A Review of Service Delivery and Clinical Outcomes

at

Public Maternity Units

in the

Australian Capital Territory

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1 EXECUTIVE SUMMARY

This review was commissioned by the ACT Health Minister to assess service delivery arrangements and clinical outcomes at public maternity units in the ACT.

1.1 FINDINGS AGAINST EACH OF THE TERMS OF REFERENCE INCLUDE:

- An assessment of mortality, morbidity and other clinical outcomes. In assessing these outcomes, the reviewers will be expected to examine relevant benchmarking data, performance indicators and other appropriate data and research;

  The benchmarked data provide evidence that the clinical outcomes at both public maternity services in the ACT are consistent with comparable hospitals in Australia and New Zealand.

- An assessment of consumer satisfaction and patient experience, including an assessment of complaints and compliments, RISKMAN data, recommendations from clinical review committees and other consumer related feedback mechanisms;

  Consumer participation in the Canberra Hospital maternity service processes is inadequate.

  There are insufficient consistent, planned measures of consumer satisfaction.

  Access to continuity of midwifery care is limited; however, those women who are able to access the Birth Centre express high levels of satisfaction with that model of care.

  There is no ACT Health policy guiding standardised clinical risk management that covers both public maternity services in the ACT.

  The case review mechanisms in place at both the Canberra Hospital and Calvary Public Hospital maternity services appear adequate and, for the most part, function appropriately.

- An assessment of the clinical governance of the Unit, including examination of relevant policies and protocols, clinical audit processes and other quality improvement activities;

  Clinical governance at the Canberra Hospital maternity unit appears to be inadequate.

  The re-credentialing process of clinical staff in the Canberra Hospital maternity unit does not appear to be robust.

  There is evidence of a systematic reticence to address staff performance issues in the maternity unit at the Canberra Hospital, particularly issues relating to inappropriate behaviour by certain medical staff.

- An examination of staff roles and responsibilities and an assessment of whether the roles and responsibilities are appropriate to staff professional roles, skills and experience;

  The Canberra Hospital management team appears to lack cohesion and a clear understanding of their roles and responsibilities. Formal lines of responsibility appear to have been regularly breached.

Reporting lines and accountability at the Canberra Hospital appear confused in relation to ACT Health and hospital management. Members of the management team appear to have responsibilities at a range of levels within ACT Health.

On-call registrars are expected to cover the Labour and Delivery unit as well as the Birth Centre, the acute gynaecology presentations and some clinics or operating theatre lists. This creates a potential clinical risk for a patient who requires urgent attention.

- An examination of staff numbers and workloads, and assessment of whether the staffing numbers are sufficient and workloads are appropriate;

  The 27 increase in births at the Canberra Hospital over the last 5 years has not been accompanied by a commensurate increase in staffing. Both midwifery and medical staff are currently carrying unsustainable work loads. This issue should be urgently addressed.

  Some of the management staff in the maternity unit at the Canberra Hospital appear to be carrying a full clinical load and do not appear to have or be accessing sufficient non-clinical time for management. This reduces time available for management and supervision of trainees or inexperienced staff.

  Current on-call arrangements for medical staff at the Canberra Hospital place a disproportionate load on part time staff and are adversely affecting recruitment and retention of skilled clinical staff.

- An assessment of the service delivery and working arrangements between all obstetric units in the ACT, and potential options for improvement.

  There is strong support from both public and private providers for exploring a Territory-wide maternity service.

  There appear to be three key barriers for medical clinicians interested in working at the Canberra Hospital. These include:
  - The current on-call load which requires part time staff specialists and Visiting Medical Officers (VMOs) to carry a full on-call load.
  - A perceived culture of resistance by the Canberra Hospital to the engagement of VMOs.
  - The Canberra Hospital has not effectively addressed issues of inappropriate behaviour by certain medical staff.

1.2 COMMENT ABOUT OVERALL PERFORMANCE

In terms of clinical outcomes, both the Canberra Hospital and Calvary Public Hospital are performing consistently with comparable hospitals in Australia and New Zealand. However, this appears to be achieved at considerable physical and emotional cost to staff at the Canberra Hospital.

1.3 SUMMARY OF RECOMMENDATIONS

ACT Health should ensure the timely production of an annual comprehensive report of the outcomes from the maternity and newborn services. Such a report should include all maternity and neonatal care outcomes across ACT maternity services – both public and private. The release of each annual report should be subject to external expert review.

ACT Health should include consumer representation within the governance framework of maternity services. Regular consumer satisfaction surveys, at the individual clinical service level, should be undertaken.

ACT Health should support the implementation of further caseload models.

A standardised Clinical Risk Management Programme should be implemented across both public sector maternity services in the ACT.

Clinical governance within the maternity unit should be improved and should include a process of regular re-credentialing and thorough performance review.

Staff roles and responsibilities at the Canberra Hospital should be clarified. This should include clear reporting lines, robust response to complaints and improved procedures to manage inappropriate behaviour.

Staffing numbers and workloads at the Canberra Hospital maternity unit should be urgently reviewed. In particular, midwifery staffing and skill mix for Labour and Delivery needs to be increased. Rostering of medical and midwifery staff should be revised.

Both the Canberra Hospital and Calvary Public Hospital should develop agreed joint clinical protocols. Both units should move towards similar staffing with a mixture of staff specialists and Visiting Medical Officers. A single Territory-wide obstetric resource should be the goal.

1.4 CAVEATS

The review team were provided with a number of cases purporting to demonstrate adverse outcomes from individuals and disaffected clinicians.

Team members interviewed several patients and found their observations and concerns of benefit in framing issues for consideration. Members also met with those clinicians who requested to be heard.

The terms of reference and time available for the review precluded a detailed analysis of cases. Many of the events had previously been reviewed while others are the subject of current investigations.

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3 BACKGROUND

The Australian Capital Territory has a population of 345,000. The Canberra Hospital maternity service is a tertiary referral service and so provides care to complex patients from adjacent areas.

Four maternity services operate in the Territory. Two are public: the Canberra Hospital with 2,625 births last year and Calvary Public Hospital with 1,303 births. Two are private: Calvary Private Hospital with 756 births and John James (now owned by Calvary) with 1,200 births a year.

ACT Health is in negotiations to explore the option of purchasing Calvary Hospital.

The Canberra Hospital operates 9 birthing rooms in the labour and delivery suite. A separate Birth Centre has 3 birthing rooms. Staff pride themselves in offering a woman-centred service.

3.1 HISTORY OF MAJOR CHANGES

A teaching hospital maternity service was first established at the Canberra Hospital in 1991, commencing with an antenatal clinic. This development was reportedly resisted by some VMOs at the time who believed that they provided a good service and could not see the need for change.

The Birth Centre, which provides a midwifery-led maternity service was opened in 1992. Again this development was reportedly resisted by some VMOs who could not see the need for change.

With the appointment of a Professor of Obstetrics and Gynaecology in 1995, a number of staff specialists were appointed. These appointments displaced several VMO positions - a change that was reportedly resisted by some VMOs, and is still reflected on as a critical change in clinical staffing, particularly by older clinicians in the Territory.

3.2 PREVIOUS REVIEWS

Maternity services at the Canberra Hospital have been subject to a number of reviews over the past 10 years. These include:

- In 2003, ACT Health undertook an internal review of maternity services. This review focused on continuity of care, comparative costs, consumer involvement and the impact of medical indemnity insurance. The report recommended the Canberra Midwifery Programme be evaluated and expanded and that linkages be improved through communication, adoption of an electronic maternity record and resolution of cross border issues. It also recommended that consideration be given to a Territory-wide maternity service.

- In 2004, the ACT Standing Committee on Health enquired into maternity services in the ACT and subsequently published "Pregnant Pause – the Future of Maternity Services in the ACT"

- In 2005, Philip Moss, the Community and Health Services Complaints Commissioner, undertook "An Own Initiative Investigation into the Obstetric Service at the Canberra Hospital". This investigation was triggered by concerns raised by the then Chairman of the ACT State Committee of the Royal Australia and New Zealand College of Obstetrics and

Gynaecology (RANZCOG) to the Medical Board of the ACT alleging that obstetric care at Canberra Hospital was causing 'serious concerns to the vast majority of Canberra's obstetricians'. Issues were canvassed in the complaint including that: "the resignations of seven registrars, who were unable to cope with the atmosphere, personalities or standards within the Obstetrics Unit."

The Commissioner concluded that there was no issue of public safety in the obstetric service at the Canberra Hospital. The Commissioner made four recommendations. These related to assessment of performance concerning Apgar scores, review of policy and guidelines on the use of Prostin and Syntocinon and that ACT Health consider the establishment of a Territory-wide system for clinical audit and review of obstetric care.

- In 2006, KPMG (contracted by the ACT Government) published "Canberra Midwifery Program – Demand Analysis Report".

- In 2007, there was a "Review into the Canberra Midwifery Program (CMP) for ACT Health". This review focused on the CMP homebirth cases, particularly the incidence and management of unplanned homebirths and quality assurance in the CMP.

The current review panel did not have access to the conclusions, recommendations and subsequent actions for most of these reviews.

The Canberra Hospital has also been the subject of regular reviews by accreditation agencies including the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the Australian Council on Healthcare Standards (ACHS)

- The July 2008 "Re-accreditation of the Canberra Hospital" by the RANZCOG noted under Areas of Concern - point 9:

  Dysfunctional relationships within the O&G Department. This is a sensitive 'in house' matter, which would not usually fall within the brief of a re-accreditation team review. However, the impact on the trainees of conflict between senior staff with the Canberra Hospital unit is apparent, both from the documented 'statement of concerns', the trainee questionnaires and the interviews with trainees at the time of the visit. Suffice to say, that the opinion of the re-accreditation team is that such differences, (which occur in all units to a degree), should not be allowed to impinge on the delivery of quality training as such and excellent site as TCH."

  No response from the Canberra Hospital or ACT Health to this area of concern has been received by RANZCOG. The Clinical Director stated she believes that the issue had been resolved with the resignation of a staff specialist in 2009.

3.3 CURRENT REVIEW

On the 12th of March, 2010, the ACT Health Minister, Ms Katy Gallagher MLA, released the details of two independent reviews related to maternity services at the Canberra Hospital. The first review is the subject of this report and the second is an investigation into allegations of bullying and harassment which is to be carried out under the *Public Interests Disclosure Act 1994.*

The current reviews were triggered by allegations in the local media and ABC News by several Canberra obstetricians (who do not currently work at the Canberra Hospital) of sub-standard

patient care in the maternity unit, the apparent resignation of nine doctors from the department in 13 months, ongoing tension between doctors and midwives, claims of bullying and harassment in the Department and several patient complaints.

3.4 WHY NOW?

The review team was unable to identify a specific trigger for the media comments in February 2010. A number of factors appeared to compound the disquiet of VMOs working outside the Canberra Hospital and triggered their writing to the Minister and engagement with the media. These factors include:

- The resignation of two staff specialists in late 2009. Both of these clinicians were disgruntled with management and made their views known amongst the Canberra Hospital staff and other VMOs.
- The placement of advertisements for staff specialists in September and then for VMOs in November 2009 raised discussion amongst potential applicants about the positions. This raised awareness amongst clinicians of the perceived problems in the maternity service at the Canberra Hospital.
- The recently-announced changes to the safety net provisions which are anticipated by some to reduce demand for private obstetric services, encouraging private obstetricians to seek public appointments.
- The moves by ACT Health to purchase the Calvary Hospital which raises the spectre of a takeover of Territory obstetric services by the Canberra Hospital and concerns that the existing management would become the default clinical leaders of a Territory-wide service.
- The development of the new Women's and Children's facility at the Canberra Hospital which has raised the potential that the Canberra Hospital could absorb a greater portion of public births, making the Calvary public obstetric service less viable.

3.5 STATE OF THE MATERNITY UNIT

At the time of the review, several key staff were on leave and the Clinical Director had temporarily stood down. There was a general feeling of tension amongst all levels of management.

Midwifery and medical staff of the maternity and neonatal services reported concerns that the public had lost confidence in the maternity service and indicated that some patients were showing apprehension about having to receive care at the hospital.

All the medical staff and midwives interviewed indicated that they have a positive working relationship, except those staff who find it difficult to work with a particular clinician.

The recent departure of several key senior staff specialists has had a significant impact on staff. Many clearly linked the departures to interpersonal conflict within the Department

4 REVIEW FINDINGS

4.1 CLINICAL OUTCOMES

- An assessment of mortality, morbidity and other clinical outcomes. In assessing these outcomes, the reviewers will be expected to examine relevant benchmarking data, performance indicators and other appropriate data and research;

The review Terms of Reference required a benchmarked "... assessment of mortality, morbidity and other clinical outcomes" of the public maternity services in the ACT. Whilst a number of individual cases were referred to the review team, benchmarking of individual case outcomes was not possible. Therefore, only available, benchmarked measures of care outcomes were considered.

4.2 PERINATAL DEATHS

All perinatal deaths in the Australian Capital Territory are reviewed by the ACT Perinatal Mortality Committee.

In the most recently published National Perinatal Data Collection (2007), there were 3,024 reported perinatal deaths in Australia[1] from 294,205 births, resulting in a perinatal death rate of 10.3 deaths per 1,000 births.

In the Australian Capital Territory there were 64 perinatal deaths from 5,535 births in 2007, resulting in a perinatal mortality rate of 11.6 per 1,000 births. When this rate is compared with the rest of Australia (2,960 perinatal deaths in 288,670 births) the difference is not statistically significant (Odds Ratio 1.13; 95% Confidence Limits 0.88, 1.45).

The Canberra Hospital is a tertiary teaching hospital, so the ACT data were biased by the significant number of high risk women and babies referred from outside the Territory for high acuity care. The report notes that "For the Australian Capital Territory, where 16.1% of women who gave birth were non-residents, the crude rate of perinatal mortality changed from 11.6 per 1,000 births by territory of birth to 10.0 per 1,000 births by territory of mother's usual residence". These figures are, also, not statistically significantly different to the rest of Australia (Odds Ratio 0.98; 95% Confidence Limits 0.74, 1.32).

Similar trends (ie non-significant differences between the babies of Australian Capital Territory resident mothers and the rest of Australia) were seen in 2004[2], 2005[3] and 2006[4] according to AIHW National Perinatal Statistics Unit reports (Table 1).

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[1] Laws P & Sullivan EA 2009. Australia's mothers and babies 2007. Perinatal statistics series no. 23. Cat. no. PER 48. Sydney: AIHW National Perinatal Statistics Unit.

[2] Laws PJ, Grayson N & Sullivan EA 2006. Australia's mothers and babies 2004. Perinatal statistics series no. 18. AIHW cat. no. PER 34. Sydney: AIHW National Perinatal Statistics Unit.

[3] Laws PJ, Abeywardana S, Walker J & Sullivan EA 2007. Australia's mothers and babies 2005. Perinatal statistics series no. 20. Cat. no. PER 40. Sydney: AIHW National Perinatal Statistics Unit.

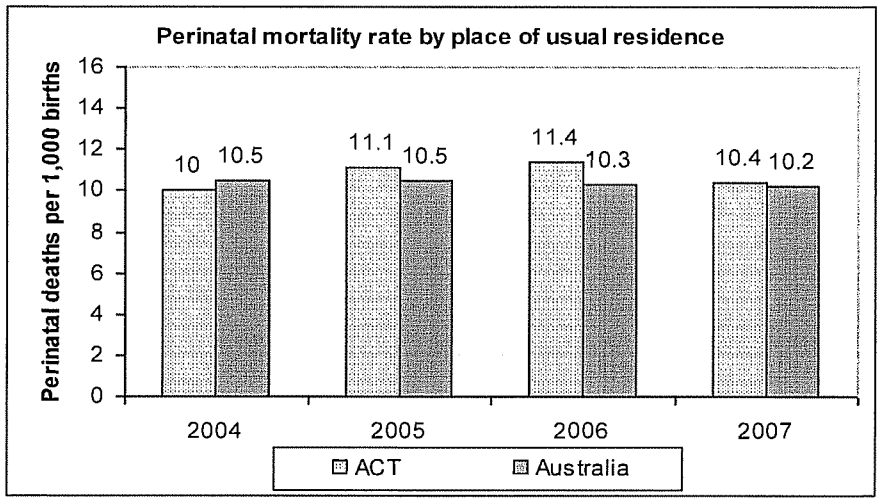

Table 1. Comparison of perinatal mortality rates Australian Capital Territory and Australia, by place of usual residence of mother.

4.3 OUTCOMES AT INDIVIDUAL PUBLIC MATERNITY SERVICES

Outcomes at both the Canberra Hospital and Calvary Public Hospital public maternity units are benchmarked under two external programs; the Australian Council on Healthcare Standards (ACHS) Comparative Clinical Indicator program and the Women's Hospitals of Australasia (WHA) program. Each public maternity service also has an internal audit system which includes the investigation of adverse outcomes.

4.3.1 THE CANBERRA HOSPITAL

The most recent recorded, reported and benchmarked obstetric indicator set available to the review team was the ACHS indicator set from the first half of 2009[5]. This shows the majority of clinical indicators statistically similar to peer hospitals (Table 2).

	ACHS Indicator	The Canberra Hospital (%)	ACHS Peer Benchmark (%)	Statistical comparison *	Desirable outcome
1.1	Selected primipara who have a spontaneous vaginal birth	54.51	49.48	≈	High
1.2	Selected primipara who undergo induction of labour	22.74	28.92	≈	Low
1.3	Selected primipara who undergo an instrumental vaginal birth	19.13	23.68	≈	Low
1.4	Selected primipara undergoing caesarean section	14.08	22.25	↓	Low
2.1	Women delivering vaginally following a previous primary caesarean section	31.76	18.52	↑	Unspecified

[4] Laws PJ & Hilder L 2008. Australia's mothers and babies 2006. Perinatal statistics series no. 22. Cat. no. PER 46. Sydney: AIHW National Perinatal Statistics Unit.

[5] Australian Council of Healthcare Standards clinical indicator report for The Canberra Hospital Part 1 2009

3.1	Selected primipara with an intact perineum	25.21	11.14	↑	High
3.2	Selected primipara undergoing episiotomy and no perineal tear giving birth vaginally	4.62	23.68	↓	Low
3.3	Selected primipara sustaining a perineal tear and no episiotomy	69.33	51.92	↓	Low
3.4	Selected primipara undergoing an episiotomy and sustaining a perineal tear while giving birth vaginally	0	9.54	↓	Low
3.5	Selected primipara undergoing surgical repair of the perineum for third degree tear	4.20	6.26	≈	Low
3.6	Selected primipara undergoing surgical repair of the perineum for fourth degree tear	1.68	0.42	≈	Low
4.1	Women having a general anaesthetic for a caesarean section	10.71	8.38	≈	Low
5.1	Women who receive an appropriate prophylactic antibiotic at the time of caesarean section	94.44	79.23	↑	High
6.1	High risk women undergoing caesarean section who receive appropriate pharmacological thromboprophylaxis	91.53	56.67	↑	High
7.1	Women who give birth vaginally who require a blood transfusion during the same admission	1.85	1.75	≈	Low
7.2	Women who undergo caesarean section who require a blood transfusion during the same admission	2.78	2.71	≈	Low
8.1	Deliveries with birth weight less than 2750g at 40 weeks gestation or beyond	2.07	1.79	≈	Low
9.1	Term babies born with an Apgar score less than 7 at five minutes post delivery	1.55	1.55	≈	Low

Table 2. ACHS obstetric clinical indicators – the Canberra Hospital.

* Statistical comparison: ↑ Above the aggregate rate of peer organisations
≈ Statistically similar to the aggregate rate of peer organisations
↓ Below the aggregate rate of peer organisations

Also available to the reviewers was the 2007-2008 WHA indicator set[6], with the comparison hospitals being other "level 3" maternity services which have a neonatal intensive care unit. Again, the majority of clinical indicators were statistically similar to the aggregate rate of peer organisations (Table 3).

WHA Indicator	The Canberra Hospital (%)	WHA aggregate of comparable hospitals (%)	Statistical comparison*	Desirable outcome
Live term singletons	87.6	88.8	≈	High
Induction of labour in selected primiparas	18.2	27.3	↓	Low
Spontaneous unassisted vaginal birth in selected primiparas	49.6	52.6	≈	High
Women giving birth by caesarean section	22.4	28.0	↓	Low
Caesarean section in selected primiparas	14.7	22.5	↓	Low
Women with only one prior baby by caesarean section	6.0	8.54	↓	Low
Vaginal birth after a caesarean section	31.4	23.8	≈	High
Vaginal birth after caesarean: repeat section without labour	54.6	56.2	≈	High
VBAC: Vaginal births in women who attempted labour	51.9	61.6	≈	High
All uterine ruptures	0.043	0.037	≈	Low
Rupture of uterus attempting a vaginal birth after one caesarean section	0	0.21	↓	Low
Peripartum hysterectomy during admission for childbirth	0.043	0.10	≈	Low
Assistance with forceps only	7.3	5.36	↑	Low

[6] Women's Hospitals of Australasia clinical indicator report for The Canberra Hospital 2007-2008

Assistance with the vacuum extraction only	5.8	9.01	↓	Low
Assistance with both vacuum extraction and forceps	0.82	0.84	≈	Low
Use of a regional anaesthetic for a vaginal birth	21.3	28.0	↓	Opinion varies
Use of a general anaesthetic for a caesarean section	13.3	9.05	↑	Low
Episiotomy	5.3	18.0	↓	Low
Episiotomy in primiparous women birthing vaginally	10.1	30.5	↓	Low
Primipara birthing vaginally without surgical repair	25.2	30.8	≈	High
Third and fourth degree tears for all of vaginal births	3.1	2.81	≈	Low
Third and fourth degree tears in primiparas birthing vaginally	6.6	5.17	≈	Low
Post partum haemorrhage, 1000 – 1500ml, after a vaginal birth	2.3	1.94	≈	Low
Post partum haemorrhage, > 1500ml, after a vaginal birth	1.8	1.39	≈	Low
Post partum haemorrhage, 500 – 1500ml, after a caesarean section	17.9	50.2	↓	Low
Post partum haemorrhage, > 1500ml, after a caesarean section	2.9	2.81	≈	Low
Maternal blood transfusion after any birth	2.4	1.68	≈	Low
Maternal admission to an intensive care unit	0.3	0.21	≈	Low
Babies born before 32 completed weeks of gestation	4.0	3.51	≈	Low
Babies born before 37 completed weeks of gestation	12.7	12.1	≈	Low
Stillbirths	1.22	0.89	≈	Low
Intra-partum stillbirths	0	0.045	↓	Low
Neonatal deaths within 7 days of birth	0.64	0.33	≈	Low
Neonatal deaths within 28 days of birth	0.81	0.42	↑	Low
Perinatal deaths	2.0	1.31	↑	Low
Apgar score of 6 or less at 5 minutes	1.6	1.18	≈	Low
Apgar score of 4 or less at 5 minutes	0.49	0.33	≈	Low
Hypoxic ischaemic encephalopathy	0.21	0.11	≈	Low

Table 3. WHA obstetric clinical indicators –the Canberra Hospital compared with other WHA hospitals with Level 3 NICU

* Statistical comparison: ↑ Above the aggregate rate of peer organisations
≈ Statistically similar to the aggregate rate of peer organisations
↓ Below the aggregate rate of peer organizations

4.3.2 CALVARY PUBLIC HOSPITAL

In the 2009 calendar year there were 1303 public births at Calvary Public Hospital, compared with 1301 in 2007.

The most recent recorded, reported and benchmarked obstetric indicator set available to the review team was also the ACHS indicator set from the first half of 2009[7], which shows all clinical indicators statistically similar to peer hospitals (Table 4). A broader indicator set has been collected since the second half of 2009, though this data has not yet been benchmarked.

	ACHS Indicator	Calvary Public Hospital (%)	ACHS national aggregate (%)	Statistical comparison*	Desirable outcome
1.1	Selected primipara who have a spontaneous vaginal birth	64.84	45.20	≈	High
1.2	Selected primipara who undergo induction of labour	17.58	28.67	≈	Low
1.3	Selected primipara who undergo an	19.78	23.91	≈	Low

[7] Australian Council of Healthcare Standards clinical indicator report for Calvary Health Care ACT Part 1 2009

	instrumental vaginal birth				
1.4	Selected primipara undergoing caesarean section	15.38	27.25	≈	Low
3.1	Selected primipara with an intact perineum	22.73	17.53	≈	High
3.2	Selected primipara undergoing episiotomy and no perineal tear giving birth vaginally	16.88	26.14	≈	Low
3.3	Selected primipara sustaining a perineal tear and no episiotomy	51.95	45.60	≈	Low
3.4	Selected primipara undergoing an episiotomy and sustaining a perineal tear while giving birth vaginally	3.25	6.48	≈	Low
3.5	Selected primipara undergoing surgical repair of the perineum for third degree tear	6.49	4.11	≈	Low
3.6	Selected primipara undergoing surgical repair of the perineum for fourth degree tear	1.34	0.32	≈	Low
4.1	Caesarean section under general anaesthesia	12.67	Not specified		Low

Table 4. ACHS obstetric clinical indicators –Calvary Public Hospital.

* Statistical comparison: ↑ Above the aggregate rate of peer organisations
≈ Statistically similar to the aggregate rate of peer organisations
↓ Below the aggregate rate of peer organisations

Also available to the reviewers was the 2007-2008 WHA indicator set[8], with the comparison hospitals being other maternity services which did not have a "level 3" neonatal intensive care unit. Again, the majority of clinical indicators were statistically similar to the aggregate rate of peer hospitals (Table 5).

WHA Indicator	Calvary Public Hospital (%)	WHA aggregate of comparable hospitals (%)	Statistical comparison*	Desirable outcome
Live term singletons	95.1	93.2	≈	High
Induction of labour in selected primiparas	18.7	25.5	≈	Low
Spontaneous unassisted vaginal birth in selected primiparas	65.5	54.1	↑	High
Women giving birth by caesarean section	24.4	27.0	≈	Low
Caesarean section in selected primiparas	23.1	26.0	≈	Low
Women with only one prior baby by caesarean section	6.9	8.7	≈	Low
Vaginal birth after a caesarean section	12.8	16.9	≈	High
Vaginal birth after caesarean: repeat section without labour	66.3	66.1	≈	High
VBAC: Vaginal births in women who attempted labour	37.9	49.7	≈	High
All uterine ruptures	0	0.04	≈	Low
Rupture of uterus attempting a vaginal birth after one caesarean section	0	0	≈	Low
Peripartum hysterectomy during admission for childbirth	0	0.02	≈	Low
Assistance with forceps only	6.1	3.2	≈	Low
Assistance with the vacuum extraction only	8.3	8.9	≈	Low
Assistance with both vacuum extraction and forceps	0.3	0.6	≈	Low
Use of a regional anaesthetic for a vaginal birth	43	21.7	↑	Opinion varies
Use of a general anaesthetic for a caesarean section	12.8	9.7	≈	Low
Episiotomy	9.7	10.6	↓	Low
Episiotomy in primiparous women birthing vaginally	12	19.8	↓	Low
Primiparas birthing vaginally without surgical repair	16.4	24.6	↓	High
Third and fourth degree tears for all of vaginal births	3.1	2.7	≈	Low

[8] Women's Hospitals of Australasia clinical indicator report for Calvary Health Care ACT 2007-2008

Third and fourth degree tears in primiparas birthing vaginally	3.9	4.9	≈	Low
Post partum haemorrhage, 1000 – 1500ml, after a vaginal birth	3.3	4.5	≈	Low
Post partum haemorrhage, > 1500ml, after a vaginal birth	2.4	1.5	≈	Low
Post partum haemorrhage, 500 – 1500ml, after a caesarean section	10.1	20.7	↓	Low
Post partum haemorrhage, > 1500ml, after a caesarean section	1	0.56	≈	Low
Maternal blood transfusion after any birth	1	1.2	≈	Low
Maternal admission to an intensive care unit	0.16	0.15	≈	Low
Babies born before 32 completed weeks of gestation	0.2	0.85	↓	Low
Babies born before 37 completed weeks of gestation	3.7	7.3	↓	Low
Stillbirths	0.32	0.57	≈	Low
Intra-partum stillbirths	0.08	0.03	≈	Low
Apgar score of 6 or less at 5 minutes	0.7	0.8	≈	Low
Apgar score of 4 or less at 5 minutes	0.5	0.2	≈	Low

Table 5. ACHS obstetric clinical indicators –Calvary Public Hospital compared with other WHA hospitals without Level 3 NICU

* Statistical comparison:
↑ Above the aggregate rate of peer organisations
≈ Statistically similar to the aggregate rate of peer organisations
↓ Below the aggregate rate of peer organisations

4.4 SUMMARY

The benchmarked data provide evidence that the quality of the clinical outcomes at both public maternity services in the ACT is consistent with comparable hospitals in Australia and New Zealand.

4.5 RECOMMENDATION

1. In order to address the apparent culture of recurrent anecdotal criticism of the standards of maternity care provided in the Australian Capital Territory, ACT Health should ensure the timely production of an annual comprehensive report of the outcomes from the maternity and newborn services as occurs in a number of other services in Australasia.
    - Ideally, such a report should include all maternity and neonatal care outcomes across ACT maternity services – both private and public.
    - The release of each annual report should be subject to external expert review.
    - Assembling such a report would not be possible within the current service workloads and additional staff support will be required to achieve this recommendation.

5 CONSUMER SATISFACTION AND RISK MANAGEMENT

- An assessment of consumer satisfaction and patient experience, including an assessment of complaints and compliments, RISKMAN data, recommendations from clinical review committees and other consumer related feedback mechanisms.

5.1 CONSUMER SATISFACTION

In addition to examining the data provided by the Canberra Hospital, the review team conducted a number of interviews with a range of interest groups and consumer representative organisations. The international evidence outlining the limitations of consumer satisfaction surveys is acknowledged[9,10]. However, ongoing and focused consumer reviews may provide a useful barometer of overall satisfaction with the maternity service and assist in identifying important areas for improvement in service provision.

The review panel felt unable to adequately assess consumer satisfaction within ACT maternity services as no systematic process for data collection was apparent. In addition, processes for gathering consumer feedback were observed to be passive rather than active. Factors affecting consumer satisfaction with maternity services are clearly outlined in Section 5 of *Primary Maternity Services in Australia*[11] and may provide a useful framework to guide the collection of future satisfaction data within the ACT.

5.2 COMPLAINTS AND COMPLIMENTS

All comments, complaints and compliments received by the Canberra Hospital maternity service are entered into the RISKMAN database and assigned a priority for action.

During the 12 months to the end of March 2010, 44 complaints relating to the obstetric service were recorded. Nine of these are rated Priority 1. During this time 127 compliments which relate to the obstetric service were also recorded.

It is not possible to determine if these volumes are higher or lower than could be expected.

The review panel was not provided with the actions or outcomes which followed from these complaints, however, it is understood that all entries into the RISKMAN system are systematically addressed and reported to the Clinical Governance Committee.

Despite the limitations in data collection, the Canberra Hospital staff and consumers interviewed identified the following key items;

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[9] Brown S & Lumley J, 1997 The 1993 Survey of Recent Mothers: issues in survey design, analysis and influencing policy, Int J Qual Health Care. 1997 Aug;9(4):265-75.

[10] Reeves R & Seccombe I, 2008, Do patient surveys work? The influence of a national survey programme on local quality improvement initiatives, Qual Saf Health Care, 2008;17:437-441 doi:10.1136/qshc.2007.022749

[11] Australian Health Ministers' Advisory Council, 2008, Primary Maternity Services in Australia – A Framework for Implementation, www.ahmac.gov.au, pp 11-12.

- Consumer satisfaction with the caseload model of care offered to women in the Birth Centre was consistently high.
- The caseload program at the Canberra Hospital is oversubscribed, with a number of women expressing significant frustration at a lack of access to this model of care. In particular, women from the Tuggeranong region of the ACT cannot access the model and are only able to receive midwifery continuity through a team midwifery model. Staff are hopeful that access will improve with the increased Birth Centre capacity planned in the new facility.
- Midwifery managers at the Canberra Hospital reported that a proposal for a model to increase access to continuity of midwifery care for higher risk women had been developed but was unable to be implemented as the work had not been included in budget forecasting to date. Such a model has the potential to significantly affect health outcomes for women as well as increasing satisfaction. In addition, such a model would support safer staffing levels in the Delivery Suite when higher risk women present for labour and birthing care.
- Except in the case of the Birth Centre, where an active consumer group (Friends of TCH Birth Centre) exists, there appears to be very little direct consumer involvement in the organisation, planning or monitoring of activities and outcomes within the maternity service.
- There was a high level of dissatisfaction with access to public antenatal clinics at the Canberra Hospital. Waiting times at the Antenatal Clinic were also identified by women as unacceptable and problematic.
- The current lack of VMO appointments at the Canberra Hospital means that women under the care of a private obstetrician who require transfer to the Canberra Hospital are almost always unable to maintain continuity of care. The reviewers were made aware of a number of women who expressed frustration with this situation. This was identified as one reason why women chose to birth in the two private maternity units within the ACT.

5.3 RISK MANAGEMENT AND CLINICAL AUDIT PROCESSES

ACT Health should have a Territory wide Clinical Risk Management Programme for maternity services such as those in other jurisdictions around Australia. Despite their separate programmes both the Canberra Hospital and Calvary Public Hospital appear to have adequate risk management and clinical audit processes in place for their maternity services.

For the Canberra Hospital, these include:

- Written policies outlining inclusion criteria for women allocated to shared antenatal care and the low risk Birth Centre models.
- Guidelines for appropriate and timely consultation and referral of women who fall outside accepted parameters for low risk care.
- Risk management and safety assessments for women on the early discharge programme 'Midcall'.
- Weekly birth review meetings. These meetings involve the review of all births in both the labour and delivery suite and the Birth Centre. Registrars and midwives are invited to present complex cases which are open to discussion and learning points are identified. While most staff indicated that this meeting is a vehicle to improve the quality of care provided by the maternity service, it was frequently described as problematic due to the behaviour of a senior clinician.
- Monthly Mortality and Morbidity meetings operate under Clinical Privilege. Any significant clinical incident is referred to the Clinical Review Committee. A number of staff indicated

that the more formal structure of this meeting was appreciated as it provided fewer opportunities for disruptive behaviour .

- Clinical Review Committee. This committee oversees the clinical review process and ensures all recommendations are brought to the Clinical Governance Committee. There are an agreed set of flags for obstetric and neonatal adverse event reporting.
- The perinatal services operate their own mortality and morbidity review and report separately to the Clinical Review Committee.

At Calvary Public Hospital, similar processes are in place including:

- Weekly Birth Suite case review sessions
- Regular multidisciplinary Maternal, Perinatal and Gynaecological Clinical Review Committees that are also attended by the Director of Fetal Medicine from the Canberra Hospital.
- A Clinical Review Committee
- A specialty multidisciplinary Patient Safety Committee for Women's and Children's services.
- Maintenance of a Maternity Services Risk Register that is reviewed by the hospital's executive team every 3 months.

Both the Canberra Hospital and Calvary Public Hospital participate in national benchmarking initiatives with Women's Hospitals Australasia (WHA), are accredited by the Australian Council on Healthcare Standards (ACHS), are accredited with the Baby Friendly Hospital Initiative (BFHI) and report to ACT Health.

Staff at the Canberra Hospital report that a number of clinical policies have not been updated due to current staff workloads. Both the Canberra Hospital and Calvary Public Hospital indicated an interest in standardising maternity care policies. This is discussed later in the report under Obstetric Service Configuration.

Territory-wide maternity care policies would add rigor to risk management processes and support the standardisation of managing and measuring risk associated with important co-morbidities, for example:

- The care of bariatric women utilising maternity services
- Appropriate antenatal and postnatal mental health screening and referral
- Smoking in pregnancy
- Identification of women with risk factors for obstetric complications such as post partum haemorrhage
- Initiation and maintenance of Breast Feeding rates.

It would be useful for ACT Health to consider implementing a defined Clinical Risk Management Programme for all public maternity services in the ACT. Given the geographical placement of the ACT and the requirement for ACT Health to provide tertiary referral maternity services to a large part of NSW, it would seem useful to adapt the NSW Health[12] program to enable consistency in data collection and comparison between the regions.

[12] NSW Health, 2009, PD2009_003 Maternity Clinical Risk Management Program.

5.4 ADVERSE EVENTS, UNEXPECTED OUTCOMES, RISKS AND HAZARDS

Both the Canberra Hospital and Calvary Public Hospital capture adverse events, unexpected outcomes, near misses, risks and hazards on an electronic database known as RISKMAN for ongoing monitoring and review.

The list of incidents requiring mandatory notification within maternity services at both hospitals could be expanded to support a more comprehensive risk management programme. A list of triggers and incidents requiring notification on a similar database in NSW may be useful in informing this process[13].

Staff at Calvary Hospital report outcome data on two separate RISKMAN databases – one for ACT Health and another for the Little Company of Mary Health Care, who retain a level of governance over the Hospital. The considerable workload generated by this duplicate reporting may be a disincentive for busy clinicians to report adverse outcomes and/or near misses.

5.5 SUMMARY

Consumer participation in the organisation, planning and monitoring of activities and outcomes at the Canberra Hospital maternity service is inadequate

Consistent, planned measures of consumer satisfaction could be improved.

Access to continuity of midwifery care is limited; however, those women who are able to access the Birth Centre express high levels of satisfaction with that model of care.

There is no ACT Health policy guiding standardised clinical risk management in maternity services across both public maternity services in the ACT

The list of clinical incidents requiring mandated reporting via RISKMAN has not been fully developed

The case review mechanisms in place at both the Canberra Hospital and Calvary Public Hospital maternity services appear adequate and, for the most part, function appropriately.

5.6 RECOMMENDATIONS

2. ACT Health should ensure meaningful inclusion and representation of consumers within the governance framework of maternity services.
3. ACT Health should undertake regular active maternity consumer satisfaction surveys which identify satisfaction at the individual clinical service level and are focused on known factors associated with both short and long term satisfaction.
4. ACT Health should consider implementing further caseload models, including access to midwifery-led models for women who fall outside the current "low risk" parameters.
5. ACT Health should implement a defined Clinical Risk Management Programme for all public maternity services in the ACT.
6. The list of incidents requiring mandatory notification within maternity services at both hospitals could be expanded.

[13] NSW Health, 2009, PD2009_003 Maternity Clinical Risk Management Program, p.11.

6 CLINICAL GOVERNANCE

- An assessment of the clinical governance of the Unit, including examination of relevant policies and protocols, clinical audit processes and other quality improvement activities;

6.1 APPOINTMENTS AND CREDENTIALING

The recruitment, credentialing and appointments function for medical staff at the Canberra Hospital has been delegated to the Medical Appointments and Training Unit (MATU) of ACT Health. This has created a perceived confusion amongst medical staff around who has responsibility for professional issues at the Canberra Hospital - a primary role of the Deputy General Manager (Medical). The Deputy General Manager (Medical) indicated that she had recently taken up some responsibilities within the MATU, which may have further increased this confusion.

With recent change in leadership of the MATU, the recruitment functions were reported to have been delegated to the Human Resource Management Branch (HR) of ACT Health. Again, this seems to have created some confusion over responsibilities.

The Calvary Hospital has a more traditional appointments and credentialing structure which is overseen by the Director of Medical Services.

6.2 RE-CREDENTIALING

The Clinical Governance Unit's Medical and Dental Appointments Policy (2006) notes that routine re-credentialing and review of clinical privileges for all medical specialists occurs at three yearly intervals. These reviews only take into account: records of training and experience gained since last review, registration status (including any conditions) and any disciplinary action taken or recommended by the health profession board.

The only grounds for an extra-ordinary review of clinical privileges are when there are indications that a clinician is medically impaired and/or where their clinical competence is questioned.

The clinical line manager has become involved in the process over the past year. A number of medical staff were unaware of the details or value of the re-credentialing process.

The re-credentialing process does not currently determine the medical staff member's individual scopes of practice or competence within the constraints of the local service or available resources. There is also no apparent attempt to explore any behavioural or attitudinal concerns as a part of re-credentialing.

6.3 MEDICAL STAFF PERFORMANCE APPRAISAL

An elementary performance appraisal process for medical staff was introduced in the Canberra Hospital around 12 months ago. The stated emphasis of the first round of performance appraisal was on establishing a process, rather than focusing on the content of the individual's appraisal. Areas of concern in staff behaviour were not highlighted in the performance appraisal.

The intent to repeat the process every six months has not been implemented.

6.4 EXIT INTERVIEWS

There appears to be no formal process of exit interviews for clinical staff or registrars who leave the Canberra Hospital. While some departing staff have been interviewed by the DGM (Medical), this did not appear to be a consistent process. Where an exit interview was undertaken, there was no apparent structure to the session and former staff who were interviewed found the outcome of the interview was unsatisfactory.

6.5 NON-REPLACEMENT OF DGM (MEDICAL)

Several staff noted that the DGM (Medical) was absent for around four months in the preceding year. There was no apparent replacement of her role during this time. This left a vacuum in medical staff support and devalued the role.

There appeared to be times when the DGM (Medical) was unavailable for support or discussion on professional medical issues.

6.6 TEAM PERFORMANCE

There appeared to be no process to assess the performance of the Maternity Unit as a team. Midwifery staff did not appear to be involved in the performance appraisal of medical staff. Many indicated that they did not feel they had the opportunity to put forward ideas on how the operation of the unit could be improved.

6.7 RETICENCE TO ADDRESS BEHAVIOURAL ISSUES

The review panel identified an apparent systematic and long-standing reticence by management to address disruptive or inappropriate behaviour by certain medical staff.

Many staff interviewed, including staff specialists, VMOs, registrars and midwives were unsure who was responsible for the performance management of medical staff with disruptive behaviour.

Most staff interviewed indicated that they had tried to raise issues about clinician behaviour with various managers, but had not been able to effect change. Some issues, such as the consistent failure to provide sufficient notice of intended leave (so as to not disrupt service, especially clinics) materially affect the efficient operation of the unit.

Both medical and midwifery staff reported that they had discussed their concerns about disruptive behaviour within the unit with their line manager and with various executive team members; however they did not believe these issues were addressed. Several staff reported that they had been asked to put their concerns in writing and understood that unless the issue was put in writing no action could be taken. These staff indicated considerable reticence to become directly involved in a formal disciplinary process, particularly when this involved a senior clinician with whom they work on a daily basis. Those who indicated that they had written to the responsible manager felt their complaints had not been followed through. Many of the staff appeared to demonstrate a culture of learned helplessness.

Management team members who were interviewed confirmed a belief that they could not investigate a complaint unless it was in writing. They acknowledged that they had received

complaints about inappropriate behaviour by a senior clinician over a number of years. They reported that these concerns often appeared to be raised as an after-thought and so were not seen as critical or urgent.

6.8 VOICE OF MEDICAL STAFF

There is no Medical Staff Council at the Canberra Hospital. While there is a Clinical Board, many clinicians were unsure of its role and function.

6.9 SUMMARY

The clinical governance at the Canberra Hospital maternity unit appears to be inadequate.

The re-credentialing process of clinical staff at the Canberra Hospital maternity unit does not appear to be robust.

There is evidence of a systematic reticence to address staff performance issues in the maternity unit at the Canberra Hospital, particularly issues of inappropriate behaviour by certain medical staff.

6.10 RECOMMENDATIONS:

7. Re-credentialing should become a regular formal process of maternity clinical and team performance evaluation involving 360 feedback and personal development plans
8. "Credentialing" of the maternity service should become a regular periodic process facilitated by a respected independent expert working closely with the Clinical Director
9. Regular formal evaluation, involving all maternity staff, should be undertaken to identify opportunity for improvement and innovation
10. Procedures need to be implemented to ensure clinicians who display disruptive or inappropriate behaviour are informed that their behaviour is inappropriate and will not be tolerated, with immediate steps taken to ensure the cessation of such behaviour.

7 STAFF ROLES AND RESPONSIBILITIES

- An examination of staff roles and responsibilities and an assessment of whether the roles and responsibilities are appropriate to staff professional roles, skills and experience;

7.1 LACK OF COHESION IN THE MANAGEMENT TEAM

There was an apparent lack of cohesion amongst the executive team at the Canberra Hospital. Since June 2009, when the current General Manager took up her role, key members of the executive team have been away for extended periods. This has effectively meant that the executive team has only been functioning together since November 2009. A number of new appointments have occurred within the management team over recent months with some of the team still identifying, learning and adapting to their roles.

There appeared to be considerable confusion over the role delineation of some senior management positions in relation to the overall function and operation of the Canberra Hospital. While members of the executive team who were interviewed acknowledged the weekly management meetings, several thought the monthly meetings with the wider Executive Directors group was the more important meeting.

Although finance is now represented at the weekly management meetings, other services such as HR, building, infrastructure, and IT are not represented. This was reported as limiting the management team's decision making ability.

Reporting lines are perceived as blurred between the Canberra Hospital management and ACT Health. It appears that the chain of command often fails with Executive Directors and Deputy General Managers having direct access to ACT Health senior executives.

The Canberra Hospital Executive Directors have apparent peers (eg ED – Aged Care) who report directly to the Deputy Chief Executive of ACT Health. This is seen as creating inequalities in reporting lines.

The Canberra Hospital General Manager and executive team perceive that they have little strategic responsibility or flexibility to re-allocate expenditure within their allocated budget. Budgets appear controlled by a client service manager from the Financial Management Unit who reports to the Chief Financial Officer of ACT Health.

Clinical managers interviewed appear to have little engagement in the budget process such as the submission of business cases for new initiatives or the ability to re-organise service delivery within allocated budgets.

While there is a recognised code of conduct, there appears to be a lack of clarity around who has responsibility for ensuring the code is policed and behaviour management plans developed.

There is a lack of understanding by staff at all levels within the Canberra Hospital as to how a complaint should be made and to whom it should be addressed.

7.2 ROLE OF THE EXECUTIVE DIRECTOR – AMBULATORY, MEDICAL AND WOMEN'S AND CHILDREN'S

The span of control of the ED (AMW&C) at the Canberra Hospital is extremely large with direct accountability for operating expenditure of $110 million and 756 staff. She is also responsible for advancing the current capital development program within Women's and Children's Health.

The recently completed Job Description Questionnaire indicates that the role provides advice to the GM of the Canberra Hospital, the DCE and CE Operations of ACT Health and to the Health Minister. This person sits on range of committees that oversee both the hospital function and also that of ACT Health. This ambiguity of line responsibility appears to detract from the core role as an executive of the Canberra Hospital.

This role's extensive span of control is apparent in the frustration expressed by a range of staff in getting focus on routine and minor items such as the delays in considering and approving non-budgeted expenditure or in gaining approval to advertise a vacancy.

7.3 ROLE OF DEPUTY GENERAL MANAGER – MEDICAL

The role of the DGM (Medical) at the Canberra Hospital appears unclear in relation to medical staff performance, particularly where there are performance issues arising from non-clinical practice such as inappropriate and disruptive behaviour.

The current position description (2007) for DGM (Medical) indicates that the role has "particular responsibility for the management of Medical Services Directors, Senior Specialists, Registrars and Junior Medical Officers." Other documents indicate that these Clinical Directors report to the ED (AMW&C).

7.4 ROLE OF DEPUTY GENERAL MANAGER - NURSING AND MIDWIFERY

The role of the DGM (Nursing and Midwifery) at the Canberra Hospital seems unclear.

The organisational chart for the Canberra Hospital indicates a line responsibility for nursing and midwifery professional practice, but this role was not consistently recognised. There was also ambiguity as to the position's responsibility for hospital accreditation and quality and safety.

7.5 ROLE OF CLINICAL DIRECTOR OF OBSTETRICS AND GYNAECOLOGY

The role of Clinical Director of Obstetrics and Gynaecology within the Canberra Hospital does not appear to be clearly articulated.

The reviewers recommend that functions currently undertaken by the Clinical Director of Obstetrics and Gynaecology be delegated to capable staff specialists. Suitable functions for delegation include:

- Clinical oversight of the Labour and Delivery unit (a potential Deputy Clinical Director role)
- Supervision and rostering of the registrar training positions
- Audit and risk management

7.6 ROLES AND RESPONSIBILITIES OF ON CALL MEDICAL STAFF

It was noted with concern that the on-call medical staff at the Canberra Hospital – both registrars and consultants, are required to cover the Labour and Delivery unit as well as providing support for gynaecology triage, the Birth Centre and other clinics or theatre lists.

The on-call registrar can be a first year trainee. There are no house staff to assist the registrar with initial work-up, routine investigations or minor procedures.

In a unit handling this volume and acuity of births, this range of responsibility with possible unavailability of senior support has the potential to create significant clinical safety issues.

7.7 SUMMARY

The Canberra Hospital management team appears to lack cohesion and a clear understanding of their roles and responsibilities. Formal lines of responsibility appear to be regularly breached.

Reporting lines and accountability at the Canberra Hospital appear confused in relation to ACT Health Executive and hospital management. Members of the management team appeared to have responsibilities at a range of levels within ACT Health.

A number of functions undertaken by the Clinical Director of Obstetrics and Gynaecology at the Canberra Hospital could be delegated to other senior clinicians, reducing both her administrative and clinical work loads.

On-call registrars at the Canberra Hospital are expected to cover the Labour and Delivery unit as well as the Birth Centre, the acute gynaecology presentations and some clinics or operating theatre lists. This creates a potential clinical risk for a patient who requires urgent attention.

7.8 RECOMMENDATIONS

11. The role and delegations of the management team of the Canberra Hospital should be clarified and communicated to staff at all levels
12. Lines of responsibility within the maternity service should be defined and adhered to
13. Senior management positions within the maternity service should be reviewed to ensure the portfolios are manageable
14. The role and responsibilities of the management team need to be clarified and communicated to all staff
15. The Clinical Director of Obstetrics and Gynaecology should formally delegate a number of functions including consideration of the establishment of a Deputy Clinical Director role or a head of the Labour and Delivery unit
16. Registrars at the Canberra Hospital should be dedicated to the Labour and Delivery unit when on-call; gynaecology emergent issues should be the responsibility of an alternative medical staff member
17. Consultants should be dedicated to the Labour and Delivery Unit when on call
18. The teaching and supervision of both midwifery and registrar trainees should be recognised as a specific task with appropriate time and resources allocated to this function.

8 STAFF NUMBERS AND WORKLOADS

- An examination of staff numbers and workloads, and assessment of whether the staffing numbers are sufficient and workloads are appropriate

8.1 INCREASING VOLUMES WITH STATIC STAFF ESTABLISHMENT

Maternity volumes at the Canberra Hospital have increased by 27% over the past 5 years. In the 2009 calendar year, there were 2625 births at the Canberra Hospital, with 1997 of those births occurring in the Labour and Delivery Suite under an obstetric-midwifery partnership model and 628 in the Birth Centre under a continuity of midwifery care model. Five years previously, in 2004, there were 2061 birth, with 1493 occurring in the Labour and Delivery unit and 568 in the Birth Centre. This represents a 34% and a 11% increase, respectively, in the two streams of care.

During this time a number of new services have been added including an early discharge program, a number of community based antenatal clinics, an emergency service for women with problems in early pregnancy, a pelvic floor clinic, an endometriosis service and a gynaecological oncology service.

There has been no apparent commensurate increase in midwifery staff establishment during this period.

The current midwifery staff roster for the delivery suite at the Canberra Hospital (with 2000 births) includes:

Morning	4 midwives including the Team Leader
Evening	4 midwives including the Team Leader
Night	3 midwives including the Team Leader

The CMC (NUM) is in addition to these staff.

A review of similar sized facilities offering similar services has highlighted that there is a need to increase the number of midwives within the Canberra Hospital.

A similar service with 2750 births and the only unit in the state with neonatal and adult intensive cares operates the following weekday rosters:

Morning	6 midwives including the Shift Coordinator
Evening	5 midwives including the Shift Coordinator
Night	5 midwives including the Shift Coordinator

In the above unit, the shift coordinator is not allocated patients but is there to direct and assist all staff with clinical load.

Another non-tertiary regional referral unit with around 2600 births a year, spread over 8 birth suites, rosters 5 midwives on both the morning and evening shifts and 4 on the night shift. The

Midwifery Unit Manager is in addition to these staff and does not usually have a clinical load but may help out in emergencies or at times of unusually high activity.[14]

The trend in increased volume and acuity of maternity patients at the Canberra Hospital has escalated since October 2009 when Calvary imposed a cap on the number of public deliveries they are willing to perform under their fixed price contract with ACT Health. Recent changes to the Safety Net are expected to further encourage women into the public sector, which may increase public births further.

This increasing work load, within a fixed staff establishment, has placed unreasonable pressure on midwifery staff in particular. Staff report serious impacts on safe working conditions as they are unable to take appropriate breaks and have reduced opportunities for training and supervision. This situation has the potential to negatively impact the outcomes for women, and carries a significant risk to the Canberra Hospital in recruiting and retaining a stable midwifery workforce.

8.2 ALLOCATED NON-CLINICAL TIME FOR MANAGEMENT

Some of the maternity management staff at the Canberra Hospital appeared to have little or no allocated non-clinical hours, particularly those in the labour and delivery area with some carrying a full clinical load. This compromises the availability and quality of supervision for trainees and less experienced midwifery staff. Guidance around the potential role and principles underlying appropriate staffing for Labour and Delivery settings is available in *SAFER CHILDBIRTH: Minimum Standards for the Organisation and Delivery of Care in Labour*[15].

Managers reported regularly working 10 hour days to accomplish their roles within the current staff establishment.

Although the Clinical Director reported giving up two sessions of clinical work when assuming the role, these two sessions for non-clinical work appear to have been absorbed by clinical work. The Clinical Director understood that there would be administrative support for the role. This support has apparently not been made available.

A previous Clinical Director indicated that he had resigned from the role when he lost his PA and she was not replaced, leaving him to do all the paperwork himself. Secretarial staff are apparently pooled and there is a feeling that they are poorly qualified, lack an understanding of the maternity service and are inhibited in their capacity to support busy clinicians by restrictions on their access to some IT and information functions.

[14] The Birthrate Plus® model may be a suitable model for determining staffing levels. A project to determine the suitability of the model in NSW Health is due for completion within the next few months. Birthrate Plus® has been in use in the UK since 1991.

[15] Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health, 2007, *SAFER CHILDBIRTH:Minimum Standards for the Organisation and Delivery of Care in Labour,* RCOG Press, London.

8.3 SHORTAGE OF CLINICAL STAFF

There is currently a significant shortage of senior staff specialists at the Canberra Hospital with roles being filled by up to four locum specialists. Recent departures of clinical staff have reduced the depth of clinical experience available for teaching and supervision of registrars.

Staff specialists and VMOs are currently working 3 day weekends on call. This is a very heavy on-call load and is inconsistent with "safe working hours" concepts.

Two staff specialists have recently been recruited – one commencing in July 2010 and the other in January 2011. ACT Health has recently approved two additional staff specialist positions and ten sessions of VMO time. These positions were advertised in late 2009; however there have been major delays in the recruitment of these positions. The review panel believe these positions should not be filled until the current issues with disruptive behaviour have been resolved.

8.4 ALLOCATION OF ON-CALL WORK

The current on-call roster for staff specialists and VMOs at the Canberra Hospital is apportioned on a per person basis, rather than on a pro-rata basis. This results in clinical staff who are working only a few sessions each week being required to take a full on-call load. This is a prime reason sighted by many VMOs for not applying to work at the Canberra Hospital.

8.5 REGISTRAR WORKING HOURS

Rosters at the Canberra Hospital indicate that the registrars are routinely working well in excess of 100 hours per fortnight. This may be outside the Enterprise Bargaining Agreement (EBA) allowances and also be inconsistent with "safe working hours" concepts.

8.6 POORLY COORDINATED HAND-OVER

Clinical and midwifery hand-over between shifts appears poorly coordinated.

8.7 SUMMARY

The 27% increase in births at the Canberra Hospital has not been accompanied by commensurate increase in staff establishment. Both midwifery and medical staff are currently carrying unsustainable work loads. There is an urgent need to address this.

Maternity management staff at the Canberra Hospital appear to be carrying a full clinical load and do not have or have not been accessing sufficient non-clinical time from management. This reduces time available for management and supervision of trainees or inexperienced staff.

Current on-call arrangements for medical staff at the Canberra Hospital place a disproportionate load on part time staff and this is adversely affecting recruitment and retention of skilled clinical staff.

8.8 RECOMMENDATIONS

19. The midwifery staff establishment and skill mix at the Canberra Hospital should be urgently addressed
20. Maternity managers at the Canberra Hospital – both midwifery and Clinical Directors, should be allocated set non-clinical hours to perform their administrative roles
21. Further recruitment of clinical staff at the Canberra Hospital should be put on hold until the recommendation around the management of disruptive behaviour are addressed
22. On-call commitments for specialist staff at the Canberra Hospital should be based on sessions or FTEs worked
23. More registrars should be employed at the Canberra Hospital so that registrar working hours can be reduced to comply with the EBA
24. Strategies to allow multi-disciplinary handover between shifts should be explored
25. Appropriate clerical support staff should be employed in the maternity service to adequately support medical and midwifery managers.

9 OBSTETRIC SERVICE CONFIGURATION

- An assessment of the service delivery and working arrangements between all obstetric units in the ACT, and potential options for improvement.

9.1 OPPORTUNITY FOR A TERRITORY-WIDE SERVICE

Several previous reports have recommended that ACT Health work toward a Territory-wide maternity service. This review again identified a significant opportunity to improve service delivery by working towards a single maternity service for the Territory.

There is considerable interest from both public and private providers to consider a Territory-wide coordinated maternity service. While a number of barriers were identified, there was wide spread support and goodwill for the concept of a single service operating across multiple sites.

Initial steps towards such a model could include:

- A single set of policies and procedures. All service providers saw merit in negotiating and adopting a territory-wide set of policies and procedures covering all aspects of maternity care. These policies and procedures would need to allow recognition of the specific values of each service provider and the varying clinical services capabilities.
- Combined mortality and morbidity review meetings. The smaller providers recognised that their volumes do not allow robust periodic review of outcomes. Clinicians from across the Territory acknowledged the merit in sharing the analysis of outcomes. This move would require the development of a trusting relationship which is not apparent between some services at present.

9.2 COORDINATION OF INTER-STATE TRANSFERS

A concern was expressed that inter-state transfers of high risk patients (elective transfers), was often not well coordinated with delays in antenatal follow-up and poor discharge planning. Ensuring support after discharge, particularly for women and families experiencing still births, is apparently fragmented.

9.3 BARRIERS TO WORKING AT THE CANBERRA HOSPITAL

Most clinicians interviewed expressed considerable interest in working at the Canberra Hospital. This included those who have trained at the Canberra Hospital but never worked there, those who have worked there but recently resigned and those who have never worked at the Canberra Hospital.

The Canberra Hospital provides opportunities for exposure to complex obstetric work, subspecialisation not found in other facilities, teaching, and working in an academic environment.

Three barriers to medical clinicians working at the Canberra Hospital were consistently sited:

- On-call load. Currently any clinician working at the Canberra Hospital must accept a full on-call load, irrespective of their clinical load. For the on-call roster to be acceptable, it would need to be based on the number of sessions that a clinician works at the Canberra Hospital.

- Culture of resistance to VMOs. There is a perception that the Canberra Hospital has a bias against VMOs. This view did not seem to be supported by the the Canberra Hospital Executive who were interviewed.
- Management of disruptive behaviour. There is a strong perception that the Canberra Hospital has not effectively addressed issues of inappropriate behaviour in the maternity unit.

9.4 GYNAECOLOGICAL SURGERY

Volumes of gynaecological surgery appear to have fallen significantly, to the point that the review panel is concerned that registrars are exposed to insufficient gynaecological surgery to develop their clinical skills.

9.5 SUMMARY

There is strong support from both public and private providers for exploring a Territory-wide maternity service.

There appear to be three key barriers for medical clinicians interested in working at the Canberra Hospital. These include:

- The current on-call load which requires part time staff specialists and Visiting Medical Officers (VMOs) to carry a full on-call load
- A perceived culture of resistance by the Canberra Hospital to the engagement of VMOs
- The Canberra Hospital has not effectively addressed issues of inappropriate behaviour in the maternity unit.

9.6 RECOMMENDATIONS

26. ACT Health should move towards a Territory-wide mortality and morbidity data collection and review process
27. ACT Health should adopt standard policies and procedures across all maternity services in the ACT
28. ACT Health should move towards a Territory-wide maternity service
29. Barriers to engaging VMOs at the Canberra Hospital should be addressed, widening the number of clinical staff and increasing the range of experience and skills
30. A mix of staff specialists and VMOs should be employed at both the Canberra Hospital and Calvary Public
31. The volume of gynaecological surgery which registrars undertake at the Canberra Hospital should be increased

10 SUMMARY OF RECOMMENDATIONS

Recommendation	Timeframe
Procedures need to be implemented which ensure that clinicians who display disruptive or inappropriate behaviour are informed that such behaviour is inappropriate and will not be tolerated, with immediate steps taken to ensure the cessation of such behaviour	Immediate
Further recruitment of clinical staff should be put on hold until the above issue is addressed	Immediate
The midwifery staff establishment and skill mix at the Canberra Hospital should be urgently addressed	Immediate
Maternity managers at the Canberra Hospital – both midwifery and Clinical Directors should be allocated set non-clinical hours to perform their administrative roles	Immediate
More registrars should be engaged at the Canberra Hospital so that registrar working hours can be reduced to comply with the EBA	Immediate
The role and delegations of the management team of the Canberra Hospital should be clarified and communicated to staff at all levels	Immediate
Barriers to engaging VMOs at the Canberra Hospital should be addressed, widening the number of clinical staff and increasing the range of experience and skills	Immediate
Registrars at the Canberra Hospital should be dedicated to the Labour and Delivery unit when on-call; gynaecology emergent issues should be the responsibility of an alternative medical staff member	Short term
Consultants should be dedicated to the Labour and Delivery Unit when on call	Short term
Regular formal evaluation, involving all maternity staff, should be undertaken to identify opportunity for improvement and innovation	Short term
Lines of responsibility within the maternity service should be clearly defined and adhered to	Short term
The senior management positions at the Canberra Hospital should be revised to ensure the portfolios are manageable.	Short term
The role and responsibilities of the management team need to be clarified and communicated to all staff	Short term
The teaching and supervision of both midwifery and registrar trainees should be recognised as a specific task and appropriate time and resources allocated to this function	Short term

The Clinical Director of Obstetrics and Gynaecology should formally delegate a number of functions including consideration of the establishment of a Deputy Clinical Director role for the Labour and Delivery unit	Short term
A mix of staff specialists and VMOs should be employed at both the Canberra Hospital and Calvary Public Hospital.	Short term
On-call commitments for specialist staff should be based on sessions worked or percent of FTE	Short term
ACT Health should adopt standard policies and procedures across all maternity services within the ACT	Short term
The volume of gynaecological surgery which registrars undertake should be increased at the Canberra Hospital	Short term
Appropriate clerical support staff should be employed in the maternity service at the Canberra Hospital to adequately support medical and midwifery managers.	Short term
ACT Health should ensure the timely production of an annual comprehensive report of the outcomes from the maternity and newborn services	Medium term
ACT Health should ensure meaningful inclusion and representation of consumers within the governance framework of maternity services	Medium term
ACT Health should undertake regular active maternity customer satisfaction surveys which identify satisfaction at the individual clinical service level and are focused on known factors associated with both short and long term satisfaction	Medium term
ACT Health should consider implementing further caseload models, including access to midwifery led models for women who fall outside the current "low risk" parameters	Medium term
The list of incidents requiring mandatory notification within maternity services at both hospitals could be expanded.	Medium term
Re-credentialing should become a regular formal process of maternity clinical and team performance evaluation involving 360 feedback and personal development plans	Medium term
"Credentialing" of the maternity service should become a regular periodic process facilitated by a respected independent expert working closely with the Clinical Director	Medium term
Strategies to allow multi-disciplinary handover between shifts should be explored	Medium term
ACT Health should move towards a Territory wide unified mortality and morbidity data collection and review process.	Medium term

ACT Health should implement a defined Clinical Risk Management Programme for all public maternity services within the ACT.	Medium term
ACT Health should move towards a Territory wide maternity service.	Long term

Immediate	Within the next four weeks
Short term	Within the next six months
Medium term	Within the next 12 month
Long term	Over the next three years

11 A WAY FORWARD

The review panel recognise that resolution of many of these issues will be painful. Much of the culture and practice apparent in the Canberra Hospital has developed over many years and change will be disruptive. Many people will be personally affected by the change.

For the hospital to retain its high clinical standard, urgent action is required to:

- Increase midwifery staffing and skill mix levels in the Labour and Delivery unit
- Increase training and supervision of midwifery and registrar trainees
- Recognise the non-clinical work load of the Clinical Director, CMC and team leaders
- Clarify the reporting lines within the hospital management team
- Clarify the role of the DGM (Medical) and ED (AMW&C), particularly in relation to the management of clinical staff
- Implement a robust programme of performance management that addresses issues of inappropriate and disruptive behaviour

12 APPENDICES

12.1 TERMS OF REFERENCE

Review of service delivery and clinical outcomes at public maternity units in the ACT
The purpose of the review is to conduct an assessment of service delivery arrangements and clinical outcomes at public Maternity Units in the ACT, and other Maternity Units across the ACT. The review will focus on the Canberra Hospital and Calvary Public Maternity Units, however all other Maternity Units in the ACT will be invited to participate.
The review will be undertaken by two suitably qualified Obstetricians and a suitably qualified Medical Administrator and a suitably qualified Midwife independent of the Canberra Hospital and the ACT Health system and identified in consultation with respective professional colleges.
In conducting the review, the reviewers will examine documentation and conduct interviews with staff as required. ACT Health will provide assistance in identifying relevant documentation and staff, organise interviews, and provide secretariat support, travel and accommodation for the reviewers.

Terms of reference
The review will cover:

- An assessment of mortality, morbidity and other clinical outcomes. In assessing these outcomes, the reviewers will be expected to examine relevant benchmarking data, performance indicators and other appropriate data and research;
- An assessment of consumer satisfaction and patient experience, including an assessment of complaints and compliments, RISKMAN data, recommendations from clinical review committees and other consumer related feedback mechanisms.
- An assessment of the clinical governance of the Unit, including examination of relevant policies and protocols, clinical audit processes and other quality improvement activities;
- An examination of staff roles and responsibilities and an assessment of whether the roles and responsibilities are appropriate to staff professional roles, skills and experience;
- An examination of staff numbers and workloads, and assessment of whether the staffing numbers are sufficient and workloads are appropriate; and
- An assessment of the service delivery and working arrangements between all obstetric units in the ACT, and potential options for improvement.

Review deliverables
The deliverables from the review will be a report detailing:

- A comment about the overall performance of the unit and potential areas of improvement;
- Findings against each term of reference; and
- Recommendations for improvement against each term of reference.

12.2 PANEL MEMBERS

Four reviewers were engaged to conduct this review. These reviewers were:

a. Dr David Rankin, Senior Advisor - Child, Youth and Family, New Zealand, nominated by the Royal Australasian College of Medical Administrators.

b. Associate Professor Robert Bryce, Clinical Director of Obstetrics & Gynaecology at Flinders Medical Centre Adelaide nominated by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

c. Ms Avon Strahle, Midwife Advisor – The Australian College of Midwives (ACM), nominated by the Australian College of Midwives.

d. Professor Michael Humphrey, Clinical Advisor, Office of Rural and Remote Health; Chair of Queensland Maternal and Perinatal Quality Council.