West Coast DHB Maternity Review: Summary Report

30 September 2013

REVIEW TEAM MEMBERS

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ABSTRACT

To provide the West Coast District Health Board with a report on the current safety of the West Coast maternity services in the context of the rural environment in which they are provided.

To provide any recommendations for service improvement that will improve the safety and quality of maternity care provided to the West Coast community.

1. Executive Summary

This report makes significant tangible recommendations for improvements in the quality, safety and sustainability of the West Coast's maternity services.

It is essential that this report is not condemned to the paper pile and that the recommendations are endorsed and implemented by the Chief Executive and the Executive Management Team. We strongly urge that a significant proportion of the report recommendations are duplicated as the recommendations needed to be part of the Maternity Safety and Quality Program and included in the 2013/14 priorities and deliverables due to be submitted to the Ministry of Health in June 2013.

The review group find that it is essential to maintain Greymouth Hospital with a secondary obstetric service for exactly the same reasons that make maintaining such a service challenging; geographical isolation, recruitment and retention difficulties, and transport difficulties as a result of terrain and weather. Not having a secondary service would in our view jeopardise the lives of mothers and babies on the West Coast. The model of care developed to deliver this requirement needs to drive the decision-making process surrounding facility development with special emphasis on the collocation of maternity, paediatrics and theatres. Maintaining the secondary obstetric service also ensures the need for anaesthetics and therefore maintains that support for other services.

We recommend that the Kawatiri primary birthing unit Buller Hospital discontinue being a place where planned deliveries can occur but becomes a site for antenatal care and inpatient postnatal care with provision for emergency delivery if needed in extenuating circumstances. The IFHCs should be being specifically designed around this model of care.

Funding for midwifery should be through the Section 88 of the New Zealand Public Health and Disability Act Maternity Notice [Section 88] and caseloading midwifery funded by the WCDHB should cease. However, a key component of these recommendations is the support for self-employed LMCs for education, leave

planning and ensuring a full caseload to ensure practice viability is maintained for these key practitioners.

Currently the workforce of SMOs in obstetrics and gynaecology is as stable as it has been for many years but it is clear that the service remains vulnerable. There needs to be a one in three roster [reducing to one in two with leave] as a minimum. It was outside our scope and expertise to develop further the approach to recruitment and retention of this workforce but we recommend that a significant piece of work be undertaken looking at recruitment and retention for small isolated DHBs. This work should involve the ASMS, NZMC and RANZCOG with workshops involving senior medical staff from both Christchurch and the West Coast with their respective management teams, but lead by the Human Resources team that now works across both DHBs.

We are pleased to report that there do not appear to be recurring themes in either the incidents or root cause analysis [RCA] investigations. The increase in frequency of such events seems to be a positive manifestation of an evolving culture change with regard to the reporting and investigating of incidents and adverse outcomes. However, the processes, timelines and monitoring of the implementation of recommendations leave considerable room for improvement and we have made a number of recommendations pertaining to this.

From interviews with staff it is clear that a significant culture change is required from all parties. We urge that all tiers of the WCDHB embrace a culture of respect, openness and relationship building that allows reciprocity of leadership that allows effective leadership that fosters trust and team working. The actions of individuals need to endorse and embrace the stated ideology, visions and values of the service.

The clinical teams including midwifery, obstetrics and quality need to be aligned carefully with appropriate reporting lines and accountability. It is therefore recommended that the Director of Midwifery and the Clinical Director Obstetrics & Gynaecology roles should be across both DHBs with a transalpine model. Both of these roles will require the incumbent to be readily visible and specifically allocated time at both sites. An integration of the two services with fully shared and developed

guidelines, policies, credentialling and performance appraisal needs to occur with dedicated time spent at each site by those clinical heads.

This will require face-to-face work from senior management, effectively conducting a complete change management process. The changes required will result in a shift from a prolonged period of poorly co-ordinated, often reactionary change based on crises without clear communication strategies to one of open, honest communication. This will need to be built upon carefully considered continuous improvements based on optimising the patient care experience for families of the West Coast.

2. Purpose of Review

Over the last two years, there have been a number of serious and sentinel events involving maternity services provided on the West Coast. There has also been a Health and Disability Commissioner investigation, incident reports and patient complaints about the service provided.

These incidents taken as a group have raised a range of concerns regarding the safety of the maternity services provided to the West Coast community. It is unclear whether these are an unfortunate cluster of isolated cases, or whether there are systemic issues in the way that maternity services are provided to the West Coast community.

Purpose

The purpose of the review is to:

- provide the West Coast District Health Board with a report on the current safety of the West Coast maternity services in the context of the rural environment in which they are provided, and
- provide any recommendations for service improvement that will improve the safety and quality of maternity care provided to the West Coast community.

Elements of the Review

The components of the review are to:

- Review the cases above, and any associated recommendations;
- Understand the key issues involved in the cases in progress;
- Review existing guidelines, protocols and systems for birthing planning and care delivery, both antenatally and intrapartum, and transfer protocols and transfer timeliness within the West Coast and between West Coast and Canterbury;
- Assess the impact of staffing issues [numbers, locum use and skill mix] on service delivery;
- Provide observations on the findings of their review;
- Recommend actions for service delivery change that will improve the safety and quality of the maternity services provided for the West Coast community.

3. Background

Geography and Rurality

The West Coast DHB covers a geographical area 600km in length [the distance from Auckland to Wellington] and about 30-40 km in width. This is 10% of the land area of New Zealand with a population density of about 1/10th the national average. Due to limited public transport the majority of transport is by private car.

Only 64 percent of West Coast residents live within 60 minutes by road from secondary hospital services. Only two percent of the population are within 180 minutes by road from the nearest tertiary hospital at Christchurch. For logistical reasons it takes about four hours to effect ambulance transfer from Westport to Greymouth. The winding nature of roads means ambulances are slower than private cars. Helicopter transfers from centres along the West Coast to Greymouth Hospital originate in Greymouth. Fixed wing air transfer from Greymouth to Christchurch takes [from decision to arrival time in Christchurch] approximately four hours. Delays often occur due to either weather conditions or staffing constraints [midwifery or air ambulance]. From 2005, to 2007 some 13.7% of requested air ambulance transfers were unable to be completed. Inclement weather was the cause of 71% of these.

Helicopter transfers from centres along the West Coast to Greymouth Base Hospital originate in Greymouth. This requires travel firstly to collect the woman and baby and then the return flight.

Section 88 defines regions based on their rurality. All areas on the West Coast are classified as either rural, semi-rural or remote rural and attract additional fees for the necessary midwifery travel time.

Population Demographics

West Coast DHB serves a population of 31,000 people, 7500 people live in Greymouth, 4000 in Westport, 1000 in Reefton and 3000 in Hokitika and 1000 in Reefton. There are multiple smaller population centres scattered along the Coast from Karamea in the north to Haast in the south.

The West Coast DHB has an older than national average age and funding for this is reflected in the population based funding formula. A 2013 estimate of the female population on the West Coast is 16,235 of which 6,910 are of child-bearing age [15 to 49 years]. There is a lower proportion of Māori [10%] compared to the national average and almost no Pacific Island people. The West Coast has proportionally more people in the more deprived section of the population than the national average.

Gloriavale Christian Community

Gloriavale Christian Community is situated in Haupari approximately one hour's drive from Greymouth and has a population of 500 with approximately 25-30 births per annum. This number will continue to increase. There is currently one qualified midwife within the community and another community member in her second year of midwifery training who will graduate late in 2014.

4 – Key Recommendations | Findings:

Key Recommendations | Findings:

- **It is essential to maintain Greymouth Hospital with a secondary obstetric service for exactly the same reasons that maintaining such a service is challenging; geographical isolation, recruitment and retention difficulties [removal of secondary service would impact upon recruitment of LMC workforce], and transport difficulties as a result of terrain and weather**

  - Planned births no longer occur at Buller Hospital due to low numbers of births, risks associated with intrapartum transfer when transport not rapidly available and unavailability of midwives for the majority of births outside the locality
  - A primary maternity service [antenatal, postnatal and emergency delivery] in Westport is essential due to isolation
  - Models of care for maternity services should help determine the design of the new IFHC facilities and hospital facilities at Grey Base Hospital
  - The model of care for primary maternity must engage GPs working alongside midwives in providing antenatal care based in the IFHCs
  - The arrangements for inpatient care in Kawatiri Maternity Unit in Buller must be urgently reviewed to ensure they are safe. Women must be attended on site 24/7 by a midwife when an inpatient
  - Buller Hospital clinical leaders must ensure closer collaboration between all disciplines including joint education and simulation training
  - The WCDHB need to reimburse LMCs who provide inpatient care when patients are resident in Kawatiri Maternity Unit in Buller using a similar model to Golden Bay

- **The issues of transport need to be addressed**

  - Development of an elective transfer policy for specific conditions [eg severe pre eclampsia or twins]
  - The current emergency in utero transfer policy needs clarification and refining

- The Neonatal transfer policy needs reviewing and updating
- Agreement reached that CDHB facilitates and are responsible for transfers [either to Christchurch or another facility]
- Consider that acceptance of a neonate or mother needing transfer is guaranteed in Christchurch because irrespective of the bed status the risk to mother and baby is less at Christchurch [or in another tertiary unit] than remain on the West Coast. i.e Christchurch becomes responsible for making appropriate arrangements for care
- Clear guidelines need to be developed, documented, and widely distributed to assist staff in managing the transport / transfer process within the DHB and DHB to DHB ensuring timely, appropriate and safe care for all women and babies transferred
- Work with CDHB Birthing Suite Transport Coordinator to ensure CDHB staff have a clear understanding of the environment West Coast staff practice in [currently underway]
- Ensure all staff who may be called upon in an emergency undergo STABLE and PROMPT training to enable them to provide best possible care whilst a retrieval is pending
- Clinical contingencies should be developed to cover options when weather conditions interfere with the above agreed plans
- Develop information material for women to ensure they understand the transfer/ transport processes on the West Coast
- Bedside fFn testing be introduced

Work is required in conjunction with St John ambulance service to:

- Establish a workable policy regarding transfer from Buller which addresses issues of patient safety. This must include addressing the perverse situation of a possible cardiac event being higher priority than an actual maternity event
- Ensure the ability of St John's to provide a timely service whilst dependent on volunteers to provide that service

- This work should be seen as a key priority for both WCDHB and CDHB and needs to tie in with the existing work being conducted to address these issues

- **CDHB and WCDHB department of Obstetrics and Gynaecology be unified with shared management and accountability lines and appropriate protected dedicated time to enable quality and service development activities**

- **A full departmental and individual credentialing process should occur**

- **A specific piece of work needs to be commissioned by WCDHB and CDHB specifically charged with looking at solving the problems of recruitment and retention for isolated DHBs and the O&G staff. This work needs to involve the SMO body at both DHBs, the NZMC, the ASMS, RANZCOG and consideration be given as to whether HWNZ be involved**

- **WCDHB should commit to a community based primary midwifery model claiming from the Section 88 of the New Zealand Health and Disability Act 2000 maternity notice and make changes to the current model so this occurs**

- **A single Director of Midwifery role should be established with professional responsibility for both the WCDHB & CDHB midwifery services with sufficient focus on and understanding of the particular needs of the West Coast. This position needs to have a regular visible presence on the West Coast**

- **Design and develop a maternity service quality plan that supports the delivery of safe clinical outcomes for the West Coast community and is consistent with the New Zealand Maternity Standards**

- **Implement the Shared Maternity Record of Care [SMRoC] as per the National Maternity Clinical Information System and Shared Maternity Record of Care Business Case [2012]**