

Hutt Valley District Health Board

Women's Health Services

External Review

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Introduction

An external review of Women's Health Services has been requested by the Chief Medical Officer (CMO) of Hutt Valley District Health Board (HVDHB), Dr. Sisera Jayathissa and Acting Chief Executive Officer (CEO) Dale Olaf. This was prompted by a number of factors including – a request from HVDHB Senior Medical Officers (SMOs) to address senior medical staff shortage with the appointment of an additional Consultant, a high rate of complaints involving serious adverse outcomes including cases reviewed through the Office of the Health and Disability Commissioner (HDC), a high rate of Caesarean section (CS) which was reported at 41%, a high rate of newborn babies being admitted to the Special Care Baby Unit (SCBU) for treatment of suspected Neonatal Encephalopathy (NE).

Purpose

- To establish a better understanding of HVDHB's Obstetrics, Gynaecology and Midwifery services
- To explore the opportunities to provide high quality and safe maternity services to the local population
- To inform the development of a programme for the Obstetric and Gynaecology (O&G) and midwifery services that provides and ensures HVDHB has a future-proof service that is clinically safe and culturally responsive to the local population

Scope

- The clinical services provided by the O&G and midwifery services, both inpatient and outpatient; an assessment of the capacity and capability within the service
- A review of service outcome data
- Opportunities to improve equity of service provision for all peoples with a focus on Maori health and Pacific health
- An assessment of the capacity and capability within the service to undertake necessary service development to address the findings of this review
- Associated clinical activities based such as teaching, clinical supervision and research for both O&G and midwifery staff
- Recommendation of the composition and skill mix of all health professionals required to deliver a comprehensive service for the region
- Governance structure of both services
- Options for service delivery models to optimise patient care, and provide supervision of staff in a resource-constrained environment
- Engage with the staff to understand what they view is working well and what could be improved. This may include key staff from support services such as paediatrics, neonatology and anaesthesia
- Engage with consumers on what is working well and the opportunities now and in the future
- Review existing data to inform recommendations

Background

Over the past two years the organisation has engaged in a programme to establish a Mission statement and set of Operational Values. There has been an emphasis on promoting staff recognition and awareness of these.

The Vision is “Healthy people, Healthy, Families, Healthy Communities”

The Mission is “Working together for health and wellbeing”

The Values are -

- Always Caring – respectful, kind, helpful
- Can do – positive, learning and growing, appreciative
- In partnership – welcoming, listens, communicates, involves
- Being our best – innovating, professional, safe

Key Considerations

Priorities in the Hutt Valley District Health Board (DHB) Annual Plan were reviewed as well as the Minister of Health’s letter of expectation, dated 12th December 2018 which is inclusive of a midwifery workforce plan, strategies to ensure sustainability and a focus on maternal and infant wellbeing.

Findings in the latest Maternity Annual Clinical Report for 2017 provided evidence of quality initiatives to support improvement in some clinical indicator outcomes but particular challenges in others, a high Caesarean section (CS) rate, a high rate of induction of labour and a high admission rate to the Special Care Baby Unit (SCBU). The rates have continued to increase and they lie significantly outside the national benchmark parameters, as is evident in the 2016 MOH Clinical Indicator report.

Demographics of the population are similar to both Midcentral and Hawke’s Bay in relation to ethnicity with similar representation of Māori, Pacifica, Asian and European. The demographics data shows evidence of high socioeconomic deprivation of the community. Poverty, family harm, drug addictions and mental health concerns are evident and these factors significantly impact the wellbeing of women, babies and whānau.

Ministry of Health (MOH) programmes and Nationwide health promotion strategies are relevant because these are key drivers of resource utilisation and prioritisation for maternal and infant health services. These include:

- Child and Youth Wellbeing strategy,
- First 1000 days
- National Breastfeeding Strategy
- National MOH Primary care review
- National Mental Health services review recommendations
- Recommendations from the Perinatal Mortality and Morbidity Review Committee (PMMRC) annual reports
- Recommendations from Health Quality and Safety Commission (HQSC) Maternal Morbidity Working Group (MMWG) to ensure safety i.e. development and roll out of Sepsis bundle of care 6±2, implementation of clinical pathways related to hypertension, peripartum hysterectomy, early detection of the deteriorating patient Modified Obstetric Early Warning score (MEOWS)

Safety Components of HVDHB Women's and Children's Health Service have been assessed during this review with an emphasis on what a safe service should look like. This has included identification of risk and identifying potentially unsafe practices, assessing the organisations ability to detect and manage risk, and assessing staff attitudes and professional capabilities to provide an environment that is protected from risk or injury.

Section One

A template for the review was developed from modification of the HQSC Clinical Governance Framework and the London Protocol template which is a root cause analysis framework for reviewing serious adverse events. The findings of the service review are presented under the following headings.

- 1) Personnel (Workforce)
 - a. Identification of different health professions
 - b. Staffing levels
- 2) Environment
 - a. Physical
 - b. For women and whānau
- 3) Culture
 - a. Values based
 - b. Equity
 - c. Responsiveness
- 4) Models of care and Clinical Practice
 - a. Safety
 - b. Quality
 - c. Education/Training / Supervision
 - d. Resources
 - e. Guidelines
 - f. Leadership
- 5) Organisational
 - a. Where Women's Health sits
 - b. Strategic priorities
- 6) External
 - a. Consumer experience and feedback

Appendix A – copies of timetables of meetings with key stakeholders and providers of maternity services

Appendix B - provides a list of the questions that were used during some of the interviews, which is taken from the HQSC (2017) "Clinical Governance: Guidance for Health and Disability Providers"

Executive Summary

Interviews with staff in the maternity unit revealed an extraordinarily committed and strong clinical team whose strength lies in their single purpose to provide safe maternity care for the women and whanau of their community. It was evident that staff were very hard working, innovative and passionate but the service has been plagued by a chronic workforce deficiency. Addressing this deficiency lies among the most urgent recommendations of the review

1. PERSONNEL

Midwifery workforce

The Maternity service has been identified on the organisational risk register and elevated to the Executive Leadership Team via appropriate channels as a major concern for safety.

Midwifery Staffing FTE is the lowest in the central region, which includes CCDHB, HVDHB, Midcentral DHB, Wanganui DHB, Wairarapa DHB and Hawkes Bay DHB, and is well below comparative secondary care DHB maternity services such as Midcentral, Northland and Hawkes Bay. There are issues with recruitment and retention of midwifery staff. There is significant current vacancy of 8.6 FTE. Reasons identified include a national shortage of midwives, local high acuity, rising complexity and very stressful work environment with insufficient staff to support minimum safe care e.g. 1:1 in labour. Furthermore there is a frequent requirement to work extra hours or shifts to support colleagues which has led to fatigue and burnout and this affects the ability to identify and manage clinical risk. Staffing deficiencies have been chronic leading to acceptance of risk, 'normalising' the shortages and moving away from recognised safety parameters.

Lack of staff has resulted in 'care rationing' and the midwives have become task oriented. This has led to significant dissatisfaction with the job and feelings of disempowerment and negativity.

The skill mix on the maternity wards is not correct – i.e. midwife/nurse ratio not balanced. There is a reliance on nurses to fill shift vacancies when midwives are not available. This significantly reduces the flexibility of workforce and impacts on the ability to respond to emergencies and acute assessments.

There is a significant reliance on the clinical midwifery manager to work clinically to fill the gaps in the roster when there is increased demand. This is not sustainable or supportive of the leadership role.

HWNZ data (MOH HW Directorate, 2017) reveals one of the highest midwife to woman ratios in the country inclusive of complexity rating. It should be 1:45 but is currently 1:97 with a 5 year forecast of 1:112.

There has been an increasing demand on DHB community midwifery team to provide primary antenatal and postnatal care.

There are high levels of LMC handover to DHB midwives to provide secondary care. The rising complexity of the secondary women is challenging the ability to meet the minimum antenatal care requirements. This has significant resource implications for both inpatient and outpatient midwifery care and midwifery staffing. Over time handover to the secondary team has increased however secondary care midwifery FTE allocation has not been reviewed to support this change.

Recommendations:

DHB midwifery base staffing levels should be increased significantly. This should include the DHB community midwifery team with an increase in FTE to match increasing demand from LMC unavailability, which is likely to require an increase in FTE of at least 4.0. It would be helpful to formally review and benchmark against MERAS Maternity facility safe staffing standards. (High priority – Initiate immediately).

Implement Care Capacity Demand Management (CCDM) to identify staffing levels in response to demand, occupancy and acuity. (Urgent – initiate within 3 months).

Associate Clinical Midwifery Manager

The introduction of the ACMM has been universally and widely appraised to have improved many components of patient safety. ACMM cover is available for the day time shifts but not overnight. This lack of overnight cover poses a risk to patient safety.

Recommendation:

The ACMM positions should be increased immediately to cover the overnight shift to provide 24 hour cover. Recruitment to these positions should be given the highest priority. (Highest priority – Implement immediately).

Theatre midwives

New roles have been established for a group of DHB midwives to attend CS deliveries. The theatre midwifery team has been run as a pilot and funded for 1 year. The initiative has been applauded as an excellent innovation which has improved safety and helped to create an improved patient experience.

Recommendation:

The funding for this CS midwifery team should be made permanent and the FTE increased to cover an on call CS midwife service out of hours plus the FTE allocation for these practitioners should include an allowance for sick leave, study leave and annual leave. (Initiative already in place – Confirm ongoing funding immediately)

Nursing workforce

Severe deficiencies in the midwifery workforce have led to the employment of RNs to fill roster gaps. RNs have a different scope of practice and skill set to midwives. They are committed practitioners who feel that they have a positive contribution to make. However there has been a lack of orientation and supervision which at times has limited their effectiveness.

Recommendation:

The service should develop a comprehensive orientation and supervision programme to support safe, high quality care provision across the postnatal ward. This should be targeted toward extending nurses scope of practice. Rotation of positions across the ward areas including SCBU should be considered to extend skill set and improve clinical expertise. (Urgent – initiate within 3 months)

Health Care Assistants

At times there are no HCAs rostered for the overnight duty. This leaves the LMCs and DHB midwives with additional duties which puts unnecessary pressure on an already stretched workforce.

Recommendations:

Recruit to fill HCA positions to ensure there is cover across all shifts. Immediate recruitment to these positions is recommended to support midwifery and nursing staff. (High priority – Initiate immediately).

Consideration of further development of HCA role in line with other models of care such as the British maternity care assistant role to provide further support for midwifery staff. (Longer term project – Consider once more immediate recommendations are in place).

Medical Obstetric Staff

Senior Medical Officers

There was a period of time when the department relied on locums to cover the roster after the retirement of two senior SMOs. This has been improved by the appointment of two newly qualified SMOs however there is still a reliance on locums to maintain elective work volumes in clinic and theatre, which comes at a significant cost. The total SMO FTE for the department is 4.95. Estimates of the FTE required to meet contracted volumes of elective work as well as On Call commitments has been calculated at 6.11. By comparison, Hawkes Bay has 7 SMOs with a total FTE of 6.05.

The SMOs will need to have a review of time allocation as this has become skewed over recent years toward covering for acute work which has come at the expense of engagement in Quality and Safety initiatives. A formal job size should be done to ensure there is adequate non-clinical time allocated for Quality activities which all SMOs should all be actively involved with.

Recommendations:

Extend the SMO workforce to 7 consultants as previously recommended in a Medical Council review, which will avoid the need for locums to meet Elective volumes. (Initiate immediately - don't wait for job sizing activity to be completed).

Engage in a job sizing exercise with ASMS to ensure there is adequate non-clinical time allocated to allow participation in Quality and Safety initiatives. Include a departmental service review of Elective volumes and caseweights, and a job size of individuals with a review of ward rounds, clinics, theatre sessions and On Call commitments. (Urgent – initiate within 3 months).

RMO workforce

Historically it was common for Junior RMOs to be 'first On Call' in medium sized maternity units in New Zealand however this is an uncommon practice now with most departments having a 3 tier roster for On Call duties, including a House Surgeon and Registrar on site and an SMO on call. Given the increasing acuity and complexity of obstetrics, and the reduction in RMO experience resulting from reduced hours of work, it seems likely that a 3 tier system will be required.

Recommendation:

Liaise with Human Resources to consider an increase RMO numbers at Registrar and SHO level to establish a 3 tier On Call system. Having Registrars on site at all times will further reduce the reliance on relatively inexperienced RMOs (is the senior SHO) as being the only available medical officer on site. (Semi urgent – Initiate within 6 months. The main priority is to ensure a full cohort of senior RMOs to cover the ‘first on call’ roster as it currently exists. Extending to a full 3 tier system will be a longer term project which should be considered this year).

Anaesthetic Service

There is no dedicated epidural service. There are limited pre-operative clinics for the anaesthetists to review Elective CS cases and to review high risk patients to assess suitability for regional anaesthesia (current provision for 6 patients per fortnight).

An initiative for Patient controlled epidural analgesia appeared to face many barriers with implementation and support. In order for the initiative to succeed more wide ranging support will be required including from Delivery Suite staff, the Quality team and RMOs.

There is no direct Anaesthetic involvement in delivery suite, such as an anaesthetic registrar presence at Obstetric handover, or scheduled education sessions. The anaesthetic Head of Department estimated that 60-70% of patients in the maternity unit will have direct anaesthetic involvement during their hospital stay.

Recommendations:

Increase resource of Anaesthetic clinics for Obstetric patients so that women requiring Elective CS may have a pre op review. The clinic would be an opportunity to review more women who are high risk from a medical or anaesthetic point of view. (Urgent – initiate within 3 months).

Support a dedicated Epidural service. This would include identification of Obstetric Anaesthetist on each roster. (Urgent – initiate within 3 months).

Allocate an anaesthetic registrar to attend Obstetric medical handover with the registrar providing some cover for the acute pain service if it is not otherwise available. (This is a simple process – initiate Immediately).

Implementation of Epidural Patient Controlled Analgesia which will require multi-departmental support. (Semi-urgent. Considerable work has already been done to implement this initiative. Once other urgent recommendations are in place address the resource required to support this).

Theatre Staff

There has been significant criticism regarding the lack of resident theatre nurses and an anaesthetic technician overnight. These staff are on call from home and there is an inherent delay waiting for staff to arrive in the hospital if an Emergency CS is required overnight. The delay in waiting for staff to arrive is a significant risk and a threat to the provision of a safe service.

Recommendation:

Permanent overnight staffing should be urgently considered. This will require an increase in nursing staff levels. (High priority – consider immediately)

Executive Interviews

Executive members (Acting CE, Acting COO, CMO and DON) acknowledged the strong clinical and professional leadership of the Midwifery Director, the CMM and the HOD for O&G. The executive team shared the concerns raised by clinical staff regarding the safety of the service and saw this review as a positive step toward addressing apparent shortcomings. A recent Board visit to women's services was viewed positively by staff meeting Board members for the first time and being able to articulate some concerns face to face.

The budget for maternity services is fragmented and sits in different places. There is a lack of visibility of 'primary maternity top slice funding' of over \$1m. The Price Volume Schedule (PVS) budget sits separately to the cost budget.

The clinical coding is behind by several months and it appears that caseweights are not correct. It is important to rectify this so that demand, acuity and complexity are accurately assessed and monitored.

Use of the Event reporting system doesn't appear to influence decisions. Midwifery staffing has been on the risk register and identified as Red since May 18. This is an indication of significant deficit in safe staffing, in the complexity and acuity of the workload and the environment. The wards are operating with minimum, or at times less than minimum staffing numbers and the skill mix limits flexibility.

Recommendations

The backlog of Clinical Coding needs to be addressed to support identification of demand, complexity and acuity of women being cared for. Further administrative support will be needed for coding. (Urgent – initiate within 3 months).

Update the Midwifery Business Case and re-present it to the executive team as a matter of urgency. (Urgent – initiate within 3 months).

Ensure that Maternity finances and budgets to be aligned to one cost centre/directorate to support visibility and improve utilisation of allocated resources e.g. Primary maternity top slice funding, PVS revenue and maternal/child contracts – this could and should support ongoing identification and resourcing according to safety, equity and demand. (Urgent – Review within 3 months).

2. ENVIRONMENT

2 A – Physical

The current state of some of the maternity facilities is very poor. There are rooms that have paint peeling off the walls and are in need of basic redecoration. Some rooms do not have piped oxygen or suction for maternal resuscitation and this limits flexibility of placement of women in the ward. The maternity reception does not protect confidentiality and staff areas are not private. Storage areas are not fit for purpose.

Early pregnancy clinic is cramped and there is a lack of privacy. Signage to direct patients is unclear.

Access to the operating theatre for an emergency CS requires a lift to descend one level. There is no clinical over-ride mechanism in the lift to prioritise a clinical emergency. There is significant potential for delay in access to theatre.

Recommendations:

Review plan for renovation and refurbishment of the maternity unit to include repainting, replacing curtains etc. (Semi-urgent – initiate within 6 months)

Consider renovation of rooms to install piped oxygen and suction so that the use of the room can be extended to higher acuity patients. (Longer term project – requires unit configuration. Review plan for change within 6 months).

Review maternity reception and consider improving record storage and privacy and address staff safety concerns. (Longer term project – requires unit configuration. Review plan for change within 6 months).

Ensure staff have a room that is private and separate from patients and their families for meals and refreshment breaks. (Longer term project – requires unit configuration. Review plan for change within 6 months).

Review storage facilities. (Longer term project – requires unit configuration. Review plan for change within 6 months).

Consider relocating EPC to improve privacy and to provide an adequate space. (Longer term project – requires unit configuration. Review plan for change within 6 months).

Review signage with a view to improving clarity and visibility. (Review of signage will be dependent on changes to clinical areas such as EPC and or ANC – review after reconfiguration).

Apply an over-ride switch on the lift that can be activated by staff in an emergency to allow prioritisation of the lift to the appropriate clinical area. (Initiate immediately as this is an important measure to improve safety in an emergency).

Undertake a detailed feasibility study to consider re-commissioning the old theatre adjacent to delivery suite. Include consideration of a Low intervention birthing unit in this project. (Longer term project – requires unit configuration. Initiate within 6 months).

Engage Consumer Reps in refurbishment projects. (Semi-urgent – Initiate at the time of review of the above renovations).

2 B - For Women and Whānau

Access to sanitary facilities such as toilets and bathrooms is not at acceptable standards. Some rooms are affected by an odour of dampness.

The Whānau room has recently been redecorated which is commendable.

Recommendation:

Fast Track the environmental/facility business case to enable some rapid progress to improve the current environment. (Urgent – initiate within 3 months).

FINAL & CONFIDENTIAL

3 . CULTURE

3 A - Values based

Despite the organisational values statement of 'Can do' there was widespread evidence of staff being expected to 'make do'. Relatively small positive changes have been difficult and slow to implement and there is a belief that nothing will change. There was a feeling that executive management do not appreciate the acute and urgent nature of obstetrics and midwifery and there was a perception that maternity was not important and not valued. Whilst morale and team work is generally positive across the women's health services; in relation to how the service is seen by the organisation the interview feedback demonstrated that morale is low and this has deteriorated over time due to a sense of not being heard and little positive change being resourced and supported.

Recommendations:

Senior management team to enact the actions evident from the Staff Wellbeing work (e.g. the Big Listen by Tim Keogh) to be completed – asking what were the most common and most important principles and changes that staff would make to bring about the greatest difference. (Semi-urgent – initiate within 6 months).

Executive team members to improve visibility with monthly visits to clinical areas and meetings with clinical managers and clinical staff. (Urgent – initiate within 3 months).

3 B - Equity

Marae based DHB community midwifery model of care

This is a proactive, preventative model of care that engages in a culturally responsive way encouraging and enabling pregnant women and their whānau to effectively engage with health services.

Recommendation:

Ensure permanent resourcing of the Marae based community midwifery model of care and enable extension of this model. This initiative has benefits for better engagement and better clinical outcomes for Hutt Valley's most vulnerable populations. (Initiative already in place – Confirm ongoing funding immediately).

4. MODELS OF CARE AND CLINICAL PRACTICE

4 A - Safety

ICU admissions

There is a high rate of maternal admission to the Intensive Care Unit (ICU) with 12 cases in 2018.

Recommendations:

Audit all mothers admitted to ICU. (Initiate immediately and ongoing review).

Increase resource of Anaesthetic review for high risk obstetric patients. (Urgent – initiate within 3 months).

Regular Review of Clinical Guidelines to support evidence based safe practice. (Semi-urgent – have a comprehensive plan for guideline review in place within 6 months in conjunction with Lead SMO for Quality and Maternity Quality team. Then ongoing review to continue).

SCBU admissions

There is a high rate of term neonates being admitted to SCBU and a high rate of transfer of babies to the Wellington Hospital Level 3 SCBU for 'cooling treatment', 18 within the last year. This is usually used to treat babies with Neonatal Encephalopathy (NE) and is an indicator of severe morbidity. NE may be linked to intrapartum fetal hypoxia which is usually detected with abnormal fetal heart rate patterns on the CTG. However the signs may be subtle hence CTG education and training is vitally important. This is provided in the unit with a weekly CTG education session and an annual RANZCOG Fetal Surveillance Education Programme (FSEP) workshop.

Recommendations:

Ensure all clinical staff involved in antenatal and intrapartum care attend the RANZCOG FSEP at least once every 3 years, i.e. this should be mandatory as well as completion of the online package in the intervening years. (Address urgently within 3 months to review previous attendance and create plan for next 3 years for ongoing staff attendance).

For LMCs consider making attendance a condition of their access agreement.

Continue weekly CTG education meetings. Encourage all staff to attend including SMOs. (This initiative is in place – Continue).

Audit of all babies transferred to Wellington SCBU for cooling. (Initiate immediately and continue ongoing review).

Review of all babies with suspected NE, including babies born with an umbilical cord pH <7.0. (Initiate immediately and continue ongoing review).

CS Rate

There is a high rate of CS which was reported at 41%. A comprehensive CS audit is indicated. A recent study by Zbiri et al 2018 found a direct correlation between staff shortages and a high CS rate. The study showed that a 10% increase in obstetricians could reduce the CS rate by 25%.

Recommendations

Conduct a Comprehensive CS Audit including

- 1 Fully dilated CS
- 2 - Category 1 CS
- 3 – Caesareans performed under General Anaesthetic (GA).
- 4 - CS for fetal distress
- 5 - SCBU admissions following CS.

(Urgent – initiate within 3 months. The project will be ongoing for several months).

Address staff shortages (as stated earlier)

- a) Recruit midwifery staff urgently to address severe deficiency, including for delivery suite, community and the theatre midwifery team. Explore the option of national and international recruitment in order to obtain staff with clinical experience
- b) Appoint a 7th SMO – with urgency (do not wait for ASMS job size to initiate this).
- c) Discuss a long term plan with HR and consider increasing RMO numbers to achieve full time onsite registrar cover.

HDC Cases

There has been a high number of HDC complaints. There was a sense from the Quality team that the care provided was not patient focussed. There was also a sense that similar adverse events continued to occur, particularly relating to consent and communication. An example was given relating to limited consent and communication at the time of a forceps delivery.

Recommendations:

Education for the Obstetric team to focus on patient communication and consent. In particular, consent for operative vaginal delivery. (Immediate review of RCOG guideline. Implementation of modified local guideline within 3 months).

Continue to review all HDC cases relating to Women's Health with a view to identifying systemic risk and ensuring steps are made to rectify it. (Initiate immediately and continue ongoing review).

Continue to critically review all stillbirth cases. (Already in place – Continue).

4 B - Quality

Maternal Quality and Safety Programme

There has been a vacant position in the Maternal Quality and Safety Team of 0.6 FTE for nearly two years. It is recommended that the position is filled. The Programme is funded by MOH.

The MQSP coordinator role should be increased and enabled with administrative support to allow implementation of recommendations made from case reviews, audits and strategies from the Quality and Safety plan. It would also create a means of ensuring data accuracy for automated reports as there were significant errors in the CS standard Primip rates in the last Clinical Indicator report.

Recommendations:

Recruit and fill the vacant position of 0.6 FTE on the MQSP team. (Urgent – initiate within 3 months).

Review current MQSP positions. Increase coordinator FTE and establish an administrator position to support full implementation of the programme as per DHB Crown Funding Agreement contract with the Ministry of Health. Ensure that the funding from the MOH is directly coded to maternity. (Semi-urgent – Initiate within 6 months).

Support development of accurate automated data reports such as the Clinical Indicators. Extend this to include automated analysis of clinical, workforce and environmental information to support healthcare planning. (Semi-urgent – Initiate within 6 months).

SMO Engagement

There has been a paucity of SMO engagement in Quality and Safety Activities for several years due to the priority of covering acute work.

Recommendations:

Ensure SMOs are allocated non-clinical time for Quality and Safety. (Urgent – initiate job size review with ASMS within 3 months).

All SMOs to actively engage in audit. (Urgent – Engagement will follow job size activity and allocation of time for Quality initiatives however a plan for audit projects should be initiated within 3 months).

Establish a lead SMO for Quality and Safety to oversee audit projects, manage PMMRC coding and to join the Maternal Quality and Safety Clinical Governance Group. (Urgent – initiate within 3 months).

4 C - Education / Training / Supervision

Midwifery

Challenges

Current midwifery educator FTE is at capacity in managing the mandatory midwifery training. This impacts on her ability to lead and implement nationally mandated campaigns.

The limited pool of available midwives restricts the ability to release staff to attend education and training sessions, and to work in multi-disciplinary teams.

Recommendations:

Focus on addressing the severe local midwifery workforce shortfall which will have a positive impact on midwifery education and training through ongoing development of the midwifery workforce plan taking into consideration the national maternity system programme and action plan. (High priority – initiate immediately).

Increase education resource to ensure mandatory training requirements are met as a minimum. This will promote an engaged and valued workforce. This would also support implementation of national HQSC programmes. (Urgent – initiate within 3 months).

RMO Supervision in Antenatal Clinic

the RMOs have expressed uncertainty around their role in Antenatal clinic, however one of the Senior Registrars has written a guideline to help clarify this. There is a potential learning opportunity at the end of clinic with a chart review exercise involving all clinic staff to review management plans and discuss cases.

Recommendations:

SMOs to consider initiating chart reviews at the end of each Antenatal clinic. (Urgent – initiate within 3 months).

Discuss clinic structure and RMO role in clinic during the Orientation period. (Urgent – initiate within 3 months).

4 D - Resources**Equipment**

There were comments from staff that there was a general lack of basic equipment such as stethoscopes, CTG machines, blood pressure cuffs, sonicaids, etc.

Recommendations:

Urgent supply of essential equipment including Infant Resuscitaire, Cardiotocographs and day to day consumables to support wellbeing of women and infants, safe practice and clinical decision making. (Identify critical equipment deficiencies and address immediately).

Outpatient Hysteroscopy

Outpatient hysteroscopy is an extremely worthwhile initiative to explore. There are significant cost and resource benefits as well as an improved patient experience. A business case for outpatient hysteroscopy has been done and apparently approved. The initiative seemed to lose momentum when SMO numbers fell to four. There is a willingness from management and from SMOs to establish the service and now that SMO numbers have expanded it should be readdressed.

Recommendation:

Establish a working group of motivated parties to progress an outpatient hysteroscopy service. (Semi-urgent – initiate within 6 months).

Administrative Support

There is a lack of administrative support for Antenatal clinic to prepare notes for the clinic and book appointments. There is also a lack of medical typing resource. Given the number of patients who require immediate intervention following their clinic appointment, it is imperative that ANC letters are typed within 1-2 days. Timely written communication between medical and midwifery teams is required to ensure that patient risk is clearly portrayed and advice regarding risk management is available.

Recommendations:

Identify specific medical typing support to ensure one day turnaround of antenatal clinic letters to LMCs to allow timely communication of the outcome of the clinic visit. (Urgent – initiate within 3 months).

Cost the provision of dedicated receptionist for women's health. This may include supporting antenatal clinic and possibly early pregnancy clinic. (Semi-urgent – initiate within 6 months).

4 E - Guidelines

Clinical Guidelines

The majority of clinical guidelines are out of date. Regular Guideline review has not occurred over recent years due to severe staff shortages. This is a significant clinical risk that requires dedicated resource and attention.

Recommendation:

Review of guidelines should be a priority for the midwifery and obstetric team once they have allocated time for Quality and Safety. (Semi-urgent – have a comprehensive plan for guideline review in place within 6 months in conjunction with Lead the SMO for Quality and the Maternity Quality team. Then ongoing review).

4 F - Leadership

The interviews portrayed a clear theme of highly supportive and visible leadership, led by the Charge Midwife Manager, the Midwifery Director (0.3FTE for HVDHB/0.2FTE Wairarapa DHB)/Service Manager Women's and Children's Health (0.5FTE), the Group Service manager and the Head of Department (HOD) for O&G. These clinical and managerial leaders are driving positive change in the culture to enable and support shared visions of safety, advocacy, cultural responsiveness and a woman focussed model of care.

Review of the current DHB executive leadership team does not include a professional midwifery leadership position in comparison to Medical, Nursing and Allied Health. Consideration of such a role at the executive and strategic level would provide a direct reporting line for expert professional advice and demonstrate visibility of safety. This would also be reflecting the new Clinical cluster in the Ministry of Health with recent identification of a Chief Midwifery Advisor position to be recruited to by the Director General of Health Ashley Bloomfield.

The Director of Midwifery currently has a dual role which also includes the Service Manager Women's and Children's Health which has benefits but also has challenges in terms of capacity. Her responsibility includes the MOH national maternity system programme and recommendations recently agreed by the Director General of Health. These will require further capacity and resourcing to ensure ongoing midwifery led strategic and operational leadership. Her current 0.5FTE allocation is less than similar sized units of Hawkes Bay (0.9FTE) and Midcentral (1.0FTE) DHBs and should be increased.

Recommendations:

Consideration of a Midwifery Leadership position within the Executive Leadership team for strategic and professional advice and for operational visibility of maternity services. (Semi-urgent – Review within 6 months).

The Service Manager Women's and Children's should be a separate position, whilst recognising the current benefits (Review in 3-6 months)

Increase FTE allocation to Midwifery Director from 0.5FTE to 0.8FTE. (Review immediately).

5. ORGANISATIONAL

5 A - Where Women's Health sits

Structurally Women's health and maternity services are aligned with Surgical and Children's' services in the same directorate. In the DHB strategic plan Women's health is not well represented in the planning documents. Structurally within the organisation professional midwifery leadership is currently sitting at Directorate rather than Executive level.

Recommendations: (As above)

Reconsider current executive leadership structure to include an executive professional midwifery position. (Semi-urgent – Review within 6 months).

5 B - Strategic Priorities

- 1) Prioritise a sustainable midwifery and medical workforce to provide a safe, equitable and accessible maternity service. (Immediate).
- 2) Prioritise maternal and infant health – evidenced in the DHB strategic plan. (Semi-urgent – Review within 6 months).
- 3) Engage the maternity workforce in strategic planning to identify key goals for service delivery and their strategic priorities. (Urgent – Initiate within 3 months).
- 4) Foster a proactive approach in quality and safety initiatives. (Urgent – Review within 3 months).
- 5) Engage with Consumer Representatives (Urgent – Initiate engagement within 3 months).

6. EXTERNAL

6 A - Consumer experience and feedback

Consumer Representatives feel they have been ignored. They have been left out of the DHB process of consumer feedback which has led them to create their own alternative process. There has been a high turnover of personnel which is concerning. They have a positive contribution to make toward configuration of services from a consumer perspective. They have been actively involved with fund raising and refurbishments. At times they have contributed personally and requests for reimbursement have been ignored.

Recommendations:

- 1) Active engagement with Consumer Representatives. (Urgent – Initiate engagement within 3 months).
- 2) Address reimbursement of the Consumer Representatives' reasonable expenses. (Urgent – review within 3 months).
- 3) Ensure that DHB consumer feedback forms are directed toward the Consumer Reps. (Urgent – review within 3 months).

Section Two

The following narrative gives further details around comments that have been presented in Section One. They are also structured according to the above template.

1. PERSONNEL

1 A – Identification of different health professions

Obstetrics and Gynaecology (O&G) – SMOs, Resident Medical Officers (RMOs) both Senior and Junior.

Midwifery – Midwifery Director, Clinical Midwifery Manager (CMM), Associate Clinical Midwifery Managers (ACMM), DHB midwives, Theatre midwifery service, Lead Maternity Carers (LMCs), DHB Community Midwives.

Clinical Nurse Coordinator, Gynaecology

Maternity unit Nursing staff.

Anaesthetics – Lead clinician for Obstetrics, Head of Department (HOD)

Paediatrics – SMO and Senior RMO. Dr Meates and Dr John had a phone interview with Paed SMO Theatre staff

Outpatient clinic staff

Managerial – Acting Chief Operating Officer (COO), Acting Chief Executive Officer (CEO),

Service Manager Obstetrics and Gynaecology

Maternal Quality and Safety Team

Consumer Representatives

Chief Medical Officer

Director Surgical Services

Māori Health

Violence Intervention Programme team

1 B – Staffing levels (Across maternity services)

Midwifery workforce

DHB Midwifery workforce

Data from the Central Region Technical Advisory Services (TAS) Midwifery Workforce 2018 Report highlighted significant national risks due to current workforce stressors. These include -

- Significantly high numbers of midwives reaching retirement age
- Decreasing overall Midwifery Workforce
- Over representation of Midwives in vacancy rates and in turnover rates,
- High annual leave balance to entitlement ratio
- Midwives have the second highest rates of sick leave among health care workers and this is increasing
- There are increasing numbers of Midwives working part time, leading to reducing and variable workforce density
- There is increasing complexity and acuity of the population being served
- Reduced numbers of midwifery students

Other national challenges include:

- High acuity and stressful and emotionally fatiguing work environments

- Alternative employment e.g. lucrative short term contracts in Australia, evidenced via Midwifery Council and local DHB LMC workforces

Locally in the Hutt Valley region

The Hutt Valley DHB correlates to all key findings of the above TAS report; in particular Hutt Valley midwifery workforce has

- one of the highest percentages of workforce over 55 years of age.
- relatively high levels of sick leave which averages 53.3 hours per FTE.
- high levels of annual leave entitlement (125%) representing a reduced ability for the workforce to consistently take annual leave.
- high annual staff turnover of 14%.
- relatively short length of service of 7.2 years which is below the mean of 7.6 years (DHB Employed Workforce quarterly report Dec 2018)

Inability to take leave and poor staff wellbeing are indicative of short staffing. High turnover rates and inability to attract new trainees are indicative of a lack of tolerance of these conditions. This is highlighted in the TAS report which indicated that the Midwifery Workforce nationally is demonstrating the second highest levels of burnout, stress and fatigue compared to all other health workforces.

- Midwifery base staffing levels have not been formally reviewed for at least 10 years. Some initiatives to address safety have been implemented within current resources but there has been no increase in overall midwifery numbers. An example is the introduction of the Associate Clinical Midwifery Manager (ACMM) positions.
- Total Midwifery staffing in HVDHB sits at 31.7 FTE (as per TAS Midwifery Workforce report, October 2018). There is now a mix of registered midwives and registered nurses (RNs). Nurses have a different skill mix and different Scope of Practice to midwives and they are not always able to provide the same level of care. The current skill mix limits flexibility to move staff to different areas of the unit to respond to high acuity.
- This FTE supports all inpatient and outpatient services and is the lowest in the central region and one of the lowest for a secondary maternity facility when benchmarked against similar sized departments. By comparison Hawkes Bay midwifery workforce stands at 39 FTE and the Mid-Central midwifery FTE is 42.7.
- The loss of 9 LMCs has had a significant impact on continuity of carer for women. Furthermore because LMCs make themselves available to fill DHB shift vacancies in times of need, the loss of these LMCs means there are fewer casual midwives available to support emergency escalation when required.
- Patients have become more complex in their healthcare requirements over time and high risk patients are more likely to require secondary care input. This includes medical assessment in antenatal clinic and transfer of care from the LMC to the DHB because of high risk status. This is evidenced in caseweight data and in the increasing number of referrals to antenatal clinic. These patients are more likely to require an emergency response in labour which is more difficult to provide when staffing levels are stretched. Hence this patient trend further increases the pressure on resources and rising intervention rates.

This is highly suggestive that the Hutt Valley DHB midwifery staffing is not sufficient to match the acuity and demand of the population being served. The deficiencies have been chronic and there have been prolonged vacancies. Staff have had to cope with the shortfall as best they can. They feel fatigued and stressed and in 'survival mode' leading to acceptance of 'risk' behaviour, normalising the shortages and moving away from recognised safety parameters. This has been coupled with compromise to the expected staffing mix with a reliance on RNs to fill roster gaps which limits

flexibility across all inpatient areas of the maternity unit. As a result of limited numbers and limited skill mix it is not always possible to have safe rosters.

Lack of staff has resulted in 'care rationing' with reduced time and attention given to each patient. Interactions are limited to minimum levels to ensure safety, for example providing pain relief and checking observations, and this comes at the expense of more time consuming activities such as education and support. In essence the midwives become task oriented and they are unable to follow best practice principles. This has led to significant dissatisfaction with the job and feelings of disempowerment and negativity among staff as well as having a negative impact on the consumer experience

Ultimately staff have been chronically overworked because of shortages and the inevitable fatigue that results from this affects ability to identify and manage risk. This is important because many obstetric complications present with subtle signs and variations from normal and the detection of these requires vigilance and an index of suspicion. The impact of workforce deficiency tends to be cumulative and this poses a risk to the safe provision of maternity services.

Recommendation:

DHB midwifery base staffing levels should be increased significantly. It would be helpful to formally review and benchmark against Maternity facility safe staffing standards (as per collective employment agreements held with the Midwifery Employee Representation and Advisory Service (MERAS) and in the development of the CCDM programme SSHW unit as per NZ nursing accord and recent Midwifery Accord agreements. (Timeframe – Immediate)

Lead Maternity Carers

There is evidence of Lead Maternity Carer (LMC) availability declining over recent years. The LMC midwifery workforce provides 90% of the midwifery care in the community which is consistent with the NZ Maternity model of care for pregnant women. When the LMC workforce is inadequate it directly impacts the DHB midwifery service as the DHB are ultimately responsible for absorbing any outstanding workload not included in the LMC capacity. Current DHB staffing levels have remained the same within the acute maternity facility for over a decade and there is evidence that the workload has expanded beyond this capacity.

Of the pool of 32 LMCs, 9 have left their role within the last two years. An average LMC caseload is 50 to 70 women per year. If each of the 9 departed LMCs had even a modest caseload the impact is that around 450 women of the 1900 per annum are now without an LMC midwife. If the LMC numbers do not increase, and there is no indication that they will in the short to medium term, then the DHB community midwifery team would require a significant increase in staffing of at least 4 full time equivalent (FTE) staff. Further staff will also be required for labour and birthing suite because the DHB community midwifery model includes the provision of antenatal and postnatal care but is not inclusive of labour and birth. However the current labour and birthing suite staffing of 2 midwives per shift is not sufficient to meet the increased demand and does not support the minimum safety parameters of 1 to 1 care in labour, and provide acute assessments. When considering Section 88 requirements, and using safe staffing standards (2014) from MERAS in relation to DHB facilities with secondary maternity services, the minimum staffing levels are 5 per shift inclusive of the Clinical Midwifery Coordinator.

The LMC shortfall has had an impact across the DHB midwifery service. It has also put pressure on the remaining LMCs to carry a higher caseload, however they are not obliged to increase their numbers and it was notable that over the holiday period in December and January that LMC

caseloads did not increase. Hence there were very high numbers of women cared for by the DHB community and hospital teams over this time. Even if some LMCs do increase their caseload it is inevitable that they will not absorb all of the patients previously cared for by their departed colleagues. If the remaining LMCs in the Hutt Valley region were to pick up these women it would increase their caseload to 82 women per year. This is significantly in excess of recommended numbers of 50 to 70 women per year.

DHB Community Midwifery Team

The community midwifery role is challenging because over 80% of their caseload have significant medical and social co-morbidities. Their usual caseload includes socially deprived members of the community, and many who require Multi-Disciplinary Team involvement. These women require more frequent antenatal input than is allowed for in the Maternity Schedule and increased attention in the post natal period also. Some of them have a history of contraceptive difficulties and hence request long acting reversible contraception (LARC) with methods such as Jadelle rods and intrauterine devices. The community midwives are able to provide this service which is important because these relatively deprived patients tend not to present to their General Practitioner on a regular basis and hence there is a limited window of opportunity for discussing LARC devices and inserting them.

The community midwives accept transfer of patients from LMCs if they are deemed to be high risk, complex or have significant co-morbidities. However there is a perception that the threshold for transfer from LMC care to care by the Community Midwives has lowered over time and that this perhaps reflects reduced willingness of the LMC group to meet the challenging demands of these patients. In addition to medically complex patients being transferred there is also transfer of care of patients who have social problems and fail to attend routine appointments. This had led to a perception that the community midwives have become a 'default service' for any woman with a degree of complexity. However, having said that, it is acknowledged that Obstetric care has become more involved over time with rising patient complexity. As such these patients require more involved clinical input per visit and a greater number of visits. This coupled with LMC shortages and pressure to carry a higher caseload has increased the challenge for LMCs to meet this demand.

Increased workload is evidenced in data showing an increase in non-specialist antenatal follow up consults from 853 in 2016/17 to 1607 in 2017/18. There was a 20% increase in non-specialist first antenatal consults from 620 to 756 in the same timeframes. With regards to postnatal data first visits increased from 64 to 195.

The increasing influx of patients requiring input from the community midwives due to LMC unavailability was particularly notable over the recent Christmas 2018 and New Year 2019 period. The usual caseload for the community midwifery team would be around 8-15 patients per month. However for the month of December there were 47 women booked and in January there were 63 booked. The midwifery manager made contingency plans to manage this over the Christmas period, which is a challenging time because DHB staff traditionally request leave, and availability of staff to cover shifts tends to be limited at the best of times. The contingency plan involved utilising inpatient based midwives in the community which further limited the pool of midwives available to cover shifts and some of these were covered with RNs.

Recommendations:

DHB community midwifery team FTE increased to match the increasing demand both in terms of complexity and in response to reduced LMC workforce (Timeframe – Urgent)

Investigate support roles such as Kaiawhina to navigate and enable earlier and ongoing engagement with Māori pregnant women and whānau

Associate Clinical Midwifery Manager

Former HVDHB CEO, Ashley Bloomfield highlighted the importance of establishing the position of ACMM in his response to the HDC on 8/4/16 (Ref C16HDC00144). He noted that the intention of the ACMM was “to enhance clinical and general oversight on a shift by shift basis in the Maternity Unit.”

Following Dr Bloomfield’s response the ACMM role has been established and has been filled during the two daytime shifts from 7.00 – 15.00 and from 15.00 – 23.00. At present the role is vacant on the overnight shift from 23.00 – 7.00 am.

The staff feedback of the clinical shift leadership was universally positive including describing a sense of relief and an improved feeling of confidence and safety. This included improved confidence in reporting risk which is evidenced by the increased use of the event reporting system. There was improved confidence within the unit and from other departments including Paediatrics, Anaesthetics and Operating Theatres. Staff reported greater confidence in the accuracy of clinical assessments, greater confidence in the information being conveyed for a phone consultation, and greater confidence in the assessment of the need for an emergency response. There was a feeling that the ACMM role has helped to bring teams together and work collaboratively, particularly midwifery and medical staff.

Benefits of the ACMM role included an ability to recognise high acuity and confidence to act directly and independently. The significance of this should not be understated because in the HDC case referred to, lack of recognition of the acuity of the situation and delay in escalation were sighted as significant contributors to the adverse outcome of stillbirth. The establishment of the ACMM role has enabled a focus of risk assessment, triage, ongoing prioritisation of workload, identification of clinical risks and management of these risks in a timely manner, including escalation of urgency if required. The ACMMs have the confidence and experience to call the SMO directly if there is a significant emergency, as well as providing direct assistance. For example gaining IV access, taking bloods and providing first aid measures such as ecbolics to treat a PPH. The direct level of clinical support has been beneficial to midwives and junior doctors.

The introduction of the ACMM has been universally and widely appraised to have improved many components of patient safety. As such the lack of an ACMM on the overnight shift signifies a deficiency in safety. This is the time when hospital staffing is at its lowest and individual performance is most likely to be impaired by sleep deprivation.

Recommendation:

That the ACMM FTE is increased immediately to provide 24 hour cover, 7 days a week. Recruitment to these positions should be given the highest priority (Immediate)

Theatre midwives

It was previously commonplace for LMCs to attend an Emergency CS if their patient required one. However over the last 5 years there has been a tendency for LMCs to ‘hand over’ care to the DHB

midwives once the patient requires 'secondary care' (as per Section 88 legislation) This has gradually led to a significantly increased workload for DHB midwives and the ability to receive handover in a timely manner is an ongoing significant concern

New roles have been established for a group of DHB midwives to attend CS deliveries. These practitioners have spent time in the operating theatre suite to become fully oriented and familiar with the operating theatre environment and personnel. Their breadth of knowledge and experience has helped to bridge gaps in communication and understanding of how the other services operate. As such, the familiarity, communication, experience and confidence of the CS Midwives has improved safety and helped to create an improved patient experience.

The results of a recent survey of the impact and effectiveness of this Pilot Theatre Midwifery team were enthusiastic and glowing. The initiative has improved working relationships between midwifery, obstetrics, anaesthetics and the theatre team. Continuity for the women was noted as a significant factor in improving the patient experience as well as supporting skin to skin contact and early establishment of breastfeeding which is an important component of BFHI accreditation because it supports early bonding and attachment. Overall safety of the maternity unit is improved because the presence of the Theatre Midwife alleviated the need for a midwife from delivery suite to go to theatre with the patient. The current Theatre Midwife model does not provide 24 hour cover and this was an overwhelming request from the survey respondents. Furthermore there was an overwhelming request for the initiative to be implemented permanently. Inclusive of this feedback was consumer experience with highly positive comments in relation to knowing the midwife, feeling safe, welcoming their new baby into the world in a calm and peaceful manner despite at times it being an emergency.

During the staff interviews this initiative was applauded as an excellent innovation by all people where it was relevant to them. The funding for it is limited to 1 year, however given the overwhelming success these midwifery roles should become permanent. The FTE allocation for these practitioners should include an allowance for sick leave, study leave and annual leave.

Recommendation:

The funding for this CS midwifery team should be made permanent and the FTE increased to cover an on call CS midwife service out of hours plus the FTE allocation for these practitioners should include an allowance for sick leave, study leave and annual leave as with other DHB positions; supporting the DHB service specifications for secondary maternity services and facilities and S88 requirements. (Immediate)

Nursing workforce

Nursing colleagues who have become part of the team on the maternity wards believe they have an important skill set to offer on the postnatal ward. They have expressed a strong desire and willingness to learn and to improve their ability in order to excel in the provision of postnatal care. This willingness should be enhanced and nurtured with ongoing education and training.

RNs have expressed feelings of being undervalued and unsupported due to limited orientation and supervision. There was also a sense of frustration among the RNs that at times their expertise was not recognised. They felt that they had a valuable skill set and could teach their midwifery colleagues.

Recommendations:

Development of a comprehensive orientation and supervision programme to support safe, high quality care provision across the postnatal ward. Target nursing staff with a view to extending their scope of practice.

Consideration of rotational positions across the ward, Special Care Baby Unit and Children's ward to extend clinical skill set and improve expertise across wider clinical areas.

Health Care Assistants

In addition to the above shortages of LMCs and Midwives, we have been informed that sometimes there are no Health Care Assistants (HCA) rostered for the overnight duty. This leaves the LMCs and Midwives having to do additional tasks that would usually be performed by the HCA, such as making beds and cleaning the room after a delivery. This puts further unnecessary pressure on an already stretched midwifery workforce. One would expect that candidates to fill shortages in HCA positions would be more readily available than midwifery candidates hence this deficiency should be addressed with priority to ease pressure on midwifery staff.

It would be advisable to consider other team roles such as the British based Maternity care assistant model. These roles hold trained specific skill sets with breastfeeding, early parenting, maternal observations, etc. Evaluation of this model of care has highlighted an improvement in support for midwives and increased ability for midwives to carry out their duties with the value of time. There was an increase in confidence of parents on discharge and increased support for overall safety for the maternity inpatient areas.

HVDHB should consider adopting a similar model of care and appoint to these roles to support midwifery staff, NOT to replace them. This could increase care provision for parenting particularly on the postnatal ward

Recommendations:

Recruit to fill HCA positions to ensure there is cover across all shifts. Immediate recruitment to these positions is recommended to support midwifery and nursing staff.

Consideration of further development of HCA role in line with other models of care such as the British maternity care assistant role or other options such as development of a structured and regulated kaiāwhina workforce.

Medical Obstetric Staff

SMO On Call commitments

There is a history of consultants 'multi-tasking' while being On Call for delivery suite. These historical practices date back many years and have previously been the norm in all maternity units over the years. Specifically this refers to performing outpatient gynaecology clinics and elective operating lists while being On Call for the delivery suite. At times this has included consultants doing clinics off site, either at Wellington Hospital or in private rooms while On Call. In these circumstances availability was potentially compromised by inability to attend immediately if the consultant was in the middle of an operation, or there may have been delay in answering the phone or attending delivery suite if the consultant was performing an examination or doing a procedure in clinic.

As well as not actually being available there was also a perception of not being available which was a potential psychological barrier to calling for assistance. This model was inherently unsafe due to limited availability and limited support for junior doctors. As such it is now uncommon in maternity units in New Zealand because this level of risk is not tolerated in modern obstetrics due to higher patient expectations, increased workload and increased patient complexity. It is noteworthy that one of the recently appointed SMO staff refused to follow the traditional work practice at HVDHB of performing elective work while being On Call. This is indicative of RMOs who have been trained in an era of more restrictive hours of work. Based on current RMO training patterns it is likely that future consultants would struggle with traditional SMO work practices.

In reviewing HDC complaints the following comments were made in the HDC report (C16HDC00144) from 2016 involving an intrapartum fetal death :

- "Whilst policy related issues may not have impacted on the final outcome of this case, I believe they stand as tangible examples of deficiencies in RMO supervision."
- "The service appears to have been relying on inexperienced doctors, often working in isolation with barriers to them obtaining help from their seniors. The organisation failed to create an environment that ensured RMOs were appropriately supported by more experienced specialists."
- "Hutt Valley DHB failed to provide an acceptable standard of care to the patient with a severe departure from accepted standards."

Significant changes have occurred since this HDC report was released. Consultants are no longer expected to perform Elective Gynaecology work whilst On Call, a change that was made in early 2018. They now have dedicated time in the delivery suite. This has allowed a degree of direct supervision that was not previously available, which is a significant benefit to the RMOs, midwives and patients. It is very encouraging to see that there has been such a significant positive change to the SMO work schedule however it appears that the change was only made in response to a serious adverse outcome. There has been a general theme from multiple staff members that the unit is 'reactive' rather than 'proactive'. It is disappointing that it appears to have taken a tragedy to precipitate positive change.

SMO job sizing

The Department has been plagued by severe SMO shortages over the last few years. There has been a reliance of locums to cover both Acute and Elective work. The permanent SMOs were frequently doing extra clinics, extra On Call duties and extra operating lists during this time. There was pressure to maintain contracted volumes of elective work and an obvious need to provide cover for acute work. As a result the SMOs were severely overworked. At times SMOs were called back from holiday because there was no locum cover for the roster.

The ability to maintain Elective throughput was hampered by the fact that at the time they were covering delivery suite whilst also doing gynaecology clinics and operating lists. It was not uncommon to get called away from Elective commitments to attend Obstetric Emergencies. This impacted on their ability to complete scheduled theatre lists and clinics and also impacted on the supervision of RMOs. Furthermore the workload meant that they were often booked to be in clinic after a night On Call. It was not uncommon for them to be up in the night attending emergencies which undoubtedly affected performance the next day due to fatigue and sleep deprivation.

It was a significant achievement to recruit and appointment two full time SMOs so that there are now 6 Consultants. The consultants have variable job sizes between 0.75 and 1.0 FTE. Total current FTE for the department is 4.95. Estimates of the FTE required to meet contracted volumes of elective work as well as On Call commitments has been calculated at 6.11. This is a shortfall of 1.2 FTE. By

comparison, Hawkes Bay has 7 SMOs in total. Six have an allocation of 0.85 FTE each and 1 has 0.95, giving a total of 6.05 for the department. With regards to junior staff in Hawkes Bay there are 8 Registrars and 8 House Surgeons.

At present the SMOs are being asked to do extra clinics to meet the shortfall and external locums have also been employed. The time that is being spent doing extra clinics and theatre sessions, and covering On Call for illness and leave is coming at the expense of time that should be allocated to non-clinical work including Quality and Safety. It is evident that 6 SMOs are just sufficient to cover the On Call roster and the acute work but are not sufficient to meet contracted Elective volumes.

A request for the appointment of a seventh SMO for O&G has previously been sought. The letter included figures sourced from the Finance Department detailing the cost of external locums for the years 2016-17 and also 2017-18, which were around \$248,000 and \$509,000 respectively. The letter also gave details of recommendations made by representatives of the New Zealand Medical Council who had recommended that there should be 7-8 SMOs in a unit the size of HVDHB.

It seems obvious that a 7th SMO should be appointed to avoid the need for locums. The SMOs need to have non-clinical time allocated and this should include time for Quality and Safety initiatives. Ideally the SMOs should all be actively involved with audits and updating policies. Time for these activities should be specified and ring fenced. We would recommend that management enter into a job sizing process with the SMOs to allocate appropriate non-clinical time, utilising the experience of ASMS for this process would be beneficial. Engagement in effective Quality and Safety initiatives will require commitment from management to allocate the required time and it will also require a commitment from SMOs to actually complete these tasks in the allotted time and not to allow it to be deprioritised and neglected as it has been, by necessity, for several years.

In years gone by it has been very difficult for SMOs to arrive in clinic on time as they were required to perform a full review of the delivery suite first. As such, it appears that routine rounds of the gynaecology ward would often be delayed until after clinic or get delegated to the RMOs. However now that the SMOs are not covering delivery suite on days that they are in clinic one would expect that the clinic would start on time. Furthermore one would expect that ward rounds in the gynaecology ward, including post-op ward rounds would now happen as a matter of routine in the morning. There was a perception among some clinic staff and RMOs that the SMOs continue to do ward rounds in the delivery suite before attending to other matters even if they are not On Call.

Similarly there were comments from theatre staff and anaesthetic staff that the Obstetric team are frequently late to start Elective CS lists and Elective Gynaecology lists, which limits the number of cases that can be done per list. Again the main reason for this appeared to be the need for the Obstetric team to complete a ward round in delivery suite before the Elective work can be started. However with the recent change in SMO schedule in early 2018 one would not expect that the doctors performing Elective work would be covering On Call duties and therefore would not need to do a full ward round in the delivery suite unless they were involved in handover as the consultant going off call. The comments regarding late starts were made by several staff but these have not been verified and reasons for possible late starts have not been fully explored. However addressing the issue of ward rounds, Elective work volumes and start times as part of a job sizing process appears to be indicated. SMOs should give an undertaking that routine ward rounds will be completed and that clinics and theatre sessions will start on time.

Recommendations:

Extend the SMO workforce to 7 consultants as previously recommended in a Medical Council review, which will avoid the need for locums to meet Elective volumes. (Initiate this appointment now and don't wait for job sizing activity to be completed)

Engage in a job sizing exercise with ASMS to ensure there is adequate non-clinical time allocated to allow participation in Quality and Safety initiatives. Include a departmental service review of Elective volumes and caseweights, and a job size of individuals with a review of ward rounds, clinics, theatre sessions and On Call commitments to set expectations of responsibilities.

Ring fence time for Quality and monitor progress of completion of Quality initiatives such as audit and policy updates.

RMO workforce

Historically the RMO mix has included Registrars of variable experience (some post membership and some pre-vocational trainees wanting to apply for the training scheme), Senior House Officers and Junior House Officers. The On Call duties were shared among them. This meant that at times there was a very inexperienced RMO as the first point of call for medical attention. In the case of an Obstetric Emergency the LMCs and midwives did not always know how experienced the RMO was. It potentially could have been someone very junior who needed to call in the consultant for assistance or one who was very experienced that could deal with the problem unassisted. This uncertainty has led to problems at times when the midwives and LMCs have assumed that the RMO was more experienced than they actually were.

This problem has been addressed by removing Junior RMOs from the On Call roster and has also been helped significantly by the appointment of the ACMMs who have a better understanding of the level of RMO expertise than LMCs. Being 'first On Call' in the delivery suite was very challenging for Junior RMOs and there were several examples of the RMOs leaving the department on stress leave. Furthermore there is a perception among many staff that the inexperience of the Junior RMOs has led to questionable clinical decisions. For example calling a Category 1 CS in response to a perceived prolonged bradycardia when in fact the cardiotocograph (CTG) changes were more likely secondary to transient hypotension associated with epidural analgesia. It is generally a difficult task to cancel a Category 1 CS if the CTG subsequently normalises. The resource implications of these decisions are far reaching. A potentially unnecessary CS affects all subsequent pregnancies for the patient and recovery is prolonged with a higher risk of haemorrhage and infection compared to vaginal delivery. If the CS is done at night time it affects the availability of theatre nurses for Elective theatres the next day.

Historically it was common for Junior RMOs to be 'first On Call' in medium sized maternity units in New Zealand however this is an uncommon practice now with most departments having a 3 tier roster for On Call duties, including a House Surgeon and Registrar on site and an SMO on call. Given the increasing acuity and complexity of obstetrics, and the reduction in RMO experience resulting from reduced hours of work, it seems likely that a 3 tier system will be required in Hutt Valley. A 3 tier system would allow for onsite registrar cover at all times. This further reduces the reliance on relatively inexperienced RMOs (i.e. the Senior House Officer) as the only on site doctor. It is acknowledged that with recent changes in RMO conditions that all DHBs in NZ are struggling with the challenge of filling RMO rosters. The increase in rostered time off has necessitated increased numbers in all departments. As such many departments are operating with less RMOs than that required to have a compliant roster. Hence a plan should be put in place now to consider increasing RMO numbers to work towards a 3 tier system.

RMO Identification - For the sake of clarity it would be helpful if photos of the RMOs were posted on the notice board in delivery suite with their names and level of expertise attached. It would also be helpful to have a brief description of procedures that the RMOs have been credentialed for. This would be particularly helpful for LMCs who are in the department between 11.00 pm and 7.00 am when the ACMM is not currently available.

RMO Orientation - It was suggested that a review of RMO orientation would also be advisable to ensure that it is up to date and complete.

Recommendations:

Liaise with Human Resources to consider increasing RMO numbers at Registrar and SHO level to establish a 3 tier On Call system.

Place photos of RMOs on the delivery suite noticeboard with a comment about level of experience and procedures they are credentialed for.

Anaesthetic Service

The anaesthetic department failed its training suitability assessment in 2012 by the Australian and New Zealand College of Anaesthetics. Since then SMO numbers have increased in anaesthetics from 9.5 FTE to 18.5 FTE and accreditation as a training institution has been restored. It is noteworthy that there was a significant increase in FTE in the anaesthetic department since that time. Assessment of staffing levels in the maternity unit during this review indicates that FTE increase will also be required with both midwifery and medical staffing.

There is an acute pain service available although not always provided because the personnel are often redirected to other areas in times of sickness or other shortage of anaesthetic staff.

There is no dedicated epidural service which is very surprising in a delivery suite the size of Hutt Valley with over 1800 hospital births per annum (2016/17 – 1876 births, 2017/18 – 1827 births).

There are limited pre op review clinics for the anaesthetists to review Elective CS cases and limited clinic access (6 patients per fortnight) to review high risk patients to assess suitability for regional anaesthesia.

An initiative for Patient controlled epidural analgesia appeared to face many barriers with implementation and support. In order for the initiative to succeed more wide ranging support will be required including from Delivery Suite staff, the Quality team and RMOs.

There is no direct Anaesthetic involvement in delivery suite, such as allocating time for an anaesthetic registrar to be present at Obstetric hand over, provide education sessions with the midwives and RMOs, and generally have a presence in delivery suite. This is certainly worth considering as it is estimated that 60-70% of all patients in the maternity unit will have direct involvement of an anaesthetist during their hospital stay. A greater presence in delivery suite would also facilitate anaesthetic involvement in Quality and Safety initiatives.

A recent audit of analgesic use postpartum showed that there was a significant discrepancy between what was charted by the anaesthetic team and what was dispensed by the nursing and midwifery staff.

Recommendations:

Increase the resource of Anaesthetic clinics for Obstetric patients so that all women requiring Elective CS may have a pre op review. The clinic would also be an opportunity to review more women who are high risk from a medical or anaesthetic point of view.

Support a dedicated Epidural service. This would include identification of Obstetric Anaesthetist on each roster.

Allocate an anaesthetic registrar to attend Obstetric medical handover with the registrar providing some cover for the acute pain service if it is not otherwise available.

Implementation of Epidural Patient Controlled Analgesia which will require multi-departmental support.

Implement recommendations identified from audit of analgesia charting to ensure medication safety.

Suggest re-audit charting variance after education sessions, which would require support from the Quality team.

Theatre Staff

There has been significant criticism regarding the lack of resident theatre nurses and an anaesthetic technician overnight. These staff are on call from home and there is an inherent delay if an Emergency CS is required overnight. There have been reports of patients arriving in the theatre suite but there was no one there and all the lights were off. On another occasion the anaesthetic technician didn't arrive in theatre at all because the pager did not function correctly.

The potential delay in waiting for staff to arrive is a significant risk and a threat to the provision of a safe service. Permanent overnight staffing should be urgently considered. It is acknowledged that it may not be necessary for an entire team of theatre nurses to be present. It may be appropriate to have just two staff resident with others on call. That would allow the instrument set up to commence immediately once a CS has been notified. Therefore it is likely that all instruments would be ready and available by the time the patient arrives in theatre. Hawke's Bay hospital has 2 theatre nurses on site overnight with others on call. Hawke's Bay hospital has 364 beds compared to Hutt Valley with 322 beds.

The current system of having nurses on call threatens the running of Elective operating theatres the following day if there has been an Emergency CS overnight. This is because the theatre staff are instructed to have a mandatory minimum break of 9 hours. This leaves a shortage in the nursing roster the next day and these shortfalls are filled on an ad hoc basis. Sometimes theatres are running with two nursing staff instead of three. This is a risk to the safe provision of Elective surgery particularly with complex major cases.

Recommendations:

Permanent overnight staffing should be urgently considered. This will require an increase in nursing staffing levels. (Urgent)

Executive Interviews

All key Executive leadership personnel (i.e. acting COO, DON, CMO, acting CE) made time available to be interviewed by either midwifery or obstetric reviewers and some of the Executive team were interviewed by both sets of reviewers.

Findings from the interviews:

- Executive members acknowledged the strong clinical and professional leadership of the Midwifery Director/Manager Women's and Children's Health, the CMM and the HOD for O&G.
- Executive members shared the concerns raised by clinical staff regarding the safety of the service.
- All Executive members identified this review as an important critique of the service and a positive step toward addressing apparent shortcomings.
- A recent Board visit to women's services was viewed positively by staff meeting Board members for the first time and being able to articulate some concerns face to face.
- There is a mixed understanding of the various health professional's roles in providing maternity care including an appreciation of Section 88 guidelines and guidelines for referral to secondary care. There appeared to be a limited appreciation of the important symbiotic relationship between the different disciplines who work in partnership to provide maternity care.
- The budget for maternity services is fragmented and sits in different places. There is a lack of visibility of 'primary maternity top slice funding' of over \$1m. The Price Volume Schedule (PVS) budget sits separately to cost budget.
- The ability of the Executive team (as identified above) to lead by example in demonstrating the Organisational Values appears to be challenged by a number of senior extended acting roles
- The clinical coding is behind by several months and it appears that caseweights are not correct. It is important to rectify this so that demand, acuity and complexity are accurately assessed and monitored.
- Use of the Event reporting system doesn't appear to influence decisions. Midwifery staffing has been on the risk register and identified as Red since May 2018. This is an indication of significant deficit in safe staffing, in the complexity and acuity of the workload and the environment. The wards are operating with minimum, or at time less than minimum safe staffing numbers and the skill mix limits flexibility. This has been reflected in significant adverse events and HDC complaints.
- All staff voiced a degree of frustration with 'executive management' and not seeing visible change in response to issues once identified.

Overall Summary of Recommendations for this section:

- 1) Urgent resourcing of DHB ACMM positions for the overnight shift to give 24 hour cover.
- 2) Urgent resourcing of DHB community midwifery team to ensure minimum visit schedule being undertaken. Likely to require an increase in FTE of at least of 4.0.
- 3) The funding for the CS midwifery team initiative be made permanent and the FTE increased to cover an on call CS midwife service out of hours plus the FTE allocation for these practitioners should include an allowance for sick leave, study leave and annual leave.
- 4) Review current theatre nursing roster to consider onsite cover overnight.
- 5) Appoint 7th O&G Consultant.
- 6) Job size SMO workload to establish appropriate time for non-clinical activities. SMOs to engage in Quality and Safety projects. As part of a job size review start times in theatre and clinic.
- 7) Ensure HCA roster supports 24 hour cover across inpatient facility.
- 8) Benchmark midwifery staffing using MERAS maternity facilities safe staffing standards and implementation of Care Capacity Demand Management (CCDM) to identify staffing levels in response to demand, occupancy and acuity.
- 9) Benchmark Medical RMO rosters against similar facilities and consider development of 3 Tier roster.
- 10) Workforce development: Development of a comprehensive RN orientation and supervision programme to support safe, high quality care provision across the postnatal ward.
- 11) Workforce Development: consideration of rotational positions across the ward and SCBU.
- 12) Review of RMO orientation would also be advisable to ensure that it is up to date and complete.
- 13) Consideration of further development of HCA role in line with national review of staffing models across maternity services.
- 14) Celebrate the evident effective leadership at the clinical, operational management and professional levels.
- 15) Executive Leadership team to be visible and known by the clinical teams delivering the care to support ongoing shared understanding of the realities currently being experienced by maternity services.
- 16) Develop a shared understanding of the significant concerns being raised by maternity services across the disciplines.

In conjunction with these above recommendations:

1. Backlog of Clinical Coding needs to be addressed to support identification of demand, complexity and acuity of women being cared for. Further administrative support will be needed for coding.
2. Updating the Midwifery Business Case and representing to executive leadership team as a matter of urgency
3. Maternity finances and budgets to be aligned to one cost centre/directorate to support visibility and improve utilisation of allocated resources e.g. Primary maternity top slice funding, PVS revenue and maternal/child contracts – this could and should support ongoing identification and resourcing according to safety, equity and demand.

2. ENVIRONMENT

The environment is a key component of the overall experience for women and their families. It has an impact on outcomes and wellbeing and is a contributory factor to the part intervention places in labour, birth and postnatal care (Birthplace Study UK, 2011 and NZ Place of Birth study, 2015). Researched evidence clearly demonstrates how the right woman in the right place of birth influences the right outcome for the mother and baby.

Environment and culture are key contributors to how clinicians practice, how safe they believe they are, how clinicians work as a team and the risk-averseness evident in practice (Organisation Culture and Place of Birth study, UK 2011).

2 A – Physical

The beautiful mural at the entrance of the maternity inpatients lifts the area. It is understood that this comes from a recent parent who wished to contribute to the maternity environment and he would be keen to support further artwork in the facility.

The current state of some areas of the maternity related facilities is very poor – to quote a postnatal woman who questioned a midwife “is that blood or coffee on that ceiling tile above my head?” to which the midwife had to reply “I honestly don’t know” and states she was mortified and extremely embarrassed.

Labour and birthing rooms have paint peeling off the walls and are in need of basic redecoration. They are generous in size and support a whanau centred approach to welcoming the new baby and could support active labour and birth.

Not all antenatal/postnatal rooms are fit for purpose with a number of rooms without piped oxygen or suction for maternal resuscitation and this limits flexibility of placement of women in the ward area and challenges safe provision of care, particularly when occupancy is high.

The current maternity reception at the entrance of the ward does not protect confidentiality and privacy of women both in relation to discussions held and where records are stored. Nor does it protect staff from agitated members or visitors. Staff report that they feel vulnerable.

Areas for staff refreshment are limited and do not provide privacy from patients or from the public. It is important for staff to have a place of privacy within the department because the nature of the work means that they do not get the opportunity to leave the clinical area.

Current storage cupboards and areas are not fit for purpose leading to a cluttered and disorganised clinical environment. Attempts to address this have been hampered by bureaucratic barriers. Current processes to address such short-comings are difficult and do not enable or empower operational managers to improve the environment easily.

Outpatient Clinics

Outpatient areas for Early Pregnancy Clinic (EPC) and Antenatal Clinic (ANC) are cramped and there is a lack of privacy. There is a shared entrance for the two clinics which is a sliding door off the main corridor. Entry to the ANC clinic requires pregnant patients to pass directly through the waiting area of EPC which is very small and particularly narrow to access an internally located Antenatal Clinic. The privacy of women in EPC is compromised by the traffic traversing the waiting room and the lack

of space. Its location does not support the emotional and psychological wellbeing of EPC patients, particularly as many patients in the advanced stages of pregnancy traverse the EPC waiting area to attend ANC. This is disrespectful to EPC patients at a time when they are vulnerable and potentially breaches the Consumer Code of Rights.

The ANC for diabetic and high risk obstetric patients operates from a different location than the usual ANC. The diabetic clinic is a run with a multi-professional team and most patients in the clinic are high risk. The separation of the clinics means that there is regular transfer of notes and equipment between the two sites and there is a risk of loss and damage occurring in the process.

Signage to direct patients to these clinical areas is fragmented and difficult to follow.

Theatre Access

Access to Theatre requires moving women from the maternity floor to one floor down. This carries significant risk in terms of ability to move safely and quickly with reliance on the lift. There is no override button to allow prioritisation of the lift to the 2nd floor and then to 1st floor. This is a potential barrier to accessing theatre quickly and to providing timely obstetric care. This is particularly significant for Category 1 CS cases which are not uncommon. Typically a baby is expected to be delivered within 10 – 20 minutes of the decision being made to carry out a Category 1 CS. In the short term it would be advisable to explore the option of having an override mechanism on the lift so that it can be prioritised for patients requiring emergency transfer between floors.

We were informed that there have been informal discussions at management level around recommissioning the unused theatre adjacent to the maternity ward so it can be used for CS. This project would require careful consideration of how the theatre is utilised and also careful consideration around staffing. It would require capital investment and would go some way toward addressing safety concerns regarding access to theatre in an emergency, and it would also increase the total theatre availability. It would be appropriate for a detailed feasibility study to assess this proposal and in the process consider overall renovations of the maternity unit. However this is a long term solution and is not likely to have an immediate impact on safety.

Renovations

There is a strong desire to have a Low intervention birthing area within or adjacent to the delivery suite complex. This model has been very successful in other centres. It should be considered in any discussion involving renovations and included in the feasibility study.

The community representatives have expressed a strong desire to have involvement in this discussion and it is likely that they will make a positive contribution. They have suggested an audit of the facilities using a Birth Unit Design Spatial Evaluation Tool (BUDSET).

Recommendations:

1. Review plan for renovation and refurbishment of the maternity unit to include repainting, replacing curtains etc.
2. Consider renovation of rooms to install piped oxygen and suction so that the use of the room can be extended to higher acuity patients.
3. Review maternity reception and consider improving record storage and privacy and address staff safety concerns.
4. Ensure staff have a room that is private and separate from patients and their families for meals and refreshment breaks.

5. Review storage facilities.
6. Consider relocating EPC to improve privacy and to provide an adequate space
7. Review signage with a view to improving clarity and visibility.
8. Apply an over-ride switch on the lift that can be activated by staff in an emergency to allow prioritisation of the lift to the appropriate clinical area.
9. Review the feasibility of re-commissioning the old theatre adjacent to delivery suite. Include consideration of a Low intervention birthing unit in this project.
10. Engage Consumer Reps in refurbishment projects.

2 B - For Women and Whānau

Access to sanitary facilities such as toilets and bathrooms is not at acceptable health and safety or infection control standards; particularly in relation to the 6 bedded room at the end of the ward area. The area seemed to have an overwhelming odour in relation to dampness within the room. The assessment room in Labour and Birthing suite was similarly affected by an odour of dampness.

The upgrade and decoration of the whānau room is commendable and is clearly identified as a positive environment among staff. The renovation was supported by an external community based service in conjunction with the Consumer Representatives.

There is a lack of privacy for women requiring the Early Pregnancy Clinic services (as noted above)

Recommendations:

Fast Track the environmental/facility business case to enable some rapid progress to improve the current environment. This should be accompanied by a detailed template of timelines, actions and completion dates of the tasks required to complete the environmental refurbishments.

3. CULTURE

3 A - Values based

The Organisational Values listed in the Mission statement include -

- Always Caring – respectful, kind, helpful
- Can do – positive, learning and growing, appreciative
- In partnership – welcoming, listens, communicates, involves
- Being our best – innovating, professional, safe

Staff Values – there seems to be a strong team based culture within maternity services and the women's health management team. Staff are aware of the Organisational values but these aren't inherently at the forefront of how things are done. What is highly valued is the trust, respect and safety demonstrated by the operational clinical leaders (CMM, Midwifery Director, HOD O&G) and they instil the same values in the clinical staff within the department.

In an HDC response letter dated 26/8/16, Dr Bloomfield, the then CEO, (Ref C16 HDC00967) stated that 'standard operating practice is that all broken equipment is taken out of use until it is either repaired or replaced, and I can confirm that we do not expect surgeons to "make do" with broken equipment'. This refers to a serious bladder injury that occurred during a Lletz procedure where the SMO was kneeling on the floor because the bed did not work and could not be elevated, and an

appropriate sized speculum was not available. However despite the words of Dr Bloomfield and the words stated in the HVDHB Vision, Mission and Values statement, there was widespread evidence of staff being expected to 'make do'.

Interviews highlighted a disconnect between the clinical teams, the care environments and 'management' at executive level. Most of the team members of maternity and paediatrics were not able to identify executive team members and commented on a lack of visibility which contributed to a perception of being undervalued and not heard. There was a feeling that management did not appreciate the acute and urgent nature of obstetrics and midwifery.

Staff interviews revealed that morale is low and this has deteriorated over time. It appears to be associated with the perception that maternity is not important or valued. Relatively small positive changes have been so difficult and slow to implement that there is a belief that nothing will change.

Recommendations:

Senior management team to enact the actions evident from the Staff Wellbeing work (e.g. the Big Listen by Tim Keogh) to be completed – asking what were the most common and most important principles and changes that would make the most difference for them.

Executive team members to improve visibility with monthly visits to clinical areas and meetings with clinical managers and clinical staff.

3 B - Equity

Marae based DHB community midwifery model of care

The community midwives have developed an award winning model of care with onsite engagement of the Māori community on the Marae. The project has been a resounding success and there have been requests from other community groups to extend the programme more widely. At present the community midwifery group are not able to extend it due to limited resources. Furthermore there is uncertainty whether there will be ongoing funding of the current programme.

It should be pointed out to management that the community groups targeted in this initiative are the ones in greatest need, they are often the most difficult to engage and have higher morbidity and complication rates as a result of lack of engagement. Typically precious time resource is inefficiently consumed on this group of patients in trying to repeatedly contact them, chasing them up to manage abnormal results and provide treatments for them when indicated. These issues are alleviated with the Marae based model of care and the positive engagement that flows from this contributes to better outcomes.

Recommendations:

That the DHB continue to fund the initiative. In essence the DHB cannot 'afford' not to fund it. It not only leads to better engagement and better clinical outcomes but it also fulfils supporting equity of access and care provision for Hutt Valley's most vulnerable populations. This is a proactive, preventative model of care that engages in a culturally responsive way encouraging and enabling pregnant women and their whanau to effectively engage with health services

Explore opportunities for further strengthening of effective partnership with Māori Health and maternity services to support cultural responsiveness to the community. Extend this to work in partnership with the Pacific Island community.

Suggest further development of a staff cultural engagement programme to support the bi-culturalism of NZ across the DHB and more specifically in maternity e.g. have the DHB values in both English and Te Reo, consider Turanga Kaupapa training through Nga Maia and resources available.

3 C - Responsiveness

There have been a number of positive changes made over the last year or so but some of these have only occurred as a result of serious adverse outcomes and HDC cases. This is a reflection of a lack of timely responsiveness by management. There is ample evidence of clinical staff requests for resources to improve safety being ignored by senior management. However a number of these criticisms were historical and it does appear that the current CEO is more responsive than her predecessor

There is evidence of a culture of 'coping' in order to meet the needs of the community. This culture limits the vision to be innovative and creative and to remain proactive in implementing national maternity standards

All clinicians clearly identified the importance of the leadership from the CMM, the HOD and the Midwifery Director. Without this leadership and support many of them stated they would leave the DHB. Many staff expressed their frustration at knowing these clinical leaders were doing their best but didn't believe that they were being listened to or heard.

Consumer feedback given to the maternity quality and safety governance group (MQSGG) portrayed a sense on not being listened to. MQSGG members indicated that there has been little evidence of this improving over time.

It is important for members of the Executive Management Team to respond to clinical risks once they have been identified. The timely development of appropriate risk management strategies will be required to support sustainability and prevention rather than what appears to be the current reactive nature of the service. This will require strong working relationships with the Quality and Clinical Leadership Teams.

4. MODELS OF CARE AND CLINICAL PRACTICE

4 A - Safety

A significant challenge highlighted by staff is to believe that the organisation takes safety seriously, that they are listened to when concerns are identified and when risks are evident within the service, and that immediate action is taken based on the evidence and solutions provided.

Various data sources have highlighted some areas of concern, including the following:

ICU admissions

There is a high rate of maternal admission to the Intensive Care Unit (ICU). There were 12 cases within the last year (2018). The reasons for these admissions was not examined as the data was not available. However it would be advisable to audit these cases as they are an indicator of serious morbidity.

Recommendations

Audit of all mothers admitted to ICU.

Increase resource for Anaesthetic review clinic for high risk obstetric patients and utilise the services of the obstetric physician when they are available (Rationale – the lack of local assessment of high risk patients potentially contributes to mothers becoming more unwell).

Regular Review of Clinical Guidelines to support evidence based safe practice.

SCBU admissions

There is a high rate of term neonates being admitted to the Special Care Baby Unit (SCBU). Potentially there are several reasons for this including high community deprivation, poor antenatal care, drug dependency, diabetes, obesity and labour related complications. There has been a high rate of transfer of babies to the Wellington Hospital Level 3 SCBU for 'cooling treatment', 18 within the last year. This is a treatment that is usually used to treat babies with evidence of Neonatal Encephalopathy and is an indicator of severe morbidity. It is concerning that this is a relatively high rate although it is recognised that it may in part signify a change in clinical practice over time with a lower threshold for cooling than previously. However there was a review of 8 cases because of concern with the baby's condition at birth and there were 4 cases of confirmed Neonatal Encephalopathy of grade 2 or worse. This potentially reflects a deficiency of a safe level of practice and these concerns deserve critical analysis.

Neonatal Encephalopathy (NE) has several aetiologies but a subset of NE cases which are a particular cause for concern are those that result from intrapartum fetal hypoxia. Hypoxia is caused by interruption to the flow of oxygen along the pathway from mother to baby. It may be caused by maternal cardiovascular or respiratory disease, uterine pathology or overstimulation, placental pathology (acute or chronic or both), issues related to the umbilical cord or the fetus. Fetal hypoxia is suspected by the detection of abnormalities of the fetal heart rate (FHR) on auscultation, which would then prompt a CTG. Typically the CTG will show FHR decelerations or abnormalities of the FHR baseline or variability. A CTG also allows an assessment of the frequency and duration of contractions. Changes can be subtle and the CTG must always be analysed in the context of the progress of labour and consideration of all risk factors.

In order to address the issue of higher than expected cases of NE it is important that all staff understand what causes it, how to detect it and how to manage the patient when fetal hypoxia is suspected. In particular, knowing when to use a CTG and knowing how to interpret it as well as making accurate clinical assessments are vital. This underscores the value of CTG education sessions including the weekly departmental CTG teaching and the Fetal Surveillance Education Programme (FSEP) which is coordinated by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

Recommendations

Ensure all clinical staff who are involved with antenatal and intrapartum care attend the RANZCOG FSEP at least once every 3 years, i.e. this should be mandatory with completion of the online module in the intervening years.

For LMCs consider making attendance a condition of their access agreement.

Continue weekly CTG education meetings. Encourage all staff to attend including SMOs.

Audit of all babies transferred to Wellington SCBU for cooling.

Review of all babies with suspected NE, including babies born with an umbilical cord pH <7.0

CS Rate

There is a high rate of Caesarean section (CS) which was reported at 41%. However some data errors have been identified in relation to CS and this rate may be inaccurate. During the time of the review it was noted that CS audit is planned. There is a perception that a high CS rate was influenced by inappropriate decision making by junior RMOs on call. This vulnerability has been addressed by removing them from the 'first on call' responsibility.

A recent publication by Zbiri et al (2018) is noteworthy as it identified a direct correlation between a deficiency in obstetric and midwifery staff numbers and increased rate of CS. Hence the high CS rate at HVDHB is a likely to be due to a combination of factors including the cumulative pressures associated with inadequate obstetric and midwifery staffing.

The study was a retrospective population based cohort study covering 11 hospitals of a French perinatal network from 2008 – 2014. As the number of obstetricians, expressed as full time equivalents (FTE), increased there was a reduction in CS rate (adjusted Odds Ratio (aOR) = 0.55, Confidence Interval (CI) = 0.36 - 0.83, p = 0.005). There was also a reduction in CS rate with increased Midwifery FTE (aOR 0.79, CI = 0.69 – 0.90, p < 0.001). The study showed that with a 10% increase in obstetricians there would be a 25% reduction of CS rate from 23.4 % to 17.5 %. (Ref: Zbiri, S, Rozenberg, P. et al (2018) Caesarean delivery rate and staffing levels of the maternity unit, PLOS one, <https://doi.org/10.1371/journal.pone.0207379>)

Recommendations:

Conduct a Comprehensive CS Audit including

- 1 - Fully dilated CS (Rationale - They are often difficult procedures and can be associated with significant morbidity especially if there is a trial of forceps)
- 2 - Category 1 CS (Rationale - These are high risk patients and require significant resource allocation. The Audit should include examining the appropriateness of the assessment as Category 1, the time it took to deliver the baby, the clinical outcome particularly the infant condition, the type of anaesthetic and the indication for delivery)
- 3 - Caesareans performed under General Anaesthetic (GA). This should involve the anaesthetic department. There is likely to be a large overlap with Category 1 CS. The reasons for GA CS can largely be divided into Obstetric reasons and Anaesthetic reasons.
- 4 - CS for fetal distress (Rationale - to check for possible adverse neonatal outcomes, to review the CTG to ensure that recognition of fetal distress was accurate and management decisions were timely, to ensure that the CTG changes have been adequately documented, and to ensure that RMOs are aware of and review cord pH results as these are an objective indicator of the fetal response to labour.
- 5 - SCBU admissions following CS (Rationale - There appears to be a high rate of SCBU admissions for babies born by CS).

Address staff shortages:

Recruit midwifery staff urgently to address severe deficiency, including for delivery suite, community and the theatre midwifery team. Explore the option of national and international recruitment in order to obtain staff with clinical experience.

Appoint a 7th SMO – with urgency (do not wait for ASMS job size to initiate this).

Discuss a long term plan with HR to consider an increase in RMO numbers to achieve a 3 tier roster to increase the level of experience of on site RMOs.

HDC Cases

There has been a high number of complaints submitted to the HDC. This has included serious complaints with significant adverse outcome including stillbirth.

There was a sense from the Quality team that the care provided was not patient focussed. There was also a sense that similar adverse events continued to occur, particularly relating to consent and communication. As an example we were informed of a complaint relating to limited consent and communication at the time of a forceps delivery.

Recommendations:

Education for the Obstetric team to focus on patient communication and consent. In particular, consent for operative vaginal delivery. It is recognised that this is a procedure that is often performed urgently and under emergency circumstances which places practical limits on the degree of discussion that can occur. However there is a contemporary guideline regarding consent for operative vaginal delivery published by the Royal College of Obstetricians and Gynaecologists (RCOG). It seems appropriate that the Obstetric team carefully review the document and incorporate the suggestions into clinical practice where practical. An example of a pre-printed consent form for operative vaginal delivery and also for Caesarean section from Hawkes Bay DHB are enclosed as an example.

Continue to review all HDC cases relating to Women's Health with a view to identifying systemic risk and ensuring steps are made to rectify it.

Continue to critically review all stillbirth cases.

4 B - Quality

The resource allocated to Quality initiatives appears limited as does staff engagement. As a result there is a relative lack of audit data, continuous quality improvement and appropriate educational activities that arise from audit activity. This lack of focussed activity limits a proactive approach to problem solving. It was a frequent comment from many interviewees that departmental changes appeared to be reactive rather than proactive

Maternal Quality and Safety Programme

There has been a vacant position in the Maternal Quality and Safety Team of 0.6 FTE for nearly two years. It is recommended that the position is filled. The Programme is funded by the Ministry of Health (MOH) and the funded FTE is regarded as a baseline. HVDHB has been operating below baseline and this fact was evident during staff interviews.

The MQSP coordinator role should be increased and enabled with administrative support to allow implementation of recommendations made from case reviews and audits. The role would also facilitate implementation of strategies referred to in the HVDHB Maternal Quality and Safety Plan for 2018 – 2020. It would also include providing support to initiatives such as Patient Controlled Epidural Anaesthesia, providing administrative support for data retrieval and analysis. Currently there is significant time resource being consumed by manual retrieval of data, by staff in delivery suite, gynaecology clinic and staff in the operating theatres. The role would also include ensuring data accuracy for automated MOH reporting as this seems to be a significant problem at present. It was noted that in the last clinical indicator data set that 9 out of 50 Elective CS operations for standard primips were miscoded, and 4 out of 50 Emergency CS operations were also miscoded.

Theatre

Theatre staff expressed a need for basic data relating to patient flows through the theatre complex, including theatre start and finish times, and day of surgery cancellations, etc. Such analysis is currently performed after manual data extraction

Recommendations:

Recruit and fill the vacant position of 0.6 FTE on the MQSP team.

Review current MQSP positions and increase coordinator FTE and establish an administrator position to support full implementation of the programme – ensure that the funding from the MOH is directly coded to maternity.

Provide basic data as requested by Theatre nurses.

Support development of accurate automated data reports such as the Clinical Indicators. Extend this to include automated analysis of clinical, workforce and environmental information to support healthcare planning.

SMO Engagement

There has been a paucity of SMO engagement in Quality and Safety Activities for several years, although there has been an improvement over the last year. There is now a regular CTG education and review meeting (although SMO support and attendance is intermittent), there has been a major policy review for 'planned birth', there is a clinical review committee for adverse outcomes and triggered events, and there are CS audits being planned. However there has been a lack of time for SMOs to undertake Quality and Safety initiatives. It is expected that prescribed time for quality initiatives would be an outcome of a departmental and SMO job size. We would recommend a lead SMO for Quality and Safety, which ideally would be someone other than the Head of Department. It is expected that this SMO would take responsibility for oversight of coding and reporting to the Perinatal Mortality and Morbidity Review Committee (PMMRC) and provide oversight for regular meetings, as well as being an active member of the Maternity Quality and Safety Governance Group.

It is recommended that all SMOs oversee a major audit project in conjunction with other staff, particularly RMOs. Audit activity should be supported by the Maternal Quality and Safety team and the Clinical Leadership team. Involvement with midwifery and nursing staff should be encouraged where appropriate.

Recommendations:

Ensure SMOs are allocated non-clinical time for Quality and Safety.

All SMOs to actively engage in audit.

Establish a lead SMO for Quality and Safety to oversee audit projects, manage PMMRC coding and to join the Maternal Quality and Safety Clinical Governance Group.

Clinical Review Team

The clinical review team examine the case notes of patients that are identified via a trigger list, including emergency CS, obstetric emergencies e.g. shoulder dystocia, postpartum haemorrhage, cord prolapse, eclampsia, etc. The ACMM is notified of any cases that are triggered. The committee includes the Head of Department O&G, Charge Midwife Manager (CMM), ACMM, the Midwifery Educator and Admin staff. After an initial review the committee makes a decision about whether a more extensive formal review is required. Any themes or contributory factors are identified, for example, organisational factors, patient related factors, or staffing related issues. Reviews are designed to be a supportive and educational process and not a punitive one. Several staff acknowledged the significant input of Karen Daniells and Dr Meera Sood in providing a supportive environment.

4 C - Education / Training / Supervision

Midwifery and Obstetric

The CMM, Karen Daniells and Midwifery Educator, Eleanor Martin have an annual education programme to support mandatory midwifery educational requirements as well as optional professional study days. The mandatory programme is set for the central region with shared agreements of access by midwives from around the region. A number of the educational opportunities are multi-professional and support shared learning and standardised responses particularly for emergencies.

Practical Obstetric Multi-Professional Training (PROMPT) course which is run twice a year – this is a multi-professional obstetric emergencies study day involving obstetric, midwifery and anaesthetic staff. The course focusses on practical case management in the delivery suite environment and encourages team work and standard responses to obstetric emergencies. The PROMPT programme supports identification of roles and responsibilities, and emphasises a timely and seamless response.

The Fetal Surveillance Education Programme (FSEP) is a programme coordinated and provided by RANZCOG and is held once a year. This programme provides education on fetal physiology and the fetal response to hypoxia. In particular it focusses on patterns of fetal heart rate (FHR) alteration to aid interpretation of an abnormal cardiotocograph (CTG) and to recognise fetal hypoxia. The education includes guidelines about when to use a CTG and there is a focus to ensure that delivery suite staff use a common language to describe CTG changes. The programme can also be accessed on line or across the central region.

Weekly CTG meeting currently organised and chaired by the CMM.

The National PMMRC review all perinatal mortality cases nationally. Each DHB holds regular Perinatal Mortality and Morbidity Meetings to discuss and review local cases. There is a national requirement to report Perinatal mortality cases and they are notified to the PMMRC in real time using an online reporting tool. Once all investigation results are available cases are coded by consensus at the Perinatal meetings using a standard template and the details are forward to the

PMMRC. This is a multi-professional forum including obstetrics, midwifery, paediatrics, radiology and primary care, and meetings occur at least 5 times a year

Newborn Life Support teaching – multi-professional attendance and maintained at mandatory requirement standards for midwives and nurses.

National programmes from Health Quality and Safety Committee (HQSC). There are a number of programmes directed by HQSC including:

- Maternity Early Warning System
- Maternal Morbidity Working Group reporting toolkit
- Growth Assessment Programme (GAP) roll out. This focusses on the detection and management of Fetal Growth Restriction which is particularly important because growth restricted babies are at increased risk of hypoxia in labour
- Sepsis Management (development of guidelines and management bundle)
- Neonatal Encephalopathy (NE) taskforce

There is a willingness to roll out these programmes within HVDHB but there is limited ability to do so due to lack of education resources.

RMO Supervision

The SMOs are no longer obligated to undertake Elective gynaecology work while they are On Call. This has allowed more time for them to remain in delivery suite for direct supervision of RMOs at all levels and more time for teaching.

Antenatal Clinic

The RMO team expressed a degree of uncertainty around their role in clinic, especially if it is a Registrar only clinic with no SMO. To address this one of the Senior Registrars has written a guideline to help clarify this for the junior doctors.

There is a potential learning opportunity at the end of clinic with a chart review exercise. In Hawkes Bay this is referred to as a 'round up'. This involves all doctors, midwives and administrative staff in the clinic meeting at the end of clinic and briefly reviewing the patients' histories and management plans. It is a way of ensuring that follow up appointments are booked appropriately and follow up scans are arranged where necessary. It is an opportunity for the RMO to ask questions, and it is an opportunity to review the notes of patients that did not attend (DNA) the clinic and discuss any follow up arrangements that they may require. In Hawkes Bay we have found the exercise of carefully following DNA patients to be very valuable. They are often high risk, socially deprived and fail to attend because of transport or other social reasons. Recurrent DNA patients are over-represented in adverse outcome data. As such they require more intensive input and without the 'round up' exercise critical care plans and follow up arrangements are easily omitted.

Challenges

The current midwifery educator FTE is at capacity in managing the mandatory midwifery training. This impacts on her ability to lead and implement nationally mandated campaigns.

The limited pool of available midwives restricts the ability to release staff to attend education and training sessions, and to work in multi-disciplinary teams.

Recommendations:

Focus on addressing the severe midwifery workforce shortfall which will have a positive impact on midwifery education and training.

Increase education resource including the FTE allocation to the midwifery educator to ensure that mandatory training requirements are met as a minimum. This will promote an engaged and valued workforce. This would also support implementation of national HQSC programmes.

SMOs to consider initiating 'Round Up' chart reviews at the end of each Antenatal clinic.

Discuss clinic structure and RMO role in clinic during the Orientation period.

4 D - Resources

Equipment

Infant resuscitaire – there was a need for a new infant resuscitaire for twin pregnancies because there was a limited oxygen supply of only a few minutes in the existing one. The source of the oxygen supply was from a bottle rather than from the main piped supply. Management did not respond to this request despite it being highlighted as necessary equipment. A second resuscitaire was eventually donated by a benevolent source outside the hospital.

There were comments from staff that there was a general lack of basic equipment such as stethoscopes, CTG machines, blood pressure cuffs, sonicaids, etc.

Recommendations:

Urgent supply of essential equipment i.e. Infant Resuscitaire, Cardiotocographs and day to day consumables to support wellbeing of women and infants, safe practice and clinical decision making.

Outpatient Hysteroscopy

This is an extremely worthwhile initiative to explore. The benefits of performing these procedures outside of an operating theatre environment are significant in terms of cost, resource required, and patient satisfaction. Having the ability to perform simple hysteroscopic procedures in clinic rather than in the operating theatre environment would free up significant time in theatre for other procedures.

Currently Management say that they are waiting for the SMOs to progress it and the SMOs say that they are waiting for Management to progress it. A business case has been done and apparently approved. The initiative seemed to lose momentum when SMO numbers fell to four. It would appear that a working group of motivated parties should be established so that it can be progressed. There is certainly the willingness and necessary skill available to make it work well. Dr Elaine White, a gynaecologist in Hawkes Bay has initiated an outpatient hysteroscopy service in Hawkes Bay and she would be willing to provide some advice and direction to the working group if required.

Recommendation:

Establish a working group of motivated parties to progress an outpatient hysteroscopy service.

Administrative Support

There is a lack of administrative support for Antenatal clinic (ANC). This includes a lack of administrative staff to help prepare notes for the clinic and book appointments and also medical typing. Given the acute nature of obstetrics and the high number of patients who require immediate intervention following their clinic appointment, it is imperative that ANC letters are typed within 1-2 days. Timely written communication between medical and midwifery teams is required to ensure that patient risk is clearly portrayed and advice regarding risk management is available. Comments from LMCs have highlighted that it is not uncommon for their patients to deliver several days before they receive the clinic letter which contains the management plan for labour.

Recommendations:

Identify specific medical typing support to ensure one day turnaround of antenatal clinic letters to prevent delay in essential care for pregnant women and to ensure LMCs have timely communication of the outcome of the clinic visit.

Cost the provision of a dedicated receptionist for women's health. This may include supporting antenatal clinic and early pregnancy clinic. This would assist the smooth running of outpatient clinics and would support effective systems and processes across the outpatient services. It would also reduce fragmentation of communication across multi-professional teams.

4 E - Guidelines

Clinical Guidelines

The majority of clinical guidelines are out of date and require attention. Regular Guideline review has not occurred over recent years due to severe staff shortages. This is a significant clinical risk that requires dedicated resource and attention. Of note one of the new SMOs has recently updated the Guideline on 'Planned Birth;.

Recommendation:

Review of guidelines should be a priority for the midwifery and obstetric team once they have allocated time for Quality and Safety.

4 F - Leadership

The interviews portrayed a clear theme of highly supportive and visible leadership, led by the Charge Midwife Manager, the Midwifery Director/Service Manager Women's and Children's Health, the Group Service Manager and the Head of Department (HOD) for O&G. These clinical and managerial leaders are changing the culture to enable and support shared visions of safety, advocacy, cultural responsiveness and a woman and whānau focused model of care. The service is currently developing a supportive leadership framework at various levels within the department including the introduction of the ACMM, the theatre midwifery pilot and the community midwifery Marae based care. These initiatives have increased autonomy and confidence which has allowed these staff to demonstrate clinical leadership at multiple levels.

Review of the current executive professional leadership team does not include a professional midwifery leadership position in comparison to Medical, Nursing and Allied Health. Consideration of such a role at the executive and strategic level would demonstrate the organisational value for midwifery and its workforce, would provide a direct reporting line to the CE for expert professional advice and demonstrate visibility of safety. This would also be reflecting the new Clinical cluster

model in the Ministry of Health with recent identification of a Chief Midwifery Advisor position to be recruited to by the Director General of Health Ashley Bloomfield.

The medical obstetric team has been somewhat transient over the last few years due to a high reliance on locums to fill staff shortfall. This has limited the ability for them to work in partnership with the midwifery teams. As such it has been difficult to foster a shared vision and direction of healthcare. And despite the hard working nature of the SMOs and their willingness to do extra clinics and days on call there is a feeling that they are working as individuals and not as a team. It is reassuring that the SMOs meet regularly with managers from different areas including Obstetrics, Gynaecology Outpatients and Theatre. There is a sense that these meetings have helped SMOs develop a strategic view within the department and also foster a greater understanding of the important inter-relationships with other departments. It is hoped that a 'Proactive' rather than a 'Reactive' approach will be enhanced by SMO engagement in Quality and Safety initiatives. Time for Quality will lead to increased focus on identifying and remedying systemic risk by adverse event review and audit. Time for Quality will also allow timely updates of policies and guidelines as well as allowing time for education and the development of efficient systems for patient management.

The Director of Midwifery currently has a dual role which also includes Service Manager Women's and Children's Health. Whilst this provides significant benefits it also has challenges in terms of capacity of the professional lead for midwifery and the accountability for safety, quality, and management of the workforce. Her position as Director of Midwifery is spread across both Wairarapa (0.2FTE) and Hutt Valley (0.3FTE) DHBs. Her responsibility includes significant current national work on the MOH maternity system programme and recommendations recently agreed by the Director General of Health. These will require ongoing capacity and well-resourced midwifery strategic and operational leadership to enact actions and support vision and direction for Hutt Valley Maternity services.

The allocation of time to achieve expected goals is inadequate in comparison to other DHBs and it should be increased, e.g. Hawkes Bay 0.9 FTE, Midcentral 1.0 FTE. The ability of the current Director of Midwifery to achieve what she has within her current 0.3FTE for Hutt Valley FTE allocation should be acknowledged; with a strong recommendation to increase the Hutt Valley position to at least 0.8FTE and separate the Service Manager Women's and Children's position; recognising the importance of the partnership between those two positions.

Recommendations:

Increase Hutt Valley Midwifery Director FTE allocation from 0.3FTE to 0.8FTE in line with benchmarked national positions

Recognise the Service Manager Women's and Children's as a separate position

Consideration of a Professional Midwifery Leadership position at the level of the Executive Leadership team for strategic and professional advice and for operational visibility of maternity services.

Increase FTE allocation to Midwifery Director from 0.5FTE to 0.8FTE. (Review immediately).

5 ORGANISATIONAL

5 A - Where Women's Health sits

Structurally Women's health and maternity services are aligned with Surgical and Children's' services in the same directorate. Whilst partnership of Women's health with Children's health is effective there is uncertainty from staff about the suitability of alignment with surgical services. There is a perception that surgical services has a focus on targets and waiting times with an unintentional effect of limited focus for maternal and children's' services.

Women's Health is considered a small service, however the challenge is to recognise the acute nature of the Specialty and to understand the importance of addressing all aspects of risk. The potential for harm if areas of risk are not addressed has been demonstrated in the HDC complaints. Proactive management of risk and prevention of adverse outcomes will ensure that finite resources are not diverted away from clinical work toward complaint management. Complaints involving mortality and severe morbidity demand significant time allocation by clinical managers and they are emotionally draining.

The DHB strategic plan shows evidence of the MOH 1st 1000 days priority and focus on maternal and infant health and the draft child and youth wellbeing strategy along with recognition of mental health. However overall Women's health is not well represented in the DHB planning documents e.g. the Clinical Services Plan, DHB strategic priorities. These are significant projects and work evident in this plan will require strong and effective leadership at all levels of the organisation.

Structurally within the organisation professional midwifery leadership is currently sitting at Directorate rather than Executive level. There has been a recent change in reporting line to the Director of Nursing and there didn't appear to be a clear reason for this change or evidence to support a midwifery reporting line to nursing. A question to consider is why midwifery isn't evident at Executive level as per other professions such as medical, nursing and allied health?

Challenges:

Recognition of the PMMRC reports and the key findings in relation to maternal mortality and morbidity do not appear to be visible in the key actions for this and the next planning cycle.

Processes to elevate service issues and complexities have a lot of red tape and check points leading to a lengthy and delayed timeframe where responsiveness was seen to be limited or lacking e.g. getting a business case to the Board – historically business cases identified had been on the table for more than 2 or 3 years, for example the Midwifery workforce business case and the Environmental improvement business case.

Recommendations:

Reconsider current professional executive leadership structure to include an executive professional midwifery leadership position. This would streamline responsiveness and it would also improve awareness of current and future needs and facilitate action to them. An executive professional midwifery leadership position would demonstrate equality and equity of professional representation alongside medical, nursing and allied health professionals.

Ensure that when services are combined under the same directorate that there is an equal value and focus placed on each service represented. This is important to ensure swift recognition and elevation of concerns and issues.

5 B - Strategic Priorities

Prioritise a sustainable midwifery and medical workforce to provide a safe, equitable and accessible maternity service.

Prioritise maternal and infant health – evidenced in the DHB strategic plan.

Engage the maternity workforce in strategic planning to identify key goals for service delivery and their strategic priorities .

Foster a proactive approach in quality and safety initiatives.

Engage with Consumer Representatives.

6. EXTERNAL

6 A - Consumer experience and feedback

- Consumer members are an integral part of the Maternity Quality and Safety Governance Group (MQSGG). They support engagement in community feedback to inform staff and management about the consumer experience.
- Consumer members expressed disappointment and frustration at the lack of response to the feedback they have provided to the MQSP group over the last 4 years.
- The consumers do not believe that 'management' are prioritising maternal health to make the much needed changes as they are identified.
- The Consumer Representatives feel that they have been ignored which is concerning and this should be addressed with urgency. It will be beneficial to the department and to patients if active engagement with consumer reps is encouraged.

Renovations – The Community Representatives have a positive contribution to make to renovation projects including support for design and layout of non-clinical areas, support with funding and support with smaller DIY type projects.

The consumer reps have offered to do an audit of the facilities using prescribed Birth Unit Design Spatial Evaluation Tool (BUDSET) criteria. The BUDSET was developed in Australia in 2010 and has been applied across several maternity units. It provides a way to assess the optimality of birth units to determine which domain areas may need improvement. It is based on 18 design principles and is divided into four domains (Fear Cascade, Facility, Aesthetics and Support). Each domain has 3-8 assessable items and at completion each area is given a score from 1 to 100.

A letter was recently written to the current CEO from Vida Rye, one of the Consumer Reps on the MQSGG. She indicated that there appeared to be too many obstacles to making progress, that several areas within the maternity department required upgrading and renovating and that an appropriate investment would be required. Out of frustration from delays in providing this commitment the Consumer team took responsibility for undertaking some improvements into their own hands. The much needed upgrade of the whanau room, which was recently completed, is an example. The Community Team have organised fund raising activities for these types of projects and

at times have sought modest reimbursement for funds that they had committed personally, however no reimbursement has been forthcoming.

There is significant unease amongst the group of Consumer Reps. Several have left the role as they felt as though they were being ignored and they were overwhelmed by beaurocracy and barriers to change. The current Consumer Rep is considering leaving the role which is a concerning trend.

Consumer feedback forms

The consumer feedback forms are sent to the Human Resources Department or perhaps another department in the hospital. The Consumer Reps do not get an opportunity to view or review these. As such they feel left out of the feedback process and disconnected from this component of community opinion. Out of frustration they have developed their own feedback system where patients respond to an email survey and the reply goes directly to the Consumer Team. They have noted a good response thus far.

Priorities stated by the Consumer Reps based on their feedback included a greater need for Post Natal support and in particular Breast feeding support, and ensuring that hospital staff respect patients' opinions at all times.

Recommendations:

Active engagement with Consumer Representatives.

Address reimbursement of Consumer Rep reasonable expenses.

Ensure that DHB consumer feedback forms are directed toward the Consumer Reps.

Section Three

Conclusions

Several areas of risk have been identified that threaten the safety of the maternity service. The most pressing of these is severe staff shortage. Addressing safety will require a significant increase in FTE within the department including Midwifery Director FTE, ACMMs, Midwives for inpatient areas as well as community midwives, HCAs and SMOs including an allocation of time for quality and the appointment of a 7th SMO, HR review and further RMO recruitment will be required to address changes in rostering with greater limitations being imposed on hours of work. A 3 tier on call system should be considered to further reduce the risk of relatively inexperienced RMOs as the only available doctor on site.

With adequate staffing in place there will be an opportunity to look forward and be proactive in risk management. Adequate staffing will enhance access to education and training and it will create opportunities to develop efficient care streams.

It is reassuring that several previously identified areas of risk have been addressed including review of SMO work schedules so they are not committed to elective work whilst on call, recruitment of two SMOs to replace retired staff and relieve pressure on the requirement for locums, removing junior RMOs from the 'first on call' roster, the introduction of the ACMM, the introduction of the theatre midwifery team and the introduction of the event reporting system.

The establishment of the Marae based community midwifery programme has been very successful in engaging vulnerable and socially deprived women who are often otherwise disconnected from antenatal care. Continuing and extending this type of initiative will yield significant benefits in prevention and health screening. The benefits of acceptable long term contraception should not be underestimated. Adequate FTE for the community midwifery group is essential.

The importance of education cannot be understated. It is essential that all staff are able to correctly assess fetal wellbeing and detect and manage intrapartum hypoxia. Staff must be able to partake in a coordinated response to obstetric emergencies which requires drills and practice. Coordination of educational activities is essential and must be adequately supported.

There is risk in relation to potential delays in responding to emergencies requiring theatre, particularly Category 1 CS cases in the night when staff are required to come in from home. Given the frequency of these events and the implications of delay this risk should be addressed with consideration of the presence of theatre nursing staff in hospital overnight. This will relieve deficiencies in theatre nursing staff the following day.

Engagement in quality activities is essential. The high rates of adverse events demand ongoing audit activity of Caesarean sections, maternal ICU admissions and term babies admitted to SCBU. Similarly case reviews of all perinatal mortality cases, HDC complaints and cases identified through the event reporting system must continue in order to identify patterns of causality and systemic vulnerabilities. Ongoing review of clinical guidelines must be undertaken continuously to ensure that departmental policies reflect contemporary national and international practice. Adequate administrative support is required for the quality team to enable implementation of changes once the need is identified. Adequate administrative support will also be required for clinical staff to improve efficiency in clinics and to provide timely written communication which is critical for safety.

There are areas which require substantial reconfiguration and redesign, such as EPC and ANC, the project to design a low intervention birthing unit and recommissioning of the old operating theatre room adjacent to delivery suite. These are significant projects that will take time and plans must be adequately evaluated. They will not alleviate any of the immediate concerns raised but they must be undertaken with an eye to the future.

There are other areas where the need for refurbishment is relatively superficial such as painting and redecorating and there are areas where improvements will require structural repair, for example adding piped oxygen and suction to rooms in delivery suite and the postnatal ward. These should be undertaken on a semi-urgent basis (i.e. this year) and planning should be done in conjunction with more major renovations.

Members of the executive will need to have a more visible presence in the maternity unit in order to obtain a clearer understanding of the issues that staff are facing. Communication with the executive team would be enhanced with a midwifery presence at executive leadership level and should be considered.

The consumer representatives have an important contribution to make and they provide an effective link with women and their whānau. This should be acknowledged and valued.