and labour ward dashboards.

There is no obvious convergence between the Trust's Risk Management Strategy and that for the maternity unit. Furthermore the existing Risk Management Strategy document (V1) is limited in what it provides with obvious gaps as listed below. As a document it is not user friendly and pre-dates obstetric working on a single site.

Root cause analyses

RCAs were generally of a satisfactory standard but hampered by the absence of forensic analysis typified by acceptance of statements without any interviews or meetings with the clinicians concerned where there were apparent conflicts between statements or when the clinical description of the sequence of events was not entirely credible. In addition there was a lack of clarity over outcomes following on from the conclusions reached as a result of the RCAs in relation to clinical governance. These outcomes should be clearly documented, monitored and developed, e.g. SUI 2013/10830. There was clear substandard care on behalf of the consultant and the registrar in this case but, in contrast to midwifery supervision, all that was noted was that the clinical director would have a conversation with the clinicians concerned. The outcome of this conversation or indeed whether this conversation ever took place has never been documented but should have been.

In addition there is a need to strengthen the responses to situations where good medical practice is potentially compromised, e.g. SUI 2012/20174 when the registrar's actions were entirely inappropriate as indeed were his subsequent comments. Under these circumstances there was no attempt to escalate concerns about this individual within the Trust itself and no mechanism to ensure that there was accountability for the responses to this inappropriate clinical behaviour.

Furthermore it became apparent to us that whereas a number of cases involved locum staff there appeared to be a tendency to apportion inappropriate blame on the locum/junior staff in comparison to situations where similar criticisms could be made of the more senior staff in substantive posts.

Daily Datix reporting meetings

The daily Datix reporting meetings appear to be extremely successful and reflect good practice. It would probably be helpful to attempt to involve the neonatal team in these daily meetings.

Service management and clinical decision making

The evidence from the clinical risk assessment highlights serious service delivery issues with significant risk to patient safety. It is acknowledged that these are the drivers for the change in service configuration within the service. However, a robust operational plan to address these issues within the new structure needs to be developed and implementation will require effective clinical and managerial leadership.

The operational plan should include a knowledge and skills review that ensures that at all locations within the maternity and neonatal services care is being provided by staff that are appropriately skilled to deliver safe and effective patient care.

It is clear that the Senior Management Team has trust in the obstetric team and the introduction of a management rota for the maternity unit has been a good move forward. There remain issues with paediatric clinical staff where two clinicians are currently restricted in their clinical work. It is noted that a review team from the RCPCH is providing advice on these issues.

There should be an identified Labour Ward Midwifery Manager Lead rather than a system of rotating the Band 7 coordinators. This will allow for accountability and continuity of responsibility in respect of clinical risk and day to day management of the unit.

Consultant presence on the labour ward involves a system of signing in and out, with which there is limited compliance. Trainees have reported that their supervision on the labour ward tends to amount to consolidation of skills rather than learning, raising the need for a greater degree of direct supervision by the labour ward consultant than is currently provided. There is a need to ensure progress is made in this respect to avoid the risk of poor practice.

Routine auditing of case notes has not been taking place on a regular basis and this should be reintroduced in order to maintain standards and reduce risk.

There would appear to be some additional work in terms of the understanding and implementation of existing guidelines.

RECOMMENDATIONS

Risk Management Strategy

The reviewers had sight of individual pages from a revised draft version of the strategy (V2) but before this is published we recommend the following:

a) The Risk Management Strategy should be targeted beyond the Maternity Department itself.

b) Titles are not necessarily appropriate and roles and responsibilities need to be clearly defined.

c) There need to be references to guidelines, risk management coordination processes and responsibility for Root Cause Analyses.

d) There should be separate sections on incident reporting, serious incidents and links to the Trust Risk Management Board.

e) There should be references to the Maternity Dashboard, mechanisms for minimising risk and future risk management planning.

f) There should be evidence of compliance monitoring and audit and hyperlinks to related documents.

g) There are no references and there is a need to include links to external bodies.

h) It seems unclear to us why there are separate lists relating to the type of incidents to be reported and we recommend that these are put together under one heading rather than for instance a separate supervisory list.

i) The manner in which incidents are categorised should be reviewed with emphasis on breaking down incidents relating to antenatal, labour and postnatal care. This is especially important given the marked increase in incidents reported even prior to single site working. The increase in reporting has continued thereafter and the reasons for this should be explored and clarified.

j) Root Cause Analyses should be more 'forensic' with detailed interviews with key members of staff corroborating the written information.

k) Root Cause Analyses should have ownership and be dated appropriately with adequate evidence of closure of the process.

Service management and clinical decision making

a) In keeping with previous recommendations, routine random audit of case notes should be regularly performed and viewed as an essential component of good practice.

b) The merger provides the opportunity to ensure that the service provided at each of the locations is supported by staff with appropriate knowledge and skills. This will require a comprehensive review of staff numbers, knowledge and skills.

c) Delivery of the recent service changes will require strong and effective clinical leadership and a review of service management structures should be considered.

d) Continuing professional development of all clinical staff should focus on the deficiencies in service delivery highlighted in the reviews of the serious untoward incidents, for example, escalation of levels of care, interpretation of CTGs, record keeping, supervision of junior/locum clinical staff and neonatal resuscitation.

e) There should be an identified Labour Ward Midwifery Manager Lead rather than a system of rotating the band 7 coordinators. This will allow for accountability and continuity of responsibility in respect of clinical risk and day to day management of the unit.

f) The consultant presence and role within the labour ward requires consolidation. There is a need for clarity in respect of the role of the consultant, more robust monitoring of consultant presence and specific guidance as to when consultants should be supervising trainees directly.

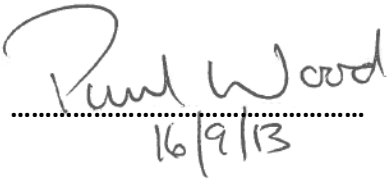
g) It is unusual for a hospital with over 3000 deliveries per annum to provide only Level 1 neonatal intensive care and the option of the neonatal unit operating as a Level 2 Unit should be achievable working in collaboration with a tertiary centre.

CONCLUSION

The interim arrangements for obstetric and neonatal services at the Conquest Hospital have had positive outcomes for clinical governance and these should be monitored and developed. The Trust appears to be generally risk averse and there is much to build on. Our recommendations will hopefully provide clear guidance on mechanisms to strengthen risk management and clinical governance. Working on one site since 7 May 2013 has resulted in increased opportunities for senior staff, improving the workforce, increasing the resilience of middle grade staff and increasing the workload and as a result staff appear to be happier, more confident and feel better supported. As a result the hospital is seen as a more attractive place to work and hopefully this will improve recruitment of both junior and senior staff. There is an incidental benefit of an enormous potential for reducing the numbers of staff in middle grade posts and potentially expanding consultant numbers to increase labour ward presence, supervision and training.

We note that the changes since the interim arrangements have been mainly operational and there is now an opportunity to consolidate governance arrangements.

Mr Paul L Wood

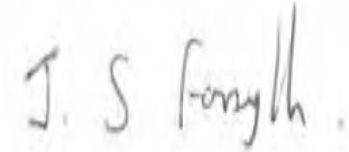


Date: 16/9/13

Mr Andrea Galimberti

Date: 10/9/2013

Professor Stewart Forsyth



Date: 4 September 2013