IECOCONSULTING
integrity . excellence . community . opportunity

Ms Kathrine Morgan-Wicks
Secretary
Department of Health

Independent Review of the Quality, Safety and Management of North West Maternity Services

Dear Ms Morgan-Wicks,

Thank you for the opportunity to chair the Independent Review of the Quality, Safety and Management in the North West Maternity Services. On behalf of the review team, I am pleased to provide a copy of the final report.

This review had as its primary focus, the systems and processes supporting the delivery of safe and quality maternity services to the community of the north west of Tasmania. This included an examination of the governance structures, workforce and models of care. The enclosed report provides an analysis of the key findings of the review and the rationale for the 15 recommendations.

In providing the final report, I would like to take the opportunity to emphasise two things. The first relates to the challenges of providing public maternity services to a geographically disbursed population in a regional location. Many of the challenges identified in this report are not unique to the north west of Tasmania but are shared with other regional communities across the country. The challenges in the north west have been well recognised and responded to by successive Tasmanian governments and past decisions made to develop and consolidate public maternity services were valid at the time of making them and remain valid today.

The second point that I would like to emphasise is the commitment and engagement of the clinical staff providing care across the service. This is a significant strength. While there were differences of views about approaches to providing optimal care, it is clear that all staff share a commitment to provide safe and high-quality maternity care to the community of the north west, now and in the future.

The recommendations contained within the enclosed report have a focus on strengthening governance models, leveraging off the work, investment and expertise of those involved in the provision of public maternity services elsewhere in the state. In doing so, it is intended to address the issues identified in this report, while continuing the journey toward full integration of a state-wide maternity service, with seamless access to safe and high-quality maternity care for all women and babies in the north west of Tasmania.

Yours sincerely

Dr Jo Burnand
Chair
Independent Review of the Quality, Safety and Management in the North West Maternity Services

IECOCONSULTING
integrity . excellence . community . opportunity

Independent Review of Quality, Safety and Management in the North West Maternity Services

FINAL REPORT

PO Box 4313, Hawker ACT, 2614 Australia ABN 40 161 895 914 www.iecoconsulting.com.au

Ms Kathrine Morgan-Wicks
Secretary
Department of Health

Independent Review of the Quality, Safety and Management in the North West Maternity Services

Dear Ms Morgan-Wicks,

Thank you for inviting me to chair the panel to review the North West Maternity Services. On behalf of the review panel, I would like to submit this report.

This review had as its primary focus, the systems and processes supporting the delivery of safe and quality maternity services to the community of the north west of Tasmania. This included an examination of the governance structures, workforce and models of care. The report provides an analysis of the key findings of the review and the rationale for the 15 recommendations.

While the provision of safe and high-quality public maternity care to any regional community with a dispersed population has a number of inherent challenges, these are amplified in the north west of Tasmania by complex governance arrangements, multiple models of care and longstanding workforce issues.

The review team noted that there have been multiple past reviews and while there have been significant efforts to address concerns, many issues remain. Having said that, the review team were impressed with the commitment and engagement of staff providing care to mothers and babies, often in very challenging circumstances. Many staff recognise the need to address issues and in part, their voice (and distress) was the impetus for the review.

The provision of safe and high-quality maternity services is everyone's responsibility, including clinical and non-clinical staff, managers, executive leadership and government. While it is recognised that the two primary recommendations will require a significant investment, the review team are firmly of the view that the time has come for definitive change. Importantly, this is a critical opportunity to move to a more fully integrated public maternity service for the whole of Tasmania, to address longstanding issues and provide the community of the north west of Tasmania with seamless access to safe and high quality public maternity services in the future.

I would like to acknowledge those individuals, numbering over 60, who participated in the review and thank them for their contributions and engagement. I would also like to acknowledge the significant work and expertise of the review panel and finally, Rhonda Smith and Jenny Killworth for their assistance and support for the duration of the review process.

Yours sincerely

Dr Jo Burnand
Chair
Independent Review of the Quality, Safety and Management in the North West Maternity Services

Executive Summary

The provision of maternity services in the north west of Tasmania has a complex history with public inpatient maternity services previously being provided across two sites, one of which is undertaken through a contractual arrangement with a private hospital operator to provide intrapartum care of public patients at the North West Private Hospital.

In 2016, as part of a package of statewide health reforms, the North West Integrated Maternity Services (NWIMS) was implemented heralding a reconfiguration of public maternity services across the region, including all inpatient services being concentrated to one site (NWPH) and a Midwifery Group Practice (MGP) established.

There have been multiple concerns raised regarding the delivery of maternity services in the region, some with a focus on the licensing arrangements with the private hospital and this has been the subject of multiple internal and external reviews spanning over 15 years.

The two compelling findings of the current review relate to governance and workplace culture, both of which were of significant concern to the review team.

While providing safe and high-quality maternity care to a regional community with a dispersed population of known socio-economic disadvantage has a number of inherent challenges, these have been amplified in the north west by multiple models of care being delivered at multiple sites, under complex governance arrangements characterised by opacity and lack of a single point of accountability.

This is further compounded by longstanding workforce issues, difficulties recruiting and retaining a stable specialist obstetric workforce in addition to workplace cultural issues.

Put simply, the North West *Integrated* Maternity Services is anything but integrated.

While broadly speaking, the elements of a clinical governance framework were in place, there was significant evidence to support the lack of integration, with duplication of committee structures, lengthy times for investigation and lack of reporting back to relevant staff members.

The structure of clinical services, delivered across multiple sites, involving different models of care (which is to be encouraged), but under a complex leadership and governance structure has presented significant challenges to ensuring the delivery of safe care, despite the best efforts of individual clinicians. Many clinicians (medical, midwifery and others) currently working in the service raised concerns with the review team about their capacity to deliver safe care.

Concerns held by clinical staff about their capacity to provide safe care appears to be taking its toll. There was evidence of a poor workplace culture with hallmark features of fragmented services operating within professional and organisational silos; blaming and multiple interprofessional conflicts. The poor workplace culture is threatening the very viability of the service through high attrition of staff and continued difficulties recruiting and retaining permanent staff.

It is clear that many of the issues identified in this review have been longstanding, evidenced by multiple prior reviews and while it is acknowledged that significant effort and progress has been made to address some issues, a number of others remain unresolved.

In giving consideration to the issues, the review team is firmly of the view that simply tweaking the service or committee structure will not address the underlying structural and governance issues. More fundamental changes are required.

After careful consideration, the review team recommend that public maternity services should move to a single governance structure and that this is best placed under the governance of the Tasmanian Health System. It is recognised that this cannot practically be achieved while the existing public private contract is in place and transition arrangements will need to occur with consideration given to all parties.

That said, it is hoped that moving the governance of all public maternity services under the Tasmanian Health Service will support a more fully integrated public maternity service across the state, thereby ensuring equitable and seamless access to high quality and safe patient care for all women and infants, regardless of postcode.

It is also intended that the implementation of this recommendation will increase opportunities for maternity services in the north west of the state to better connect with existing expertise in the delivery of public maternity services at a state and national level, including in the areas of policy development, clinical practice and clinical governance functions. Further, a single employer model will support the development of a range of strategies to address longstanding workforce issues, including removing some of the

barriers identified in the body of this report with respect to education, training and skill maintenance.

While the NWIMS faces a number of challenges, the review team also noted a number of recent positive developments. They include:

- The recent successful recruitment of 3 obstetricians, due to commence during 2021. One of the successful applicants is known to be strongly supportive of MGP models.

- The relatively recent appointments to the Nurse Unit Manager positions at both the NWPH and NWRH, with both positions being job shared.

- The capital works project with the build of a new antenatal clinic on the Burnie site and an expected completion of October 2021.

Taken together, these positive developments may provide an important catalyst for a whole of service reset but will require significant investment and support.

The following recommendations are intended to address issues identified in the body of this report and provide a way forward to improve the delivery of public maternity services to the north west Tasmanian community.

Recommendations

RECOMMENDATIONS					
Primary recommendations					
No	**Recommendation**	**Relevant chapter**	**Theme**	**Priority**	**Timeframe / Comment**
1	A one employer and single governance structure, under the Tasmanian Health Service, be implemented for the provision of all public maternity services in the north west of the state. This aligns with the delivery of public maternity services elsewhere in the state and provides opportunities to move toward a more fully integrated and networked statewide service.	Chapters 2, 3 and 4	Governance	High	Given the significant amount of work required to move to a single governance structure, preparatory work should begin as soon as practicable, keeping in mind that the current contract expires in 2024. Commencement within 6 months.
2	A body of work is undertaken to address workplace cultural issues identified in this report with the aim of unifying the service. It is acknowledged that significant investment is required to build a workplace culture reflecting the shared values and build the capacity for all staff to work collaboratively across the maternity service to deliver high quality, safe patient care.	Chapter 5	Workplace culture	High	One approach may be to engage a reputable organisational psychology/executive coaching company to work with teams and individual staff to address current workplace issues and provide a positive foundation for the service moving forward. Commencement as soon as is practicable.
Additional recommendations					
3	The “special midwife” arrangements permitting an employed midwife to provide clinical care to friends/family members above and beyond their employed hours of work are to cease. Staff who have been involved in this arrangement to receive education regarding professional boundaries as per NMBA expectations re Dual Relationships and Boundaries.	Chapter 3	Governance	Immediate	Recommendation made to CEO and DON of NWPH at time of site visit. Review team advised that this was to be ceased at that time.
4	Significant work is undertaken to streamline models of care. This should include education of staff so that everyone understands each component of the service structure.	Chapter 3	Clinical services	Medium	It is anticipated that this will be an iterative process but work should commence within 6 months.
5	Medical Emergency Team (MET) service to meet requirements to provide appropriate and timely response to acute clinical deterioration of maternity patients.	Chapter 3	Clinical services	High	Immediate. There should be zero occasions where a MET service (or equivalent) is not available to NWPH.

RECOMMENDATIONS

Additional recommendations

No	Recommendation	Relevant chapter	Theme	Priority	Timeframe / Comment
6	Ensure that all midwives and theatre nurses have access to relevant education and training to support the delivery of safe and high -quality clinical care in all circumstances , for example, care of a woman with an epidural, management of obstetric emergencies in theatre.	Chapter 3	Education and training	Medium	Within 12 months.
7	The committee and clinical governance arrangements be strengthened in line with the future service direction. The review team is of the view that the issues identified in this report are of such complexity, that simply restructuring the existing committees will not address the underlying issues.	Chapter 4	Governance	Medium	Pending a decision on Recommendation 1.
8	The contract committee membership to be reviewed with the aim to separate operational management from contractual functions. It is suggested that the THS be represented by someone from within the Department, (albeit with contribution and advice from the relevant executive).	Chapter 4	Governance	High	While it is understood that this recommendation may be ultimately superseded through the implementation of Recommendation 1, in the interim, the contract committee will need to continue to operate effectively.
9	Credentialling arrangements of midwives to be reviewed and endorsed by the ACM professional body. These should remain in line with existing registration requirements regarding Midwifery scope of practice through NMBA and AHPRA.	Chapter 4	Governance	Medium	Work to be commenced in second half of 2021.
10	Handover processes across the service to be strengthened. This should include establishing shared rules for documentation of management plans, alignment of clinical care pathways with shared forms for all models of care across sites.	Chapter 4	Clinical services	High	Work to be commenced in second half of 2021.

RECOMMENDATIONS

Additional recommendations

No	Recommendation	Relevant chapter	Theme	Priority	Comment
11	Appointments to the senior positions of THS clinical leads (Head of Department and Midwifery DON) to be progressed as soon as practicable. These positions will require significant support at all levels of the service.	Chapter 5	Leadership	High	Pending a decision on Recommendation 1.
12	The Grade 5 midwife position for the Midwifery Group Practice to be reinstituted and recruitment progressed.	Chapter 5	Leadership	Medium	Pending a decision on Recommendation 1.
13	Midwives on the north west are engaged and supported through secondment arrangements to work at other sites within Tasmania. This might include for example, allowing for a block of 4 weeks every 3 years to practice at other midwifery service sites. This is in addition to engagement with other professional development activities.	Chapter 5	Education and training	Medium	Work to commence within 12 months.
14	Work arrangements for midwives be reviewed to encourage and support the capacity to work across the full scope of practice.	Chapter 5	Workforce	Medium	Pending decision made on Recommendation 1.
15	Succession planning for the obstetric, anaesthetic and midwifery workforce be undertaken. This will involve a comprehensive understanding of the demographics of the workforce and planning for the future.	Chapter 5	Workforce	Medium	Work to be commenced in second half of 2021, although it is understood that this recommendation has interdependencies with Recommendation 1.

Table of contents

List of tables and figures

Acronyms

ABS	Australian Bureau of Statistics
ACHS	Australian Council on Healthcare Standards
ACM	Australian College of Midwives
ACN	Australian College of Nursing
AHPRA	Australian Health Practitioner Regulation Agency
AMA	Australian Medical Association
ANMF	Australian Nursing and Midwifery Federation
ANZCA	Australian and New Zealand College of Anaesthetists
CHaPs	Child Health and Parenting Services
CEO	Chief Executive Officer
CSP	Clinical Services Profile
ECM	Extended Care Midwife
EDMS	Executive Director of Medical Services
EDNM	Executive Director of Nursing and Midwifery
LGH	Launceston General Hospital
MAC	Medical Advisory Committee (NWPH)
MCH	Mersey Community Hospital
MET	Medical Emergency Team
MGP	Midwifery Group Practice
NETS	Neonatal Emergency Transport Service
NMBA	Nurses and Midwifery Board of Australia
NWIMS	North West Integrated Maternity Services
NWPH	North West Private Hospital
NWPH KYM	North West Private Hospital Know Your Midwife Program

NWRH	North West Regional Hospital
PCRC	Patient Care Review Committee (NWPH)
RANZCOG	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RHH	Royal Hobart Hospital
SAC	Severity Assessment Classification
SCN	Special Care Nursery
THS	Tasmanian Health Service
TRDF	Tasmanian Role Delineation Framework

Preamble

Impetus for this review

In 2016, as part of a statewide package of health reforms, maternity services in the north west of Tasmania were consolidated into a single service, the North West Integrated Maternity Services.* (NWIMS).

The consolidation of maternity services occurred against a backdrop of a longstanding private public partnership whereby the North West Private Hospital (NWPH) had been contracted over nearly three decades to provide public inpatient maternity services to the north west of the state.

In November 2013, an independent review of maternity services was undertaken at the NWPH under Section 46 of the Act, for the purpose of providing advice to the Secretary as to whether the NWPH was meeting its statutory requirements in accordance with the legislation. The review resulted in 28 recommendations to improve clinical governance, safety and quality of the maternity service.

A follow up inspection in 2015 found that while a significant amount of work had been undertaken on a number of the recommendations, six remained outstanding and eight remained incomplete.

No further analysis on actions taken against the recommendations has been completed since October 2015, although the Regulation, Licensing and Accreditation Unit continues to monitor compliance with the current licence conditions.

In late 2017, just over 12 months after the implementation of NWIMS, an independent review was conducted of the consolidated service, resulting in 13 recommendations.

Figure 1 depicts a summary of key milestones in reviews into maternity services in the north west.

* The review team note that NWIMS is variably referred to in documents as either the North West Integrated ***Midwifery*** Service or the North West Integrated ***Maternity*** Service. For the purposes of this report, the latter has been adopted.

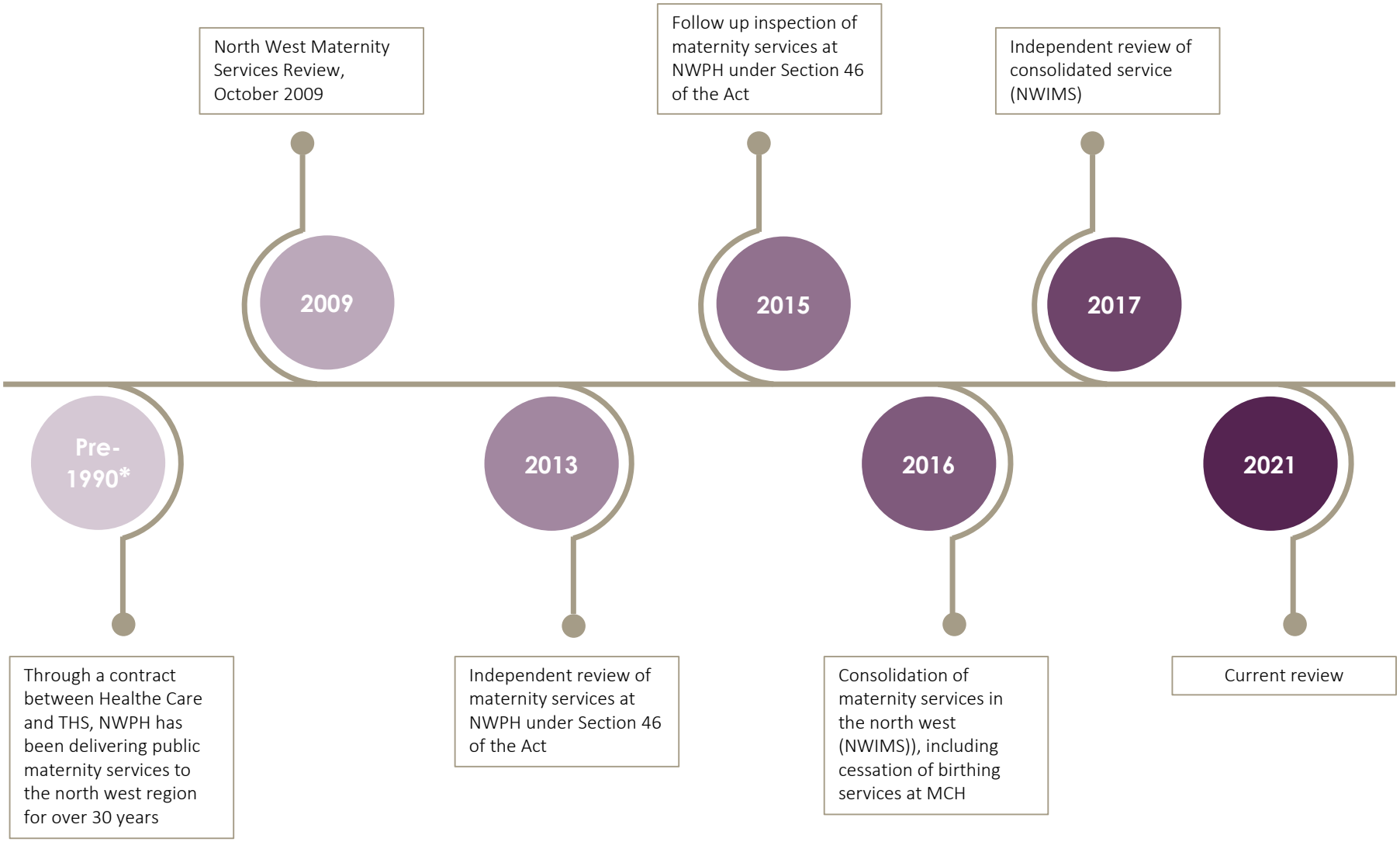

Figure 1: Summary of key milestones in reviews into maternity services in the north west

This review has arisen due to:

- Clinical concerns regarding the North West Integrated Maternity Service (NWIMS) raised by medical clinicians to the Tasmanian Branch of the Australian Medical Association reflecting a lack of confidence in the NWIMS program.
- Anecdotal feedback indicating that there are ongoing issues with clinical governance and leadership across the North West Integrated Maternity Service.
- Continued ongoing issues with respect to clinical governance and workforce stability, identified on analysis of the *Follow up review of maternity services at North West Private Hospital, October 2015* recommendations.
- A potential increase in serious maternal and neonatal incidents that have occurred in the North West Tasmania.

Purpose

The Secretary is seeking to:

- Understand, based on evidence, the quality, safety and management of the integrated maternity services in the North West Tasmania
- Maintain public confidence in the maternity services provided to the region
- Understand the viability of the integrated midwifery service model for the women of Tasmania
- Identify inconsistencies between the contract and the *Health Service Establishment Regulations 2011*

The terms of reference for the review are provided at Appendix A.

Scope

The scope of the review is the adequacy and appropriateness of accountability arrangements, including the culture, systems and procedures that apply to maternity providers, which ensure quality and safety in maternity services.

Using primarily an in-depth study of document reviews, interviews and observations techniques, the reviewers will explore the following:

- Antenatal care related to childbirth
- Intrapartum Care at North West Private Hospital
- Postnatal care at North West Private Hospital
- Governance [North West Integrated Maternity Service (NWIMS)]
- Workforce
- Data and Monitoring
- Support Services
- Clinical Protocols
- Contractual obligations

Importantly, the intent of the review was a focus on the systems, governance structures, policies, workforce and service configuration that supports the delivery of safe and high quality maternity care. Specifically, the review did not seek to undertake a detailed examination of specific clinical incidents or make comment on individual performance.

Review methodology

The review was conducted between mid-November 2020 and mid-February 2021. In completing the review, the review team used the following methodology:

- Review and analysis of documentation provided by NWPH, THS and other sources. A list of source documents is provided at Appendix B.
- Interviews with over 60 individuals including executive, management, clinical and non-clinical staff involved in the delivery of maternity and relevant support services. A list of those interviewed by position is provided at Appendix C.
- Site visit by the chair of the review team to North West Regional Hospital on 16 November 2020
- Site visit by the chair of the review team to North West Private Hospital on 17 November 2020
- Site visit by the chair of the review team to Mersey Community Hospital on 18 November 2020

- Follow up interviews with relevant staff during late November and December 2020
- Review of further evidence and staff submissions during period January - April 2021
- Preparation and drafting of interim report April - June 2021
- Interim report submitted early June 2021
- Completion and submission of final report August 2021.

A summary of the review methodology is provided at **Figure 2**.

Review team

The composition of the review team is as follows:

- Dr Jo Burnand, BMed, MPH, FRACMA, [Chair] Specialist Medical Administrator, Independent Consultant
- Dr Kristine Barnden, MBBS, FRANZCOG, DDU, Senior Obstetrician and Gynaecologist [subject matter expert]
- Dr Ruth Matters, BMedSci, MBBS, FANZCA, CertHSM Senior Anaesthetist, [subject matter expert]
- Ms Ana Navidad, BPsych, BMid, Senior Midwife, [subject matter expert]

The Secretary appointed two clinical sponsors to provide oversight of the review process:

- Professor Anthony Lawler, Deputy Secretary, Clinical Quality, Regulation and Accreditation and Chief Medical Officer; and
- Adjunct Associate Professor Francine Douce, Chief Nurse and Midwifery Officer.

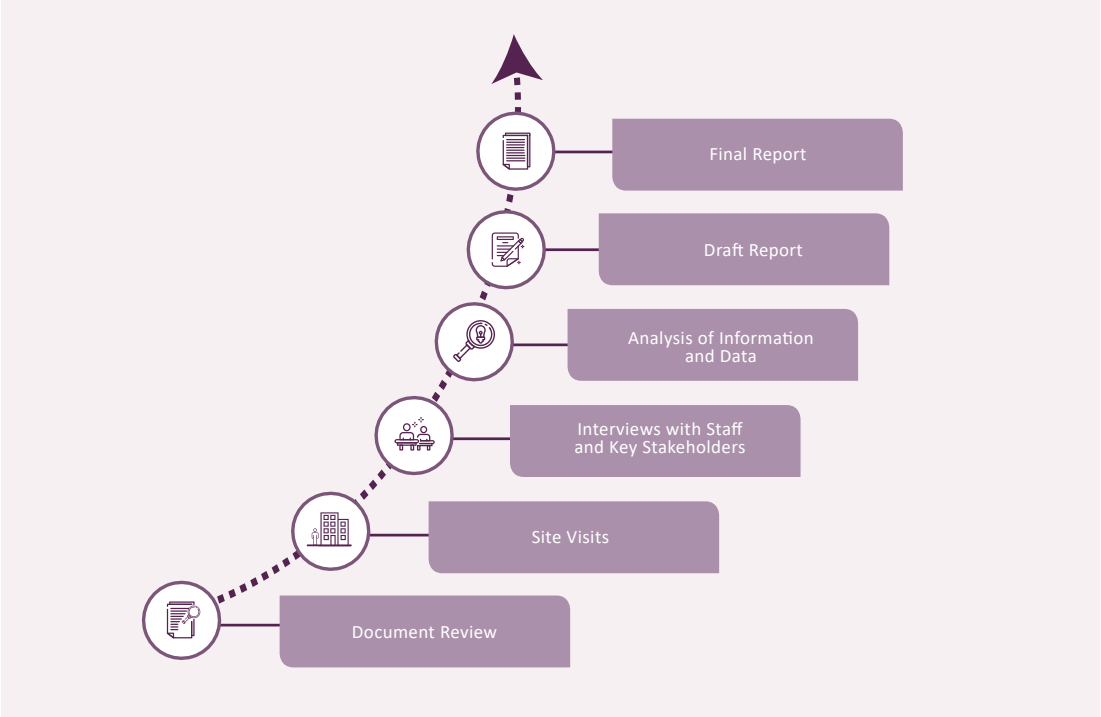

Figure 2: Summary of review methodology

Purpose of this report

The purpose of this report is to provide a summary of key findings emerging from the review process, including recommendations to address identified issues.

Report structure

The body of this report is structured around five chapters, each aligned with a key theme identified from the terms of reference as follows:

1. Service configuration
2. Regulatory environment
3. Clinical service delivery
4. Clinical governance
5. Workforce

Each chapter contains a description of the current status (at the time of the review), followed by a summary of key findings under that theme and where relevant, recommendations for improvement.

Context

Introductory remarks

Prior to a discussion of the provision of maternity services in the north west of Tasmania, it is worth highlighting some features of maternity services more broadly:

- In every clinical encounter, there are two patients to consider [and sometimes more].
- Delivery of care is longitudinal, occurring over the course of the pregnancy and beyond. A clear relationship exists between the quality of delivery of care during the antenatal and intrapartum periods and birth outcomes.
- Similarly, the outcome of a birth has significant longitudinal impacts on the baby, mother and family unit. Birth experiences and outcomes can impact a family over a generation and the impacts of poor outcomes on the infant may be lifelong.
- While the majority of the time, childbirth is considered a safe and natural process, issues can arise and clinical deterioration of either the mother or infant may occur rapidly. Escalation of care and seamless access to appropriate clinical services is critical.
- The potential risks in the delivery of maternity care are reflected by high medical indemnity insurance premiums, recognised as among the highest of any medical specialty.
- From a community perspective, the anticipated birth of a child is an important milestone in a family unit and usually the source of positive expectation and celebration. A poor outcome occurring in the context of positive anticipation and expected celebration can be all the more profound, felt not just by the parents, but a number of others, including cross generational family members, friends and the community.

Demographics

Tasmania has a population of approximately 520,000, dispersed across the state with a concentration in Hobart and Launceston, and to a lesser extent the north west of the state. The north west

region of Tasmania has a total estimated population of 113, 834 (ABS 2019 estimated population data), with an estimated 91,192 (80.1%) residing in the two major centres of Burnie and Devonport.

The north west region occupies a land area of 22523 Km sq, consists of 9 Local Government Areas (LGAs) and includes the island community of King Island. Population densities range from 230 persons per km square in the urban LGA of Devonport to 0.4 persons per km square in the largely rural LGA of West Coast. This reflects both the urban concentration and the geographically dispersed nature of the Tasmanian population generally. Figure 3 shows the population density for the state.

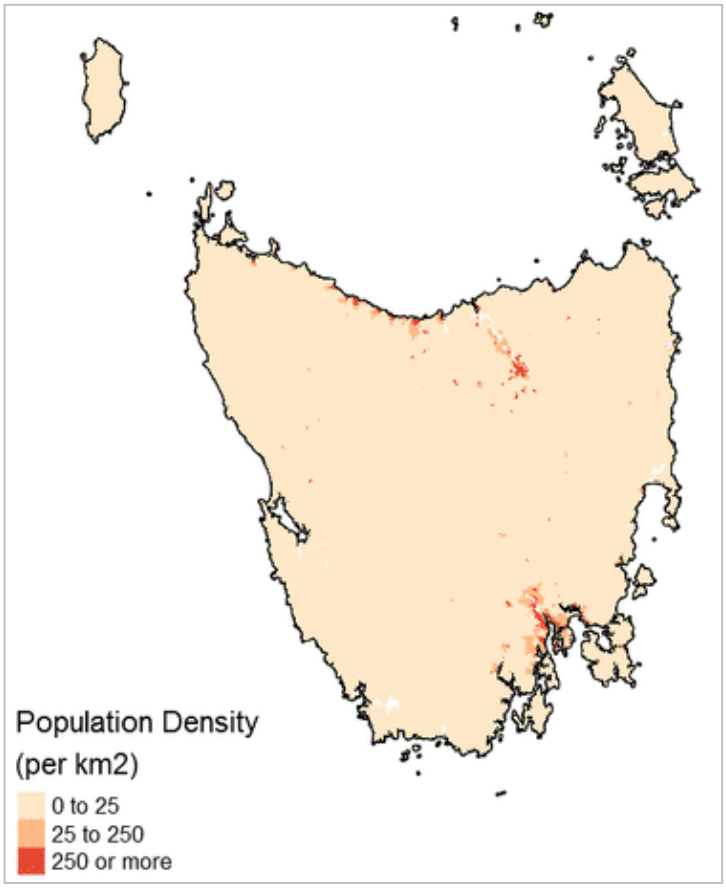

Figure 3: Map of Tasmania showing population density for the state.

This is significant to this review, in that the provision of maternity services to a geographically dispersed population has additional challenges, particularly in terms of cost efficiencies for the clinical workforce requirements to deliver quality midwifery care.

The socioeconomic demographics of the north west region reflect the underlying challenges present in the broader Tasmanian population with the consequential impact on broad health outcomes.

Tasmania's demographic is of a generally older population (average age 39.7 in 2016[1] compared with other states and one with the lowest levels of income and wealth. This is particularly the case in the north west of the state, where the medial personal income as determined by the Australian Bureau of Statistics (ABS) was $48,224 against a state medial income of $49,898 and a national medial income of $59,559.[2]

Quarterly (September 2020) unemployment rate statistics indicate that north west Tasmania has a higher unemployment level (6.8%) compared with the rest of Tasmania (6.0%) and the national average (6.1%) (ABS Labour Force survey catalogue No 62.2.0 ND).

Similarly, higher education levels achieved in north west Tasmania, including the female population, are below the state average for achievement of bachelor, higher degree education and diploma level education. The number of individuals indicating no qualification were also higher than the state average[1].

In the maternity population specifically, these demographic features translate to higher rates of obesity, diabetes, smoking and other health complications associated with socio-economic disadvantage.

Health status

Tasmania has a lower health status compared with the national average (reference). Life expectancy is lower than the national average (78.8 for males and 82.9 for females versus the national average of 80.4 and 84.6 respectively)[3]

The chronic disease burden is also significant. The state has the highest rates of asthma, chronic obstructive pulmonary disease, renal disease, cardiovascular disease and mental health issues of any other state or territory in the country.

Table 1 shows current chronic conditions by region, age standardised, 18 years and over, Tasmania 2019.

The 2019 National Health Survey results indicate that Tasmania has the highest proportion of overweight/obese individuals of any state. The state results (65.3%) contrast with the results for NSW (58.0%), Northern Territory (57.5%) and the ACT (57.2%).

[1] ABS, Census of Population and Housing, 2011 and 2016

[2] ABS Estimates of Personal Income for small areas 2011-2015

[3] DOH, Tasmania, 2020, Report on the Tasmanian Population Health Survey, 2019 Hobart

Similarly, the north west region of Tasmania has a higher prevalence of Type 2 diabetes in the female population (6.6%) than the state average (5.6%). Two of the LGAs that constitute the north west region have "very high" prevalence rates above 7.2%.[4]

Levels of daily smoking amongst Tasmanians continues to be higher than the national average, with reported levels of 16.4% amongst Tasmanians, and high smoking rates in women of child-bearing age, compared with the national average of 13.8%.

		North		North West		South		Tasmania
Condition	%	**95% CI**	%	**95% CI**	%	**95% CI**	%	**95% CI**
Heart disease (a)	4.3%	[3.6%, 5.1%]	6.8%	[4.0%, 11.4%]	4.8%	[4.0%, 5.8%]	4.9%	[4.2%, 5.6%]
Stroke (b)	0.7%	[0.5%, 1%]	0.8%	[0.5%, 1.3%]	0.5%	[0.3%, 0.7%]	0.6%	[0.5%, 0.8%]
Cancer	2.1%	[1.5%, 2.8%]	1.5%	[1.1%, 2%]	2.6%	[1.9%, 3.5%]	2.2%	[1.8%, 2.7%]
Osteoporosis	5.5%	[4.7%, 6.5%]	5.2%	[4.2%, 6.4%]	4.7%	[4.0%, 5.6%]	5.0%	[4.5%, 5.6%]
Depression / anxiety	24.6%	[19.5%, 30.6%]	18.8%	[15.6%, 22.5%]	22.6%	[18.8%, 26.9%]	22.5%	[19.8%, 25.5%]
Other mental health condition	6.8%	[4.6%, 10%]	4.9%	[3.3%, 7.2%]	5.7%	[3.8%, 8.4%]	5.8%	[4.4%, 7.5%]
Arthritis	20.7%	[18.7%, 22.9%]	22.3%	[19.9%, 24.9%]	20.7%	[18.6, 23.1%]	21.1%	[19.6%, 22.6%]
Hypertension	14.2%	[12.5%,16.1%]	15.7%	[13.7%, 17.9%]	12.5%	[11.1%, 14%]	13.7%	[12.7%, 14.7%]
COPD*	1.3%	[1.0%, 1.8%]	1.5%	[1.2%, 2%]	1.2%	[0.9%, 1.5%]	1.3%	[1.1%, 1.5%]
Kidney disease*	1.3%	[0.7%, 2,2%]	1.1%	[0.8%, 1.5%]	1.7%	[1.1%, 2.6%]	1.4%	[1.1%, 1.9%]
Asthma (c)	16.2%	[12.4%, 20.9%]	13.5%	[10.9%, 16.7%]	13.2%	[10.6%, 16.3%]	13.7%	[11.8%, 15.8%]
Diabetes	7.9%	[6.0%, 10.3%]	7.0%	[5.5%, 8.7%]	6.1%	[5.0%, 7.4%]	6.7%	5.8%, 7.7%]
High blood sugar	6.0%	[3.3%, 10.5%]	3.6%	[2.7%, 4.8%]	4.1%	[3.1%, 5.5%]	4.5%	3.5%, 5.8%]

Tasmanian Population Health Survey 2019; * chronic obstructive pulmonary disease and chronic kidney disease (excl infections, stones)
Includes (a) cardiomyopathy, coronary and ischaemic heart disease, heart failure, hypertension and inflammatory heart disease, disease of heart valves, heart murmur, having pacemaker (b) mini strokes, aneurisms and trans-ischaemic attacks (c) active symptoms during last 12 months or symptoms prevented/managed

Table 1: Chronic conditions by region, age standardised, 18 years and over, Tasmania 2019

Birth data

Tasmania has the second highest fertility rate of any state, after the Northern Territory at 1.79 in 2019 against a national average of 1.66 (ABS 2019 birth data), but conversely experiences the second highest infant mortality rate.

For the north west region, the fertility rate was higher than the state average at 1.85 with a total number of births recorded for

[4] DOH, Tasmania, 2020, Report on the Tasmanian Population Health Survey, 2019 Hobart

2019 across all LGAs that constitute the north west region being 1159 (ABS 2019 birth data). This overall number has been consistent over the 2015-2019 period. **Figure 4** shows birth data for north west Tasmania for the period 2012 to 2019.

Figure 4: Birth data for north west Tasmania for the period 2012 - 2019

Summary

The north west region of Tasmania is geographically dispersed, socio-economically disadvantaged and, like the rest of Tasmania, has a high prevalence of chronic disease and lifestyle risk factors.

In the obstetric population, these social determinants of health translate to increased rates of obesity, smoking and Type 2 diabetes, all of which are known risk factors for complications of pregnancy and birth.

Chapter one: Service configuration

This chapter provides commentary on the structure of maternity services within the north west of the state.

Prior to a more detailed discussion on the configuration of maternity services in the north west of Tasmania, it is relevant to note the broader governance framework which underpins clinical service planning and delivery across the state.

Clinical services profile and role delineation framework

In June 2015, the Tasmanian Government outlined its '*One State, One Health System, Better Outcomes*' reform agenda through the release of a White Paper - *Delivering Safe and Sustainable Clinical Services*.[5] The White Paper outlined a design for a single health system and included a package of reforms to the configuration of clinical services across Tasmania, including maternity services in the north west of the state.

The Tasmanian Role Delineation Framework (TRDF)[6] articulates the minimum support services, safety standards, skills and competencies, networking arrangements, and other service requirements necessary to provide a service at a specific level to ensure safe and appropriately supported clinical service delivery for a given level of complexity.

The TRDF consists of (1) Core Clinical Services and (2) Clinical Support Services, the latter including anaesthetics, intensive care, medical imaging, pathology and pharmacy. Core Clinical Services and Clinical Support Services are generally categorised into six levels of service provision with increasing acuity as described in Figure 5.

The Clinical Services Profile (CSP)[7] function is responsible for delineating which clinical services and clinical support services will be delivered at each site.

[5] Department of Health and Human Services, Delivering Safe and Sustainable Clinical Services, June 2015

[6] Department of Health, Tasmanian Role Delineation Framework and Clinical Services Profile, Version 4.0, 2018

[7] Department of Health, Tasmanian Role Delineation Framework and Clinical Services Profile, Version 4.0, 2018

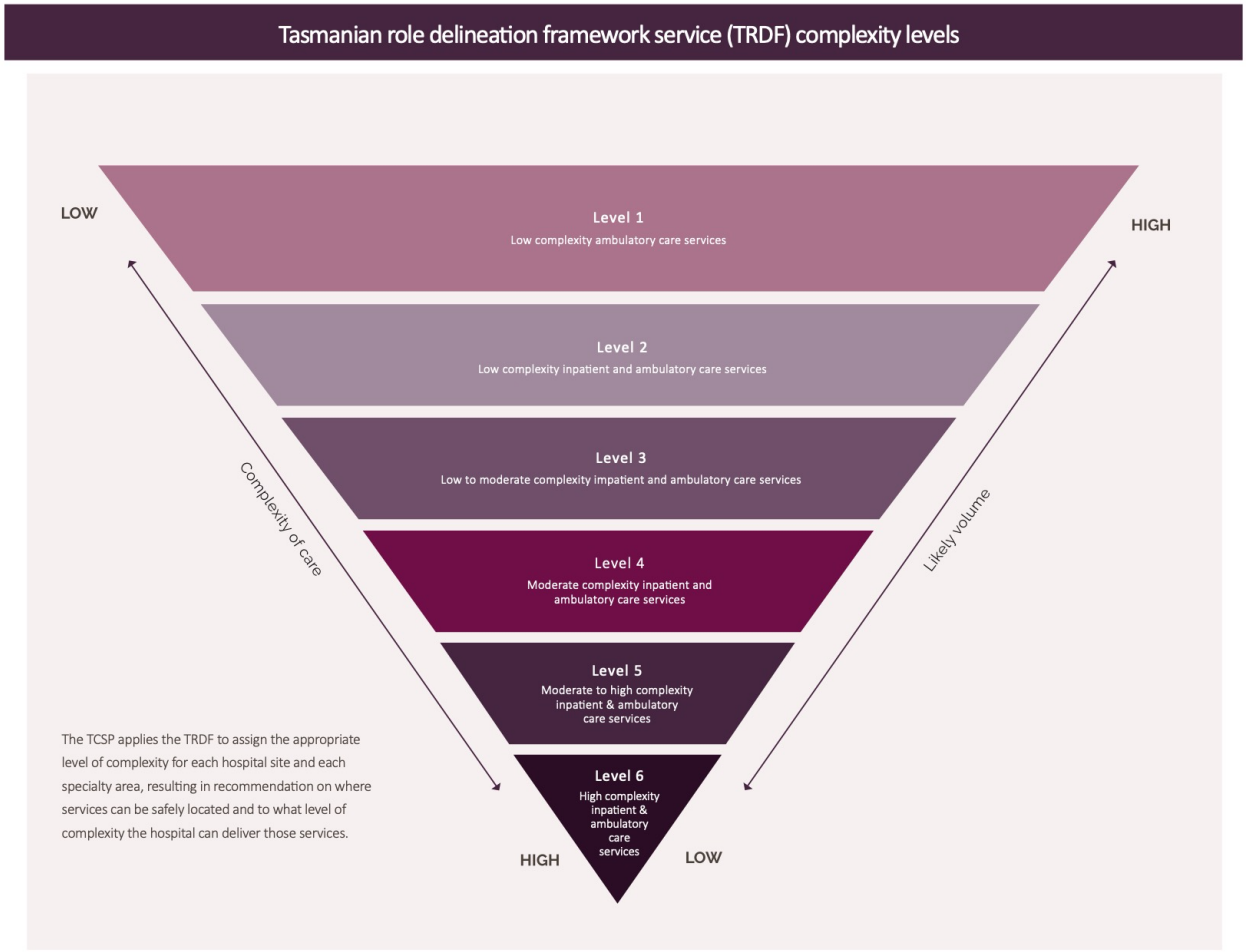

Figure 5: Tasmanian role delineation framework service complexity levels (Source: Department of Health, Tasmanian Role Delineation Framework and Clinical Services Profile, Version 4.0, 2018)

A summary of the clinical services profile for maternity and neonatal services as each of the four public hospitals is provided in **Table 2**.

	RHH	LGH	NWRH*	Mersey
Maternity services	6	5	4	1
Neonatal services	6	5	4	No level
* Public maternity services are provided at the NWPH under a contractual arrangement				

Table 2: Summary of clinical services profile for maternity and neonatal services. Source: Department of Health, *Tasmanian Role Delineation Framework and Clinical Services Profile*, Version 4.0, 2018

In line with other states and territories across the country, Tasmania has used the *National Maternity Services Capability Framework*[8] to inform the role delineation and clinical services profile with respect to the provision of maternity services.

North West Integrated Maternity Services (NWIMS)

Maternity services in the north west of Tasmania are provided across multiple sites. The current configuration reflects the complex history and iterative changes made to the service structure over several decades with two employers and multiple models of care.

In 2016, maternity services in the north west of Tasmania were consolidated to form the North West Integrated Maternity Services.

Antenatal care is provided at multiple sites across the north west but primarily at NWRH, (in the private medical centre joining the NWRH and NWPH) and at the Mersey Community Hospital (MCH) site. Public outreach antenatal services are provided by Midwifery Group Practice (MGP) midwives in addition to TAZREACH.

TAZREACH is an outreach program funded by the Australian Government. One of the priorities of this program is maternity and paediatric health on the north west of Tasmania, which has the aim of improving health outcomes through increasing access to services that the community or region would not normally have access to. Outreach maternity services are provided by THS-NW employed midwives. Outreach locations include King Island, Smithton, Queenstown, Rosebery and other areas where a need is identified and a clinic venue is available.

In addition, there are private outreach services provided through the NWPH Know Your Midwife (KYM) Program.

Historically intrapartum care was provided across two sites, the NWPH, which is co-located with the NWRH at Burnie and the MCH. With the consolidation of services in late 2016, birthing services were ceased at MCH.

Public maternity services were contracted out to NWPH nearly 30 years ago. Public inpatient maternity services are currently managed under a service contract between the THS and Healthe Care Australia. Under the contractual arrangements, the NWPH is

[8] AHMAC, National Maternity Services Capability Framework, Commonwealth of Australia, 2013

responsible for providing the inpatient facilities, core midwifery staff, theatre nursing staff and some support services. The THS-NW provides obstetric medical staff, anaesthetic medical staff, and the Midwifery Group Practice midwives. MGP midwives see their women at both antenatal NWRH and MCH clinic sites and at the MGP unit located near the NWRH campus.

The NWPH has a role delineation of a Level 4 facility with patients requiring higher levels of care referred to either Royal Hobart Hospital (RHH) or Launceston General Hospital (LGH). The NWPH has a total of 21 maternity beds, an operating theatre used for emergency and elective caesarian sections, and a Special Care Nursery (SCN) with 8 nursery cots (six Level 1 cots and two Level 2 cots). Women who require escalation for high level medical care post-delivery are transferred to the NWRH Intensive Care Unit (ICU) if required.

Postpartum care is delivered through a mix of services, some of which offer continuity of care with the intrapartum period through the MGP and KYM midwives. The THS -NW provides an Extended Care Midwifery (ECM) service for public women, with dedicated midwives (who provide post-natal care and breast-feeding support) and some allied health staff, for example, social workers.

Clinical support services

Pathology and imaging services for maternity patients are provided through the NWPH during hours and through the NWRH after hours.

The NWRH also provides clinical support services including access for maternity patients to medical assessment and acute management (via code blue or MET calls) and if required, access to intensive care services.

Summary

Arguably, the description of the service configuration provided above does simply not do justice to its complexity, particularly when considering the perspective of a patient accessing the service.

The service configuration is characterised by multiple entry points, variable access, (at times determined by the postcode of the woman) and multiple service providers working under different employment and contractual arrangements.

While the services exist within an appropriate role delineation framework, there was evidence of multiple models of care, fragmented and sometimes, discontinuous patient care pathways and confusing governance structures. This is amplified by the challenges of delivering maternity services in a rural location, across a relatively large geographical footprint to a population of known lower socio-economic status and other social determinants of health.

In the patient safety literature, borrowing lessons from high-risk industries such as aviation and nuclear power, significant attention is given to the design and organisation of systems as foundational elements for building a safe system.

It is the review team's opinion that the system design of maternity services within the north west of the state, particularly with respect to multiple models of care operating within different governance frameworks has some inherent risks. Further details regarding these are provided in the following chapters.

Chapter two: Regulatory framework

This chapter provides information about the regulatory and contractual framework which supports the delivery of maternity services in the north west of the state.

Legislative framework

There have been a number of changes to the governance of public health services within Tasmania over the last decade. The Tasmanian Health Service (THS) was established on 1 July 2015 following the Tasmanian Government's direction to amalgamate the three Tasmanian Health Organisations.

On 1 July 2018, the Department of Health was established with responsibility for Ambulance, Corporate Services, Health Professional Policy and Advisory Services, Planning, Purchasing and Performance and Public Health Services.

The commencement of the *Tasmanian Health Service Act* 2018 marked the beginning of a new governance model for the administration and oversight of the THS. The key feature of the model was the establishment of the role of the Secretary, Department of Health as the single point of accountability for the performance of the THS.

The *Tasmanian Health Service Act* 2018 requires an annual Service Plan between the Minister for Health and the THS which sets agreed performance standards, targets and measures, and standards for patient care and service delivery.

In the case of the NWPH, like other private hospitals in Tasmania, the NWPH is licenced by the Secretary to the Department of Health, under the *Health Services Establishment Act 2006* and the *Health Service Regulations 2011*. The licence was originally issued under the Hospitals Act 1918 and 'grandfathered' to the new Act.

The objectives of the Act and Regulations are to ensure:

a) the quality and safety of services provided at private health establishments by specifying the standards to be met by those establishments; and

b) that services are provided to meet effectively the needs of Tasmania in accordance with clinical practice guidelines as

to the provision of services and standards observed in Tasmania and elsewhere in Australia.

Previous inspections of NWPH

In 2013, under section 46 of the Act, the Secretary authorised inspectors to enter and inspect the NWPH for the purpose of providing advice and recommendations to the Secretary as to whether the NWPH was meeting its statutory requirements in relation to the delivery of safe, high quality maternity care. Following the inspection, a report was provided which documented key findings and included 28 recommendations.

In 2015, the Acting Secretary authorised inspectors to enter and inspect the NWPH for the purpose of providing advice to the Acting Secretary regarding the progress made by the NWPH in relation to the implementation of the recommendations and whether the NWPH was continuing to meet its statutory requirements. A supplementary report documented key findings and included a detailed assessment of progress against each of the recommendations.

During the current review, an assessment of progress against the recommendations contained within the original report was Undertaken by the Regulation, Accreditation and Licensing Unit of the Department of Health.

Contractual arrangements

In addition to the provisions of the legislation in relation to private hospitals, the THS has contracted Healthe Care to provide public maternity services at the NWPH.

The review in 2013 and the follow up review in 2015 noted that the contractual arrangements in place at the time were having a negative impact on access to and quality of public maternity services. Further the contractual arrangements were impacting on the implementation of clear and effective clinical governance structures designed to support the delivery of safe, high quality maternity care, (particularly, in the area of governance and accountability).

Two previous reviews of maternity services at the NWPH, undertaken in 2013 and 2015 have made comments regarding the contractual arrangements.

In the 2013 report, the following comment was made:

"The contractual arrangements underpinning the provision of maternity (2013) review. Nevertheless, the review team formed the view that the current provisions are having an impact on access to and quality of public maternity services, in addition to the implementation of clear and effective clinical governance structures designed to support the delivery of safe, high quality maternity care."

Similarly, the 2015 review identified that issues with respect to clarity of clinical governance structures and accountability remained unresolved.

Since the 2015 review, work has been undertaken on some revisions of the contract between THS and Healthe Care, most notably setting the following requirements:

- Participation in Women's Hospital Association (WHA) data collection and benchmarking
- Collection and reporting against the National Core Maternity Indicators
- Revised Committee Governance structure

Further requirements were also included as a condition of the NWPH Licence as follows:

a. This establishment must maintain formal links between the Office of the Chief Nurse and Midwifery Officer, Department of Health and Human Services and the Director of Nursing, North West Private Hospital in accordance with the *Guidelines for Professional Engagement between the Office of the Chief Nurse and Midwifery Officer and North West Private Maternity Services.*

b. This establishment must conduct six monthly audits of times to category 1 caesarean sections coinciding with the end of the financial and calendar year. A copy of these audits must be provided to the Secretary, Department of Health and Human Services in January and July each year.

Role of Regulation, Licensing and Accreditation Unit

The Department of Health and Human Services (the Department) is responsible for licensing and monitoring private health service establishments under the *Health Service Establishments Act 2006* (the HSE Act) and *Health Service Establishments Regulations 2011* (the HSE Regulations). The Regulation, Licensing and Accreditation

Unit (RLA Unit) undertakes the regulatory functions of the HSE Act and Regulations on behalf of the Secretary.

The Unit also regulates the accreditation of all Tasmanian health services (both public and private) to the Australian Commission on Safety and Quality in Health Care's National Safety and Quality Health Service (NSQHS) Standards.

Regulation through licensing seeks to balance the business needs of the private health service industry with the health care, safety and quality needs of the public.

Government has a role in ensuring minimum standards of safety and quality in health care are upheld, and licensing provides an assurance that private health services and establishments in Tasmania are safe, quality services; in circumstances where the public are unable to more efficiently obtain this assurance for themselves.

Quality and safety standards are determined and audited through licensing standards (for example in statutory regulations or licence conditions) and accreditation requirements (for example through the NSQHS Standards).

The RLA Unit monitor:

- Times to category 1 caesarean sections in January and July each year and seek further information on any cases where times have exceeded the recommended 30-minute timeframe.

- Monitor the implementation of recommendations following incident review, including NWPH's internal audit results where applicable.

- Development of new policies and procedures and revision of existing where applicable:
    - As at October 2020, 51% of NWIMS policy documents were out of date.
    - 100% of NWPH maternity protocols were current.

- Workforce requirements in accordance with the Act and Regulations

- Transfers to higher level care for mothers and infants where there was no injury reported

Private hospital compliance audit

Private health services are required to comply with the standards and requirements set out in the Act and Regulations. As part of its compliance program, the RLA Unit works with licencees to ensure facilities are operating in accordance with legal requirements.

The Private Hospital *Maternity Services Compliance Audit* aims to assess private hospitals providing maternity care against the Regulations to ensure safe and quality services are provided to women and babies born in Tasmania.

The purpose of the Compliance Audit enables evaluation of compliance against the regulations and components of the NSQHS Standards; and simultaneously monitors potential risks in governance, environment, clinical care, medication safety, infection control standards and where applicable, radiation safety. This audit is fundamentally important in maintaining an accurate and measurable understanding of the regulatory environment.

The licensee and clinical staff participate in the Compliance Audit to engender a more collegial understanding of regulation, so compliance is regarded as an open and communicative partnership instead of an externally imposed burden.

In addition to the Compliance Audit, all private hospital maternity services will be audited to ensure that their internal systems and processes comply with the *Advisory Notice 5/2020 Maternity Patients- Escalation to Tertiary Level Care*. The audit will include samples of 'patients' journey' from the private maternity services to the necessary public maternity services within each region to evaluate the transfer of care systems.

The audit reviewed the regulatory aspects of clinical governance, policies and procedures for delivery of midwifery and clinical care, workforce, incident reporting and management, escalation of care to higher services, and quality improvement processes.

The audit of the NWPH's intrapartum maternity service reflects that the facility and maternity clinical services meets the relevant statutory requirements of the *Health Service Establishments Regulations 2011.*

Chapter three: Clinical service delivery

This chapter provides commentary about the provision of clinical services in the north west of the state, throughout the continuum of maternity care.

Models of care - overview

In keeping with the philosophy underpinning contemporary maternity care, with an emphasis on providing a range of choices to women, there are several models of care operating within the NWIMS. Figure 6 shows patient flows for the NWIMS.

Privately insured women are managed by the private obstetrician who will deliver the baby with assistance from KYM or Core NWPH midwives. Public maternity patients have options for models of care stratified according to clinical complexity.

For women considered low risk, antenatal care is provided by midwives at MCH and Burnie NWRH campus, in addition to outreach services. Intrapartum care for low risk deliveries is provided within the NWPH under the care of midwives, (+/- involvement of obstetric medical staff as required).

For women identified as medium risk, antenatal care is provided by midwives and obstetricians, with intrapartum care within NWPH under the care of an obstetrician, assisted by NWPH employed midwives.

In the high risk pathway, antenatal care is provided by THS midwives with regular obstetric review, and referral to either LGH or RHH for intrapartum care.

Antenatal care

Antenatal care is provided to women in the north west of the state through several distinct models of care and workforce arrangements, sometimes determined by her postcode. A list of the different options for accessing antenatal care is provided below.

- Antenatal Care – NWRH Burnie outpatient clinic
- Antenatal Care – Mersey Community Hospital outpatient clinic
- Antenatal Care – Outreach services (provided through THS NW employed midwives, funded through TAZREACH)
- Antenatal Care – MGP outpatient clinic (located on NWRH campus through THS NW employed midwives)
- Antenatal Care – KYM (provided through NWPH employed midwives)
- Antenatal Care – private obstetrician (rooms in medical centre on Burnie campus)

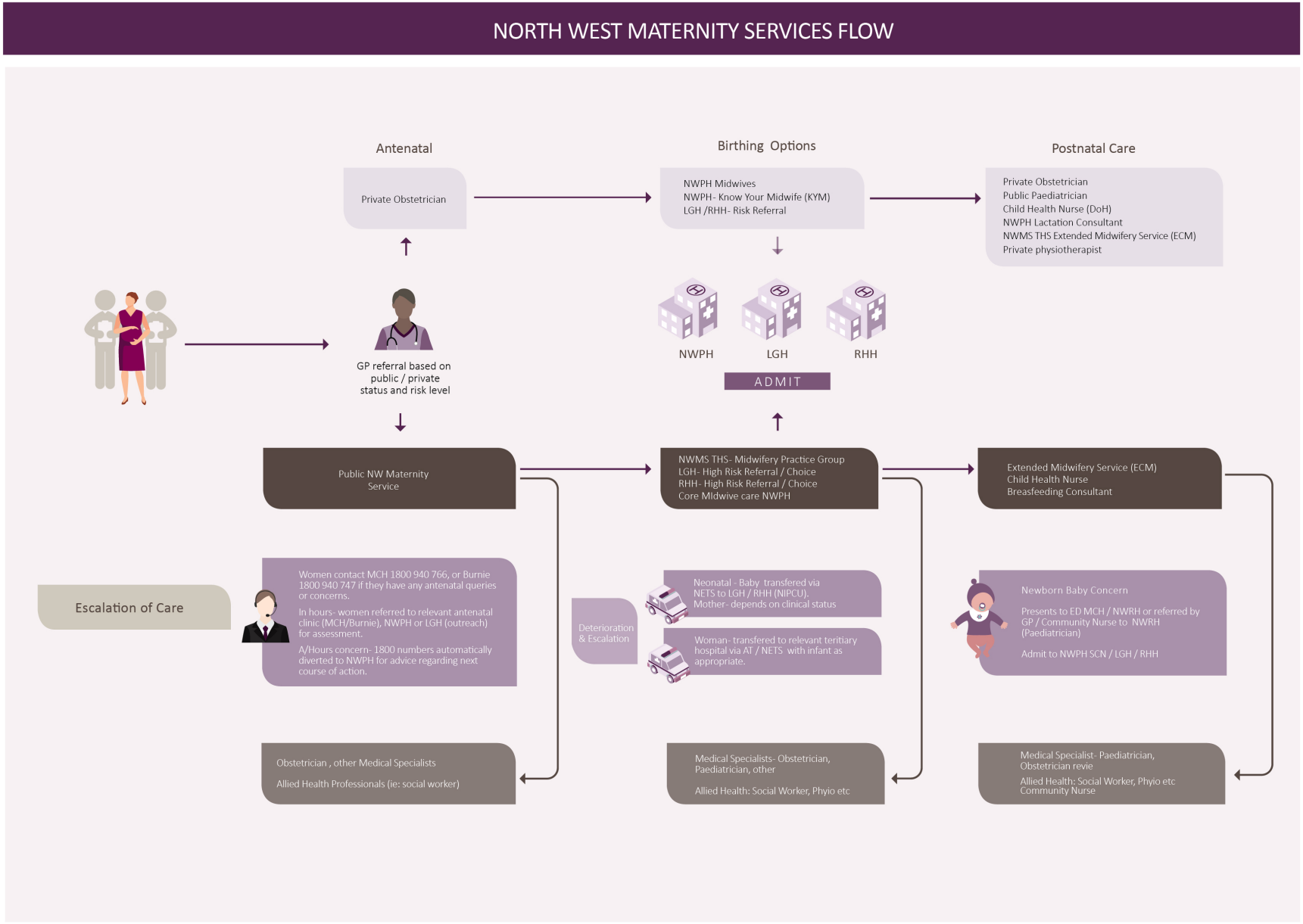

Figure 6: North West Integrated Maternity Services flow

Antenatal care is primarily offered through outpatient clinics based at the MCH (for women in the Latrobe catchment) and at the NWRH campus, (for women in the Burnie catchment).

Access to services for mothers from rural and remote areas is funded through TAZREACH and provided by NW-THS employed midwives to King Island, Smithton, Queenstown and Rosebery.

The *Tasmanian Health Service Maternity Information Package - Your guide to Pregnancy, Birth and Early Parenting* is provided to all women during their first antenatal visit. This document provides guidance to pregnancy, birth and early parenting as well as general information regarding the location of maternity services and phone numbers, specific information regarding antenatal visits, labour and birth options, postnatal care, infant feeding, postnatal services, Child Health and Parenting Services (CHaPs), breastfeeding support clinics, vaccinations and so on.

Women contact the pregnancy assessment services using a 1800 telephone number. The 1800 telephone numbers for different services are similar. Antenatal care midwives informed the review team that women were often confused regarding which 1800 telephone number to call when they had concerns regarding their pregnancy.

Intrapartum care

Intrapartum care for women of low or medium risk is primarily provided at NWPH's Maternity Unit (Huon Ward), under several different models of care, as depicted in Figure 6.

Women requiring admission for induction at NWPH are asked to present to the Huon Ward on their admission date and at the time advised. Women booked for elective caesarean section are also advised of admission dates and times.

The review team were informed of instances where women had presented to the NWRH emergency department in labour, or to the NWPH front door, which is locked at night, and required immediate assistance and transfer to NWPH Huon Ward for imminent delivery.

Women who go into labour at home are asked to phone a 1800 number (connecting to the NWRH antenatal clinic) or the NWPH prior to leaving home to enable preparation for admission. This allows assistance for direct entry into the hospital if the woman is in labour. Women are provided with a Maternity Information Package with details regarding phone numbers and access.

For low risk women delivering at NWPH, there is a requirement to update the registrar every four hours regarding the progression of labour and for any deviation from normal. Two midwives are required to be present when the woman is in 2nd stage of labour.

The review team heard that there were a number of times where MGP midwives felt their clinical decision-making skills were constrained by medical staff. Conversely, the review team also heard that medical staff were concerned that they were not being informed regarding progression of labour and emergent issues in a timely way. Further details are provided about this in a later section.

Some low to medium risk women from the Latrobe catchment have elected to deliver at LGH, although the review team were advised that LGH were currently not accepting referrals /bookings for low risk pregnancies and instead referring these women back to NWPH. It is noted that this is contrary to the stated position that women can access any public hospital of their choosing for delivery.

Women identified during the antenatal period as high risk are preemptively referred to either LGH or RHH for delivery. Systems in place for transfer of these patients as well as those identified as requiring high level care later in pregnancy appear to be appropriate.

Special Midwife Arrangement

During the review process, the review team were advised of a further model of care, whereby midwives (both THS and NWPH employed) could apply to NWPH to be the primary midwife providing intrapartum care by special request of a woman. While it may be reasonable to allow a midwife to care for a woman from one pregnancy to the next, this arrangement also allowed for an individual midwife to provide care at the request of a friend or relative.

Nursing and Midwifery Board Australia (NMBA) sets expectations regarding dual relationships and professional boundaries[9] which are endorsed by the Australian College of Midwives (ACM), Australian College of Nurses (ACN) and a broader principle shared with other health professions about minimising conflicts of interest and providing impartial and objective clinical care.

It is acknowledged that in regional communities, health care workers may find themselves unintentionally providing clinical services to friends or relatives, though this is regarded as a last resort. Dual relationships should be minimised, even in regional

[9] https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

communities and certainly not encouraged or enabled by a health service.

The additional payment to these “special midwives” when other midwifery staff are rostered (and paid) to provide care within a service is also an area of concern.

Staff who spoke about the special midwife arrangement appeared to have little insight into the potential issues involved in (by choice) being the primary clinical decision maker for a friend or relative, nor the fact that such an arrangement does not align with NMBA expectations.

Concerns were raised by members of the review team about this arrangement with the NWPH CEO and DON and advice was provided that it would be ceased immediately.

Postnatal care

Care for the mother post normal childbirth is provided by the midwifery (plus or minus the obstetric team) and, if required, care of the baby is provided by the paediatric team.

The expected length of stay post vaginal birth is 1 - 2 days and approximately 2 - 4 days post caesarean birth. The minimum length of stay is four hours post vaginal birth. Women are encouraged to discuss discharge with the midwife caring for them.

Post discharge, the Extended Care Midwives (ECM) visit women who live within a 30 minute drive from the NWPH, to provide postnatal care and support.

Further early parenting support is provided through a number of services, as follows:

- For breastfeeding support, a breastfeeding helpline or a private lactation consultant is available

- Child Health and Parenting Services (CHaPs) in the north west offer families a home visit within 2 weeks of discharge, child health assessments, healthy kids check, parenting information and referral to other early intervention services where necessary. Other CHaPs activities and programs include:
    - Parenting centres that provide day centre-based and outreach services for families needing more intensive support

- CU@home visiting program for first time parents between 15-19 years of age who have been referred to the program before 28 weeks gestation. The program continues until the infant is 2 years old, and
- A 1300 statewide parent line accessible 24 hours

Due to limited space on the maternity ward, women's partners are not able to room in and this, combined with the lack of privacy, results in many women opting for early discharge. There were reports that some women were discharging themselves against the advice of the clinical team.

The review team noted that women who undertook early discharge often required additional postnatal care and support at home, and that has significant impacts on the workload of the Extended Care Midwives (ECM).

The review team were advised that early discharge was resulting in a number of women representing with breastfeeding issues. ECM midwives reported the need for more Lactation Consultants to manage the postnatal workload.

Midwifery Group Practice

The Midwifery Group Practice (MGP) was established in 2016 and provides a midwifery model of care for maternity care across the continuum of pregnancy for antenatal, intrapartum and postnatal care for up to 14 days postpartum. This is the only model of care within the NWIMS that allows a midwife to work to their full scope of practice.

Access to the MGP is provided through referral from the antenatal clinics following the initial booking in appointment for women classified as a normal pregnancy (low risk) as per the *Midwifery Group Practice Guideline*, August 2018 and the *ACM National Midwifery Guidelines for Consultation and Referral*, 3rd edition, 2013.

MGP midwives are employed by the THS-NW and provide midwifery antenatal care at NWRH and MCH, intrapartum and postnatal care at the NWPH and postnatal care in the community after the woman's discharge for up to 14 days.

MGP midwives practice under the policies, guidelines and procedures of the THS-NW NWIMS. The model of care was designed to enable women to have a known midwife throughout their pregnancy, birth and postnatal period.

MGP midwives are a small group of experienced midwives who work together to ensure continuity of care for a caseload of between 35 - 45 patients per midwife per year.[10] Women requesting care under the MGP model may self-refer or have a referral from their GP or Obstetrician however must meet the selection criteria by having a low risk singleton pregnancy, BMI 18-35, and living within 30 km from NWRH or MCH MGP locations.

Throughout the antenatal period, MGP midwives are required to consult with and refer to the Obstetrics medical team in accordance with documented guidelines.

There is currently no dedicated clinical lead/champion to support the MGP midwives. Support for midwifery led models of care supporting continuity of care need to be embedded at all levels within the service. Evidence supports that MGP and continuity of care models improve outcomes for women and babies and reduce rates of prematurity by 17%. This is significant in Tasmania where rates are amongst the highest in the country.

Governance and support structures that ensure the right balance between autonomy for midwifery led care and effective communication and collaboration with other healthcare professionals, including medical staff, require attention within NWIMS.

Ultimately, MGP midwives need clinical nursing and midwifery leadership and obstetric leadership for support with clear lines of accountability, consistent with the ACM National Guidelines which articulate necessary points of referral, consultation and appropriate handing over of responsibility.

Know Your Midwife (KYM) Program – NWPH

The NWPH has a private midwifery program providing antenatal, intrapartum and postnatal midwifery care. This operates as a shared care model with the private obstetrician.

Private obstetrics

There is one obstetrician offering private obstetric services within the NWPH, although it is noted that this is without the support of private anaesthetists. The private obstetrician has rooms located in the privately owned medical centre which sits between the NWRH with the NWPH.

[10] This number is pro-rated for part-time MGP midwives.

Clinical outcomes

A summary of birth statistics for the NWIMS for 2020 is provided at **Table 6** on pages 42-43.

Emergency caesarean sections

Table 3 depicts the number of caesarean sections, including emergency caesarean sections for the period January – December 2020.

LUSCS for 2020	Count	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Elective LUSCS	Baby	9	7	11	7	13	6	16	14	13	10	7	9	**122**
Emergency LUSCS	Baby	12	18	14	7	17	18	29	13	19	14	15	12	**188**
TOTAL		21	25	25	14	30	24	45	27	32	24	22	21	**310**

Table 3: Number of caesarean sections for 2020[11] (April figures reflect the service closure due to a COVID-19 outbreak)

Time to Category 1 caesarean sections has been identified in previous reviews as a concern and is regularly monitored by the service, with reporting to relevant governance committees.

The aim is for the NWPH to prepare the patient, staff and theatres within 30 minutes, 90% of the time. This uses the optimal decision to delivery interval (DDI) while acknowledging that the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) recommends that no specific time interval be attached to various categories of urgency, instead, each case should be considered on its merits. That said, DDI is a useful audit tool that allows testing of the efficiency of the whole delivery team.

The THS-NW and Healthecare Contract 2016 require NWPH to report times to Category 1 caesarean sections to the Department of Health, RLA Unit as a condition of licensing. This data is provided in January and July of each year. Where times are exceeded, investigation and development of an action plan is required to be tabled at the MWNGC.

The NWPH mostly comply with this timeframe although there were reports of the time being exceeded on occasions, particularly when there have been issues locating an anaesthetist.

[11] Source: Policy, Purchasing, Performance and Reform, Department of Health, April 2021

Anaesthetic services

Public maternity patients have access to anaesthetic services from NWRH, including on-call services after-hours. There continues to be no formal arrangement for provision of private anaesthetic services at the NWPH. If a private patient requires anaesthetic services for insertion of epidural or emergency care, the woman's status is changed to a public patient for that episode of care.

Public anaesthetists find working in the private hospital challenging as they are not familiar with staff, equipment, paper-based charts and different computer systems. Anaesthetists need to have swipe cards to enter the NWPH and at times, this has proved to be a barrier to accessing either the maternity unit or the NWPH theatres.

The review team were also advised of challenges with respect to ensuring that clinical support staff within the NWPH theatres, particularly after hours had the appropriate skills, training and familiarity with emergency equipment.

Epidural service

Table 4 depicts the rates of epidurals for the period January - December 2020, reported at 22%, a significant increase from those documented in previous reviews, suggestive of improved availability of anaesthetic services. However, concerns were expressed with respect to the level of training available for midwifery staff on the maternity unit in the care of the patient with an epidural.

Epidural rates for 2020	Count	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Epidural rates	Pregnancy	21.1%	29.2%	29.7%	15.6%	19.7%	14.5%	20.6%	14.1%	24.1%	24.4%	21.7%	25.4%	**22.0%**

Table 4: Epidural rates for the period January – December 2020[12]

[12]Source: Policy, Purchasing, Performance and Reform, Department of Health, April 2021

Table 5: Birth statistics for NWIMS for 2020[13]

		2020												
	Count	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Model of delivery														
Normal vaginal delivery	Baby	51	45	59	15	42	40	58	46	45	54	40	39	524
Vaginal breech	Baby	0	0	0	0	0	0	0	1	0	0	0	2	3
Vaginal forceps	Baby	0	3	2	1	2	0	5	0	2	5	2	2	24
Vaginal ventous	Baby	3	3	5	2	3	5	1	5	4	3	5	9	48
NVB after instrumental	Baby	1	0	0	0	0	0	0	0	0	0	0	0	1
Elective LUSCS	Baby	9	7	11	7	13	6	16	14	13	10	7	9	122
Emergency LUSCS	Baby	12	18	14	7	17	18	29	13	19	14	15	12	188
TOTAL BIRTHS	Baby	**76**	**66**	**91**	**32**	**77**	**69**	**109**	**79**	**83**	**86**	**69**	**73**	**910**
Total vaginal delivery	Baby	55	41	66	18	47	45	64	52	51	62	47	52	**600**
VBACs	Baby	1	0	2	0	1	0	1	1	1	2	1	2	**12**
LUSCS for breech	Baby	2	1	0	2	4	1	5	3	1	3	0	3	**25**
Total LUSCS	Baby	21	25	25	14	30	24	45	27	32	24	22	21	**310**
Induction of labour	Pregnancy	23	25	32	9	26	22	37	31	32	27	24	25	**313**
Multiple births	Baby	0	2	0	0	2	0	4	2	0	0	0	4	**14**
Stillbirths	Baby	0	0	1	0	2	0	0	1	1	0	0	1	**6**
Neonatal deaths	Baby	0	0	0	0	0	0	0	1	0	0	0	0	**1**
Congenital abnormalities	Baby	0	1	1	0	0	1	0	1	1	0	0	0	**5**

[13] Source: Policy, Purchasing, Performance and Reform, Department of Health, April 2021

Table 5: (continued) Birth statistics for NWIMS for 2020

		2020												
	Count	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Perineum														
Intact	Pregnancy	38	32	50	23	46	38	65	48	49	54	35	41	**519**
1st degree tear	Pregnancy	7	5	7	0	6	6	2	10	8	10	8	5	**74**
2nd degree tear	Pregnancy	21	10	17	5	11	9	19	7	8	10	12	11	**140**
3rd degree tear	Pregnancy	1	0	6	1	3	3	3	0	2	1	4	0	**24**
4th degree tear	Pregnancy	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Episiotomy	Pregnancy	1	9	10	2	9	9	9	13	12	14	8	12	**108**
Complications														
Retained placenta	Pregnancy	1	0	0	0	6	0	2	1	2	0	1	1	**14**
PPH	Pregnancy	13	12	15	7	15	15	26	21	15	16	18	9	**182**
PPH (1000mls +)	Pregnancy	2	4	5	0	5	4	9	5	5	6	5	3	**53**
Babies SCN														
Babies SCN at birth only	Baby	2	3	5	1	6	3	6	2	3	5	5	3	**44**
Babies SCN postnatal	Baby	3	3	6	1	3	7	10	10	6	10	4	4	**67**
Babies SCN birth + post	Baby	9	10	3	2	5	7	11	7	5	6	6	5	**76**
Epidural rates	Pregnancy	21.1%	29.2%	29.7%	15.6%	19.7%	14.5%	20.6%	14.1%	24.1%	24.4%	21.7%	25.4%	**22.0%**

Special Care Nursery

Table 6 shows the admissions to the Special Care Nursery for 2020[14].

Babies SCN 2020	Count	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	TOTAL
Babies SCN at birth only	Baby	2	3	5	1	6	3	6	2	3	5	5	3	**44**
Babies SCN postnatal	Baby	3	3	6	1	3	7	10	10	6	10	4	4	**67**
Babies SCN birth + post	Baby	9	10	3	2	5	7	11	7	5	6	6	5	**76**

Table 6: Admissions to the Special Care Nursery for 2020

Emergency response to deteriorating patient

The provision of clinical assessment and management of deteriorating patients on the maternity unit of NWPH is provided through a MET team response, staffed through the NWRH and the subject of a contract between Healthe Care Burnie Pty Ltd and the THS. **Table 7** shows the number of times where a MET service was not available to NWPH.

While the review team noted there had been improvements to this service since previous reviews, there remain times where there are gaps in service provision for maternity patients experiencing clinical deterioration. On these occasions, patients are transferred by ambulance to the NWRH Emergency Department for assessment and management.

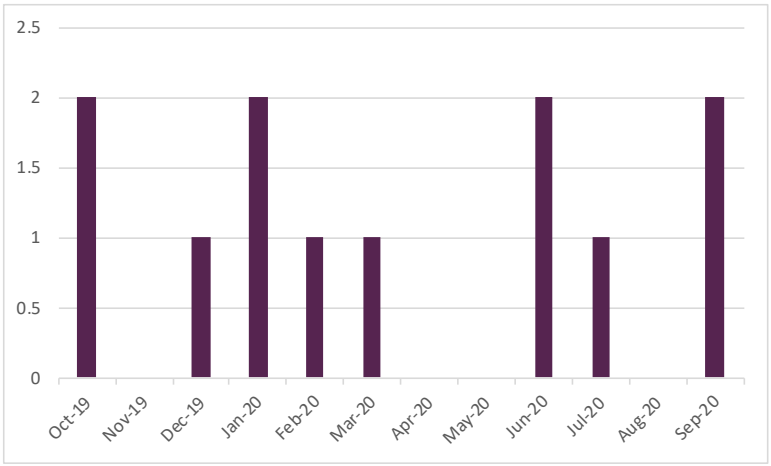

Table 7: Number of times where a MET service was not available to NWPH

[14] Source: Policy, Purchasing, Performance and Reform, Department of Health, April 2021

Transfers and retrievals to other centres

Table 8 below shows the maternal and neonatal transfers for 2020. Neonatal transfer refers to instances where the baby was transferred from the hospital where the delivery or post-natal care took place, to another hospital. Likewise, maternal transfers refers to instances where the mother was transferred from the hospital where the delivery, or immediate post-natal care took place.

	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	TOTAL
Maternal transfers (pre-birth)* Via air or road ambulance	0	0	2	1	4	1	3	3	4	0	1	3	22
Neonatal transfers (post-birth) via NETS	3	2	0	1	2	1	0	0	0	1	0	0	10
* Time critical in-utero transfers to either RHH or LGH (depending on level of care required for either mother or neonate) # Neonatal transfer post-birth due to prematurity (below 34 weeks gestation) or clinical deterioration where NICU care and management is required													

Table 8: Transfers and retrievals for higher level care for 2020[15]

Figure 7 (over page) shows a map of Tasmania with the estimated travel times between sites, including to RHH and LGH. One of the most pleasing aspects of the review was the work that has been undertaken on statewide referral pathways including escalation and transfers of patients requiring higher levels of care.

Physical environment and equipment

Clinical care within the NWIMS is delivered in a number of locations, including the NWRH, MCH, King Island, Smithton, Queenstown and Rosebery.

NWPH – Delivery Suite

The NWPH Maternity Unit has a delivery suite with 4 rooms, each with an ensuite and one which has a large bath to accommodate water births. Additionally, there is one patient assessment room that can easily be converted to a labour and delivery room if required.

NWPH – Maternity Ward

The maternity ward has 21 beds, with two public four-bed rooms (8 beds in total), two public single rooms (2 beds in total) and the

[15] Source: 2020 Data reported from NWPH to DOH Regulation, Licensing and Accreditation Unit (includes public and private patients)

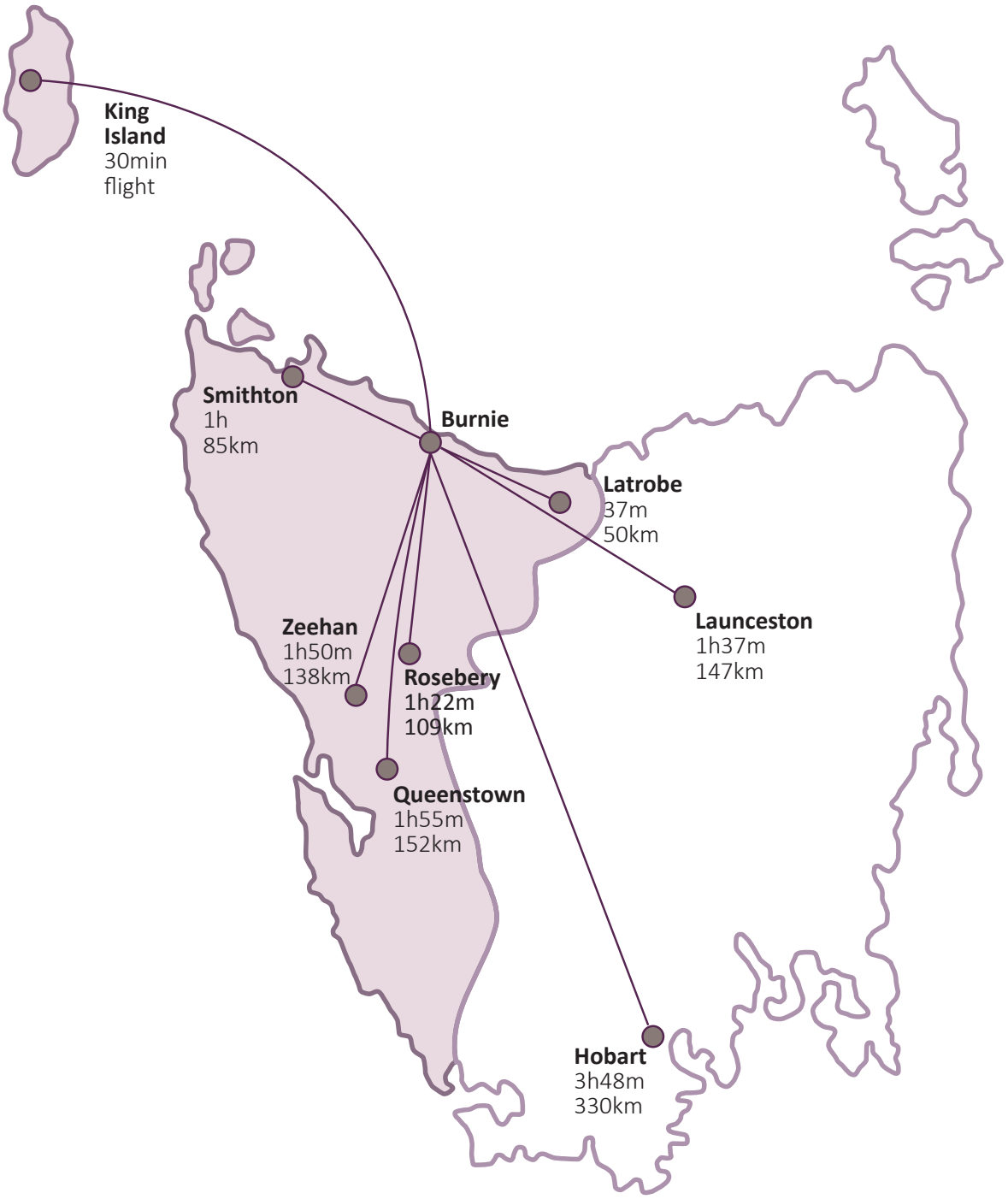

Figure 7: Map of Tasmania showing approximate distances between sites

remainder of beds (11 in total) used for private maternity patients or public patients with additional clinical care requirements.

Work has recently been undertaken to update clinical monitoring equipment and install new neonatal resuscitaires in each of the delivery suites. The labour ward appears to offer a safe and amenable facility for women with access to equipment at an appropriate standard.

A number of comments were made by a range of staff regarding the challenges of delivering care to mothers and infants in the four-bed rooms, notably with respect to privacy, infection control, noise from other patients and families and the lack of capacity to allow partners to room in.

There were a number of reports that the cramped conditions on the four-bed rooms were often given as a reason for mothers to seek early discharge, often prior to receiving adequate breastfeeding support, discharge education and preparation for transitioning home. The review team were informed that a number of women and their families have made complaints about the four-bed rooms.

There were also suggestions from some staff that the NWPH preferentially used the four-bed rooms for public maternity patients, even when a single public room might be available. On balance, observations made by the review team did not support this assertion. The allocation of public patients to single rooms appears to be determined on clinical grounds and is appropriate.

Nevertheless, the review team agreed that providing clinical care to four women and their infants (plus or minus partners) in the same room is suboptimal. Modern maternity units are designed with considerations of infection control practices, optimising privacy, minimising noise and supporting rooming-in models and ideally provide single-bed or in some instances, two-bed rooms.[16]

NWPH – Operating theatre

The operating theatres at NWPH are located within close proximity to the labour ward. The anaesthetic equipment in the operating theatres is of a satisfactory standard. Monitoring equipment is adequate and fulfills the Australian and New Zealand College of Anaesthetic (ANZCA) Standards.

Several anaesthetists expressed the view that they would prefer that emergency caesarean sections should be done in the operating

[16] Australasian Health Infrastructure Alliance, Australasian Health Facility Guidelines HPU 510 – Maternity Unit, Revision 7.0 18 May 2017

theatres of the NWRH. Several reasons were provided, including proximity to additional support, such as the intensive care unit as well as familiarity with the public hospital operating theatre staff, not just with respect to team dynamics but also with respect to managing emergencies.

On balance, there are risks with both approaches, particularly given that the NWRH operating theatres are located at some distance away from the NWPH labour ward.

NWPH – Emergency equipment

Resuscitation equipment in the operating theatres, recovery room and wards is adequate.

The NWPH's Emergency Trolley contents and placement of drugs and equipment need to align with emergency trolleys at the NWRH. This was a quality improvement process undertaken to ensure that the THS-NW MET Teams and anaesthetists attending a code blue or MET call at the NWPH were confident to locate equipment or drugs quickly in an emergency situation.

For the same reason, the Emergency Trolleys at NWPH's Huon Ward and Operating Theatre are not locked for consistency with THS Emergency Trolleys. The labour ward emergency trolley is located close to the nurse's station so the trolley can be seen and monitored by staff easily. All S4 and S8 drugs are kept in a secure locked cupboard behind the nurse's station to comply with the *Tasmanian Poisons Regulations 2018* regarding storage.

The emergency trolley checklist has been revised to ensure checking storage and availability of these S4 and S8 drugs occurs. Emergency trolleys should be checked and signed daily and restocked accordingly following an emergency event. An Epidural trolley is also available on the labour ward that is stocked with equipment and the required drugs required for insertion, and an adult AMBU bag for hand ventilation if required.

NWPH – Outpatient assessment spaces

Under the terms of the contract, the NWPH has a responsibility to provide space for the assessment of pregnant women on an outpatient basis, who may not subsequently require admission.

There is a room co-located on the delivery suite which is used for assessment of women on an outpatient basis. However, there is limited space for a dedicated waiting area and this quickly becomes problematic if more than one woman presents for assessment. The area previously used for outpatient assessment was recently converted into an office and consultation space for medical staff.

Burnie Antenatal Clinic

The antenatal clinic at Burnie is located on the ground floor in the medical centre between the NWRH and the NWPH. There are two assessment rooms, a small waiting area and a reception desk. The overall impression is one of cramped conditions for both women accessing the service (particularly if they have accompanying partners and children) and the staff who work there.

It is noted that a dedicated purpose-built clinic space is currently under construction on the Burnie campus, due to be completed in October 2021. The new antenatal clinic will offer improved access to antenatal services for women as well as a better working environment for staff.

Mersey Community Hospital Antenatal Clinic

The antenatal clinic at the MCH is located in the ward area, previously occupied by the inpatient maternity services. Given its former purpose, there is a large geographical footprint and ample space for a number of assessment rooms, waiting areas, offices and education space for both women accessing the service and staff working within it. MGP midwives also use this clinic area to see women.

NWRH / MCH antenatal clinics – equipment

The provision of equipment at the antenatal clinics as depicted in Table 9 is adequate.

Equipment within Antenatal Clinics	NWRH	MCH
CTG machines	2	2
electric BP cuff	1	2
manual BP cuffs	5	6
Ultrasound machine	1	2
dopplers	5	6
ECG machine	1	1
scales	4	3
temp gauges	2	6
IV pumps	Nil	2
Neonatal Resusitaire (Neopuff)	Nil	1
Adult suction	available	available
Defibrillator	available	available

Table 9: Equipment within the antenatal clinics

Midwifery Group Practice office

The MGP midwives' office in Burnie is temporarily in a THS owned unit 500 meters from the NWRH main entrance. MGP Midwives will see women in consulting rooms in the new antenatal clinic in Burnie when the capital works have been completed.

Recommendations

The “special midwife” arrangements permitting an employed midwife to provide clinical care to friends/family members above and beyond their employed hours of work are to cease. Staff who have been involved in this arrangement to receive education regarding professional boundaries as per NMBA expectations re Dual Relationships and Boundaries. (R3)

Significant work be undertaken to streamline models of care. Once this has been completed, provide education to staff so that everyone understands each component of the service structure. (R4)

Medical Emergency Team (MET) service to meet requirements to provide appropriate and timely response to acute clinical deterioration of maternity patients. (R5)

Ensure that all midwives and theatre nurses have access to relevant education and training to support the delivery of safe and high - quality clinical care in all circumstances, for example, care of a woman with an epidural, management of obstetric emergencies in theatre. (R6)

Chapter four: Clinical governance framework

This chapter gives consideration to some of the elements of a clinical governance framework which support the delivery of safe, high quality patient care.

As noted in the National Model Clinical Governance Framework,[17] clinical governance is "*the set of relationships and responsibilities established by a health service organisation between its state or territory department of health, governing body, executive, workforce, patients, consumers and other stakeholders to ensure good clinical outcomes. It ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high quality health care and continuously improve services*".

The National Model Clinical Governance Framework has five elements as depicted in **Figure 8**:

- Governance, leadership and culture
- Patient safety and quality improvement systems
- Clinical performance and effectiveness
- Safe environment for the delivery of care
- Partnering with consumers

The following sections provide commentary on the organisation and structure, committees supporting clinical governance functions, incident reporting, leadership, credentialing processes and accreditation. Later chapters provide further details on workforce, including culture, and the environment in which care is delivered.

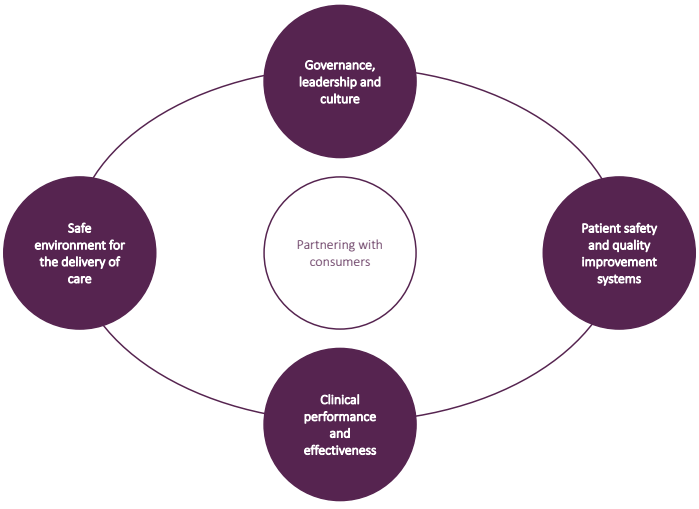

Figure 8: Components of the Clinical Governance Framework (Source ACSQHC, 2017)

[17] Australian Commission on Safety and Quality in Health Care, National Model Clinical Governance Framework. ACSQHC, 2017

Organisation and structure

There are two separate governance structures for the THS and the NWPH. The organisation chart for the THS is provided at Figure 9. The organisation chart of the NWPH is provided at Figure 10.

While public private partnerships in healthcare are not new in Australia, their ultimate success is underpinned by a clearly articulated governance framework, reporting lines and single point executive accountability in the context of working *within the spirit of a partnership* where the shared goal and responsibility is delivery of safe, high quality clinical care.

Despite the best intentions of individual staff involved in maternity services, there was a significant amount of evidence provided to the review team, confirming the impression of a lack of spirit of a partnership between the two organisations, compounded by a complex governance and committee structure and opaque lines of accountability.

Executive oversight and accountability

Executive responsibility for the THS-NW including the NWRH rests with the Chief Executive Hospitals THS-NNW, who also has responsibility for other health services as depicted in Figure 9. In the north west, (at the time of the site visit), this position was supported by an Executive Director of Medical Services and a Executive Director of Nursing. An Operations and Nursing Director for NWRH has also recently been appointed. It is intended that this position will have executive operations oversight for each of the clinical streams.

Executive responsibility for the NWPH rests with the CEO, with responsibility for quality and risk management resting with the Director of Nursing Services, supported at the corporate level by the National Risk Manager and National Quality Manager, and at the local level by the committee structure detailed later in this section.

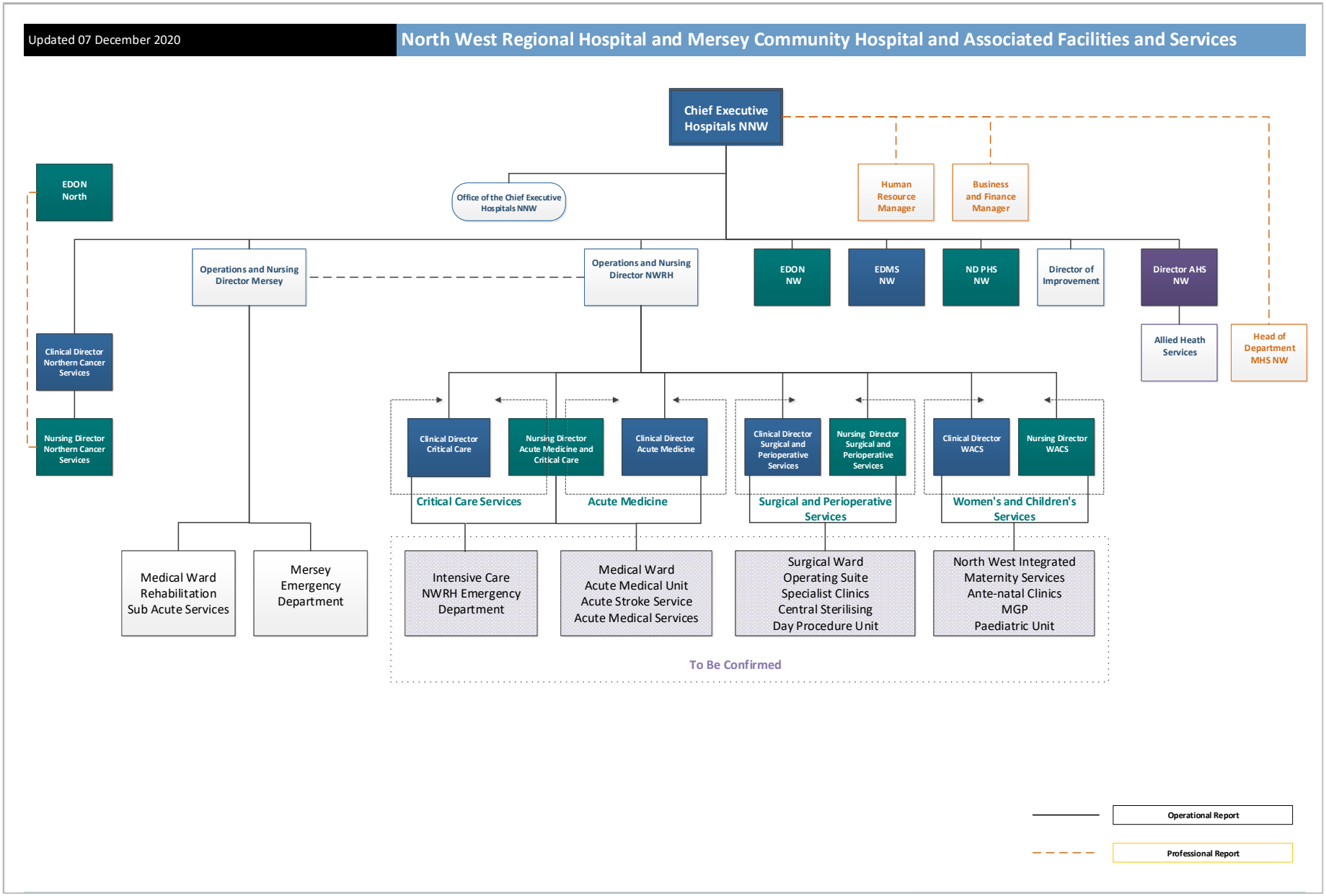

Figure 9: Organisational chart for THS-NW

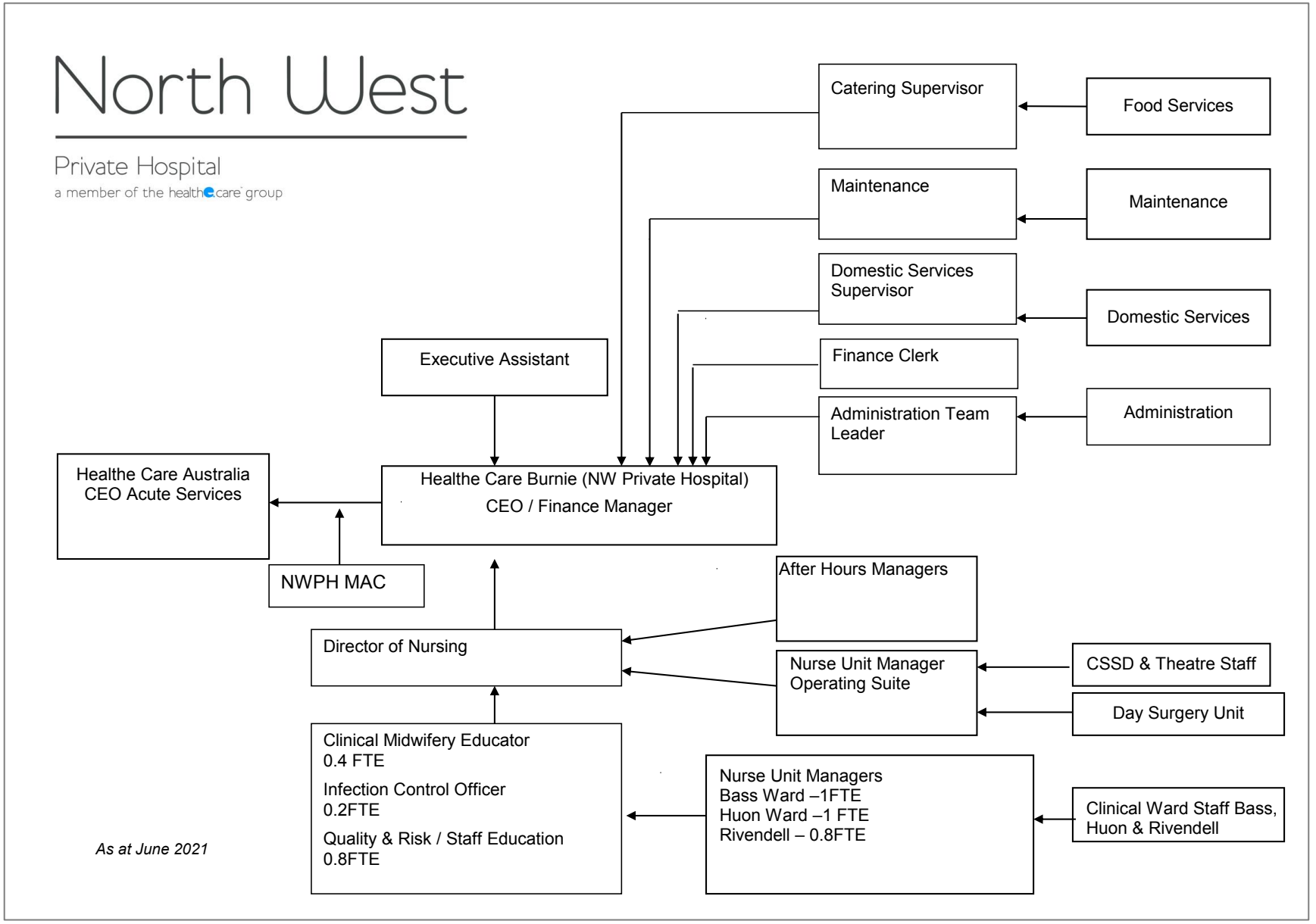

Figure 10: Organisational chart for North West Private Hospital

Committee structure

The clinical governance committees for the NWIMS are depicted in Figure 11. In essence, there is an impression of three silos of committee structures, one for the NWPH, one for the THS and one for the NWIMS. In theory, the latter is intended to connect both organisations to a shared accountability model. In practice, there is evidence that this functions as a complex system with multiple bi-directional reporting lines.

Table 10 shows each committee by meeting dates for the period July 2019 to September 2020. While it is acknowledged that the COVID-19 pandemic had significant impacts on meetings, some committees have met irregularly and not in keeping with their terms of reference.

The THS has a number of committees involved in clinical governance functions as follows:

North West Clinical Governance and Risk Committee

The Clinical Governance and Risk Committee (CGRC) is responsible and accountable for monitoring and evaluating organisational patient care, safety and quality data, and for initiating action in response to this data to improve patient care outcomes. Recommendations from the CGRC will be referred to the relevant committees for review and action.

The Committee is co-chaired by the Chief Executive Hospitals N/NW and the Executive Director Nursing and Midwifery (EDNM) and meets monthly. This meeting has a very broad remit and not surprisingly, while there is evidence of reporting up by the relevant NWIMS committees, a review of the last 12 months of minutes revealed very little discussion of issues impacting on maternity services.

It is stated in the terms of reference that the CGRC will report to the THS Integrated Safety and Quality Committee. The review team were informed that the THS Integrated Safety and Quality Committee was disbanded in 2019. Executive leads in all regions now report to the Department of Health's Safety, Quality and Accreditation Sub-Committee.

North West Peak Mortality and Morbidity Committee

The function of this committee is to contribute to the assessment and evaluation of the quality of health services provided by the THS-North West by reviewing: all deaths at rural and acute hospitals; critical incidents; findings by a Coroner where relevant; and reviewing and recommending improvement to working practices and systems within the health service.

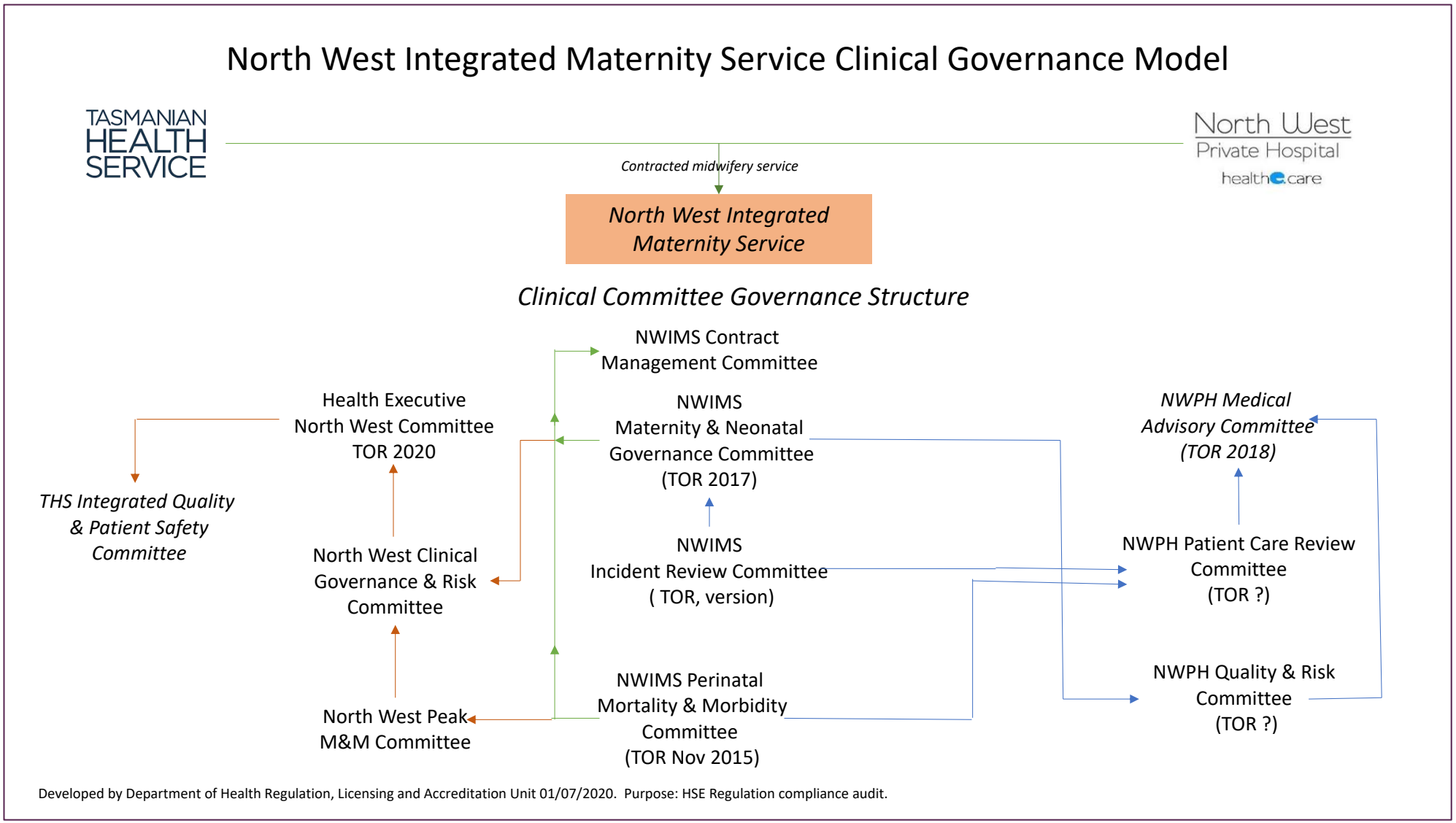

Figure 11: Clinical Governance Committee structure and reporting lines

This committee is not covered by statutory immunity and reports to the Clinical Governance and Risk Committee.

Within the NWIMS, there are 4 committees with clinical governance and related functions.

NWIMS Contract Management Meeting

The Contract Management Meeting is the peak management structure for managing the contract for maternity services between the NWPH and the THS. The terms of reference state that the Contract Management Meeting will discuss the following:

- Service statistics
- Staffing
- Financial management, including the management of disputed invoices
- Audit
- Performance against Key Performance Indicators
- Management of issues escalated for resolution by the Maternal, Women's and Neonatal Governance Committee and the Perinatal Morbidity and Mortality Committee
- Requests to review update or vary Policies and Guidelines or the implementation thereof
- Other items as required

The membership of this meeting includes the Chief Executive Hospitals THS N/NW and the EDMS Services NWRH, in addition to the CEO and DON of the NWPH. The meeting is chaired by the Chief Executive Hospitals of the THS N/NW and meets monthly.

While broadly speaking, a review of the minutes reflects that the required agenda items were discussed, there was evidence throughout the review process of persistent and unresolved issues, suggesting that the capacity of this committee to definitively address issues is constrained.

The review team also noted inherent challenges in balancing the requirement for collaborative relationships at the clinical interface, with those of contract management positioned within a legal framework.

NWIMS Maternity and Neonatal Governance Committee

The stated purpose of the NWIMS Maternal and Neonatal Governance Committee is to monitor and improve maternity services in the THS and the NWPH and the gynaecology service in the THS. This includes monitoring performance against:

- Key Performance Indicators identified in the Contract;
- Women's Healthcare Australasia (WHA) Benchmarking Maternity Care;
- ACHS Clinical Indicators; and

- National Core Maternity Indicators

This Committee meets monthly and is chaired by the EDNM. It includes representation from both the THS and NWPH, across all disciplines and members of the executive of both organisations.

While there is evidence from the minutes of appropriate review of clinical data from within the service, it is unclear from the minutes what information is presented to this committee with respect to benchmarking and comparison with other services. This is an area that requires strengthening.

NWIMS Incident Review Meeting

The purpose of the Incident Review Meeting is to monitor, analyse and discuss adverse events that occur in the provision of care to women and their infants, with the intention of informing improvements to maternity services in the THS-NW and the NWPH.

The Incident Review Meeting is held fortnightly and is chaired by an obstetrician with representation from both organisations. A review of the minutes of this meeting found evidence of discussion of clinical incidents, triaging of review processes and referral to relevant committees.

NWIMS Perinatal Mortality and Morbidity Committee

The stated purpose of this committee is comprised of area wide senior and junior Obstetric and Gynaecology and Paediatric clinical staff and is responsible for reviewing all obstetric incidents.

Ideally, the key lessons from this Committee would need to be effectively disseminated amongst the various maternity service providers.

There are some discrepancies between the Terms of Reference for this committee and those stated in Schedule 4 of the Contract. According to Schedule 4 of the Contract, the Perinatal Morbidity and Mortality Committee will meet to:

- Develop and monitor the education program for medical and midwifery staff
- Identify clinical issues and incidents
- Examine and monitor the quality of care
- Provide case review of SAC 1 and SAC 2 adverse events.

Decisions and recommendations of this committee are to be provided to the NWIMS Maternal, Women's and Neonatal Governance Committee and to the NWPH Patient Care Review Committee for noting and escalation to the NWPH Medical Advisory Committee where appropriate.

The functions noted in the terms of reference for this committee are somewhat different to those stated in Schedule 4 and importantly contain the statement: *"All discussions are to be kept confidential and all case presentations and minutes are to be protected and are bound by the Confidentiality Act."* This implies some constraints around the reporting mechanisms of discussions of concerns to the peak clinical governance committees.

The NWPH has a clinical governance committee structure comprising three committees as depicted in **Figure 12.**

NWPH Medical Advisory Committee

The review team were informed that the peak clinical governance committee for the NWPH is the Medical Advisory Committee which has the stated purpose to "*provide oversight of clinical governance for NWPH in line with best practice, legislative requirements (refer to regulations), Healthe Care Australia By-laws and NWPH Policies to ensure safe and high quality care for patients*".

The functions of the MAC are to:

a. review and consider credentialling applications for appointment and re-appointment as Accredited Practitioners to the hospital ensuring applicants are suitably qualified and make recommendations to the CEO on the accreditation, accreditation category and accreditation type.
b. Review and recommend to the CEO the appropriate scope of clinical practice for medical practitioners and dentists at NWPH.
c. Review at least every 5 year period the credentials and scope of clinical practice of each medical practitioner and dentist appointed at NWPH.
d. Review and ratify clinical policies at the hospital.
e. Review regularly and recommend to the CEO any variations considered necessary or desirable to the credentials or scope of clinical practice of medical practitioners and dentist practicing at NWPH.
f. Advise the CEO on an application to perform an approved procedure following relevant training and in particular any procedure or technique not previously performed at the hospital.
g. Review all SAC 1 and SAC 2 clinical incidents and make any necessary recommendations.
h. Communicate as may be necessary or appropriate with any other committee declared by the Minister under section 4(1) of the Health Act 1997 to be an approved quality assurance committee for the purpose of the Act in respect of any matter relevant to the functions of the committee.
i. Undertake any other function specified by the Secretary or required under the Hospital By-Laws.

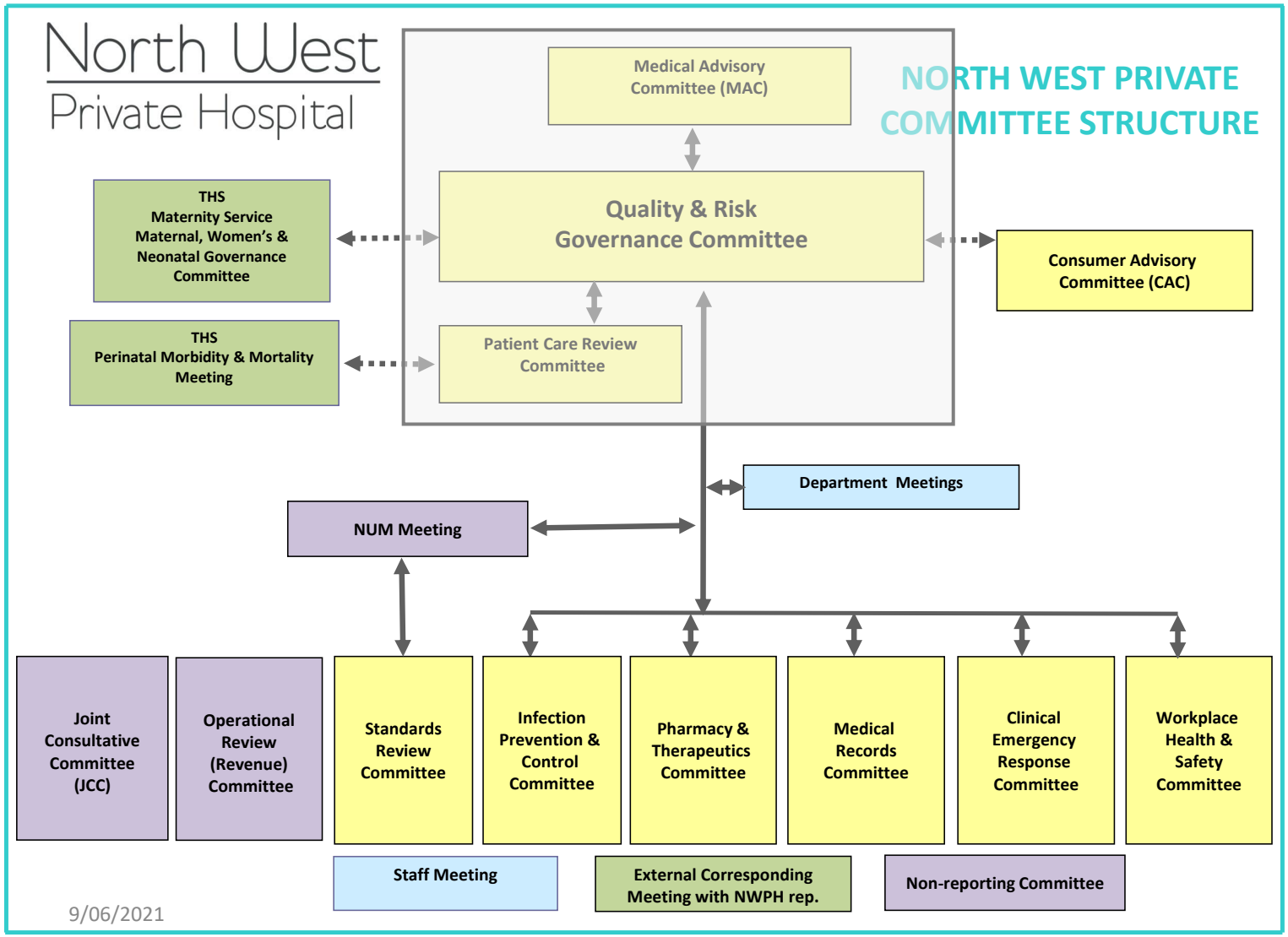

Figure 12: North West Private Hospital Committee Structure

Committee	July 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	June 2020	July 2020	Aug 2020	Sep 2020
THS NW Clinical Governance and Risk Committee	✓	✓	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓	✓	✓	✗
THS NW Peak Mortality and Morbidity Committee	✗	✓	✗	✓	✓	✓	✓	✗	✓	✗	✓	✓	✓	✓	✓
NWIMS Maternity, Women's and Neonatal Governance Committee	✗	✗	✗	✓	✓	✓	✓	✓	✗	✗	✗	✓	✓	✓	✓
NWIMS Perinatal Mortality and Morbidity Committee	✗	✗	✓✓	✓	✗	✓✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
NWIMS Incident Review Committee	✗	✗	✓	✓✓	✓	✓✓	✓	✓	✓✓	✗	✗	✓	✓✓	✗	✗
NWPH Medical Advisory Committee	✗	✓	✗	✗	✓	✗	✗	✗	✗	✗	✗	✓	✗	✓	✗
NWPH Patient Care Review Committee	✗	✗	✗	✗	✓	✓	✗	✓	✗	✗	✗	✓	✗	✗	✗
NWPH Quality and Risk Committee	✗	✓	✗	✓	✓	✓	✗	✓	✗	✗	✓	✓	✗	✓	✓

Table 10: Clinical Governance Committees meetings for period July 2019 to September 2020.

According to the terms of reference, membership of the MAC occurs through election by and from those Health Professionals who have been accredited by the hospital, with each major specialty represented. Election occurs at the annual meeting of the MAC. Obstetric representation is provided through the private obstetrician at NWPH.

It was noted, in line with the focus of the MAC on appointments and credentialing processes, that the MAC has given significant attention to the credentialing of the MGP midwives providing clinical services within the maternity unit. This is detailed in a later section.

NWPH Quality and Risk Committee

The Quality and Risk Committee has a number of functions listed in the terms of reference, including supporting a culture that facilitates the active participation of all staff in an integrated and systematic quality improvement program; implementing quality and safety activities that align with the NSQHS standards; promoting best practice; monitoring trends in complaints; and endorsing all NWPH policies prior to review and ratification by the MAC.

The frequency of meetings is monthly and while the Terms of Reference state the committee is chaired by the Quality Manager, the minutes reflect that it is chaired by the DON. While membership includes provision for medical and nursing staff, a review of the minutes reflects the absence of regular attendance by medical staff. The Quality and Risk Committee reports to the Medical Advisory Committee.

NWPH Patient Care Review Committee (PCRC)

The stated purpose of the PCRC is to be the formal committee through which organisational wide clinical outcomes and patient care issues can be monitored and evaluated and appropriate recommendations made to the Quality and Risk Committee, the MAC and the Hospital Executive Management Team. This includes review of significant clinical incidents of Severity Assessment Classification (SAC) 2 and 3.

The PCRC also serves as the mechanism for formal correlation with the THS NW Region's Perinatal Mortality and Morbidity Committee. This committee meets monthly, is chaired by the DON and membership includes the Nurse Unit Managers from the maternity ward, in addition to a medical representative from Obstetrics. The PCRC reports to the Quality and Risk Committee.

Policies and processes

Clinical policies related to maternity services were provided to the review team. Most of the policies provide comprehensive coverage of medical issues and the care of the maternity patient and infant.

There was evidence of a system of review of policies through the NWIMS Maternal and Neonatal Governance Committee and this was generally working well. At times, it was difficult to follow the pathway of approval processes of policies through the documented minutes to other relevant committees.

Strategic Document Management System (SDMS) is the storage and management system for the Department of Health (DoH) and the Tasmanian Health Service's (THS) strategic documents including policies and subordinate documents. SDMS provides the following functions:

- Single repository (filing system) for THS Policy documents which captures date of effect, review date, and risk rating
- Basic reporting function for Statewide and local service areas
- Intranet accessibility to CM9 (TRIM Database) for workforce viewing

NWPH maternity staff members do have access to NWIMS policy documents via SRLS, however they also must comply with Healthecare's policy documents for private patients.

Audit and monitoring

The quality of maternity services is monitored through regular audit and benchmarking activities, including collecting data on the 10 national core maternity indicators and submission to ACHS.

During 2020, a number of concerns regarding the MGP model of care were brought to the attention of the NWPH MAC, particularly regarding communication issues, delays in referrals and compliance with clinical policies and procedures. In response, the MAC requested that an audit be completed by the NWPH Quality Manager to measure compliance of MGP midwives working in the NWPH birthing suites.

The audit was conducted over two periods, the first being 1 January 2020 to 30 June 2020 and the second being from 1 July to 31 July 2020, following the introduction of the MGP Birthing Suite Checklist, which included the following 8 criteria:

1. Obstetric registrar/consultant notified of MGP patient admission to birth suite and provided clinical update of patients progress at least 4-hourly

2. NWPH midwife in-charge advised of progress throughout first stage of labour

3. All observations documented as per “Normal Labour and Birth Procedure”, Active First Stage of Labour Monitoring

4. Obstetric registrar contacted if there is any deviation of normal parameters during labour

5. NWPH midwife in-charge notified of the commencement of second stage of labour

6. Obstetric registrar/consultant contacted if delay in second stage is greater than 30 minutes for parous patient and 1 hour for nulliparous patient as per the “Normal Labour and Birth Procedure”, assessing the progress of Second Stage Labour

7. NWPH Midwife present as the 2nd midwife at time of birth

8. All practice compliant with “Normal Labour and Birth Procedure”

Audit findings showed an overall compliance with the 8 criteria of 55% for the Jan-Jun 2020 period and a compliance rate of 70% for the second period.

Following the initial audit, several steps were taken, including the audit being extended to all births at the NWPH (both MGP and NWPH midwives), with an expectation of results being collated monthly and reported to the MAC quarterly, and the Maternity and Neonatal Governance Committee monthly.

Incident management reporting

Management of incidents within the NWIMS is lengthy and can be complex. This is due to the governance arrangements for the NWIMS and the reporting requirement for both the public and private health service organisations to review, investigate, agree with investigation outcomes and endorse the report and recommendations, all within the required timeframes for each organisation.

The following independent reporting systems are required to satisfy the organisational governance requirements of the THS, Healthecare and the DoH:

- Safety Reporting and Learning System - SLRS (public reporting system)
- RiskMan (private reporting system)
- DoH statutory reporting requirements.

Due to the complex reporting requirements, recommendations are not always implemented in a timely manner.

The NWPH must report injuries on any patient sustained at the facility that require medical attention, all transfers due to injury or an iatrogenic condition, and deaths in accordance with the statutory requirements outlined in Clause 10 of Schedule 1, Part 4 of the *Health Service Establishments Regulations 2011* and other nationally recognised sentinel events that may occur.

As the provider of intrapartum care for the NWIMS, the most serious midwifery related incidents involving the deterioration of a woman and/or the infant during childbirth, and where escalation of care of mother and/or infant is required, usually occur at the NWPH.

The NWPH Director of Nursing or delegate must report all incidents that occur at the facility in the private hospital's incident reporting system (RiskMan), and if the incident involves a NWIMS patient, it must also be reported in the public incident reporting system (SLRS). Significant incidents as described above must also be reported to the DOH within three days via an incident report (referred to as a Form 18).

For incidents involving a NWIMS woman and/or infant, the review of the incident is led by the THS-NW Quality and Patient Safety Service to investigate and determine outcomes and recommendations.

This may involve establishment of a RCA team to interview clinical workforce, review systems and processes across the service and how they intersect between the public and private hospital, review of equipment, consultation with leading specialists in the field or research into best practice to determine changes to clinical practice requirements or other recommendations for future risk mitigation, patient safety and quality service provision.

The report is then shared with the peak North West Mortality and Morbidity Committee for sign off, prior to being endorsed by the NW Chief Executive Hospitals position. The report is subsequently shared with the NWIMS Governance Committee and the NWPH's governance committees.

The NWPH consider the report and recommendations for implementation from the service delivery perspective. This is undertaken by the NWPH Patient Care Review Committee and Quality and Risk Committee prior to being considered by the Medical Advisory Committee (as the NWPH's highest level of clinical governance) for agreement and endorsement.

The NWPH CEO and DON hold responsibility and accountability for implementation of recommendations at the NWPH and must report progress to the DOH's Regulation, Licensing and Accreditation Unit and NWIMS Governance Committee.

The NWIMS's Maternity and Neonatal Clinical Governance Committee is responsible for monitoring the implementation of recommendations until completion and escalating any concerns to the NWIMS Contract Committee.

All incidents involving private maternity patients were reported in accordance with the *Health Service Establishments Regulations 2011,* Clause 10 of Schedule 1, Part 4 and investigated through the NWPH's Governance Committees and MAC.

All incident investigations (Severity Assessment Code [SAC] 1-4) must be complete within 70 days for the private sector, unless an extension is requested and approved for additional time. In the public sector SAC 1 and 2 incidents should be completed within 70 days, and SAC 3 and 4 within 20 business days.

Where a maternal, or neonatal death has occurred, the treating obstetrician (supported by midwives) must report to the Council of Obstetric and Paediatric Mortality and Morbidity (COPMM), in accordance with the *Obstetric and Paediatric Mortality and Morbidity Act 1994.* The primary function of the council is to review and classify all Maternal, Paediatric and Perinatal deaths including stillbirths and neonatal deaths in Tasmania.

In general, evidence provided in the relevant committee minutes indicates that clinical incident reporting and review is being undertaken appropriately, although at times it was difficult to follow the flow of reporting of incidents through the various committees.

It was also noted that the reporting processes through committees has, at times, led to delays in providing feedback to staff on outcomes and key learnings of review processes.

Figure 13 depicts the incident reporting and investigation pathways for SAC 1 clinical incidents. Figure 14 depicts the incident reporting and investigation pathways for SAC 2, 3 and 4 clinical incidents.

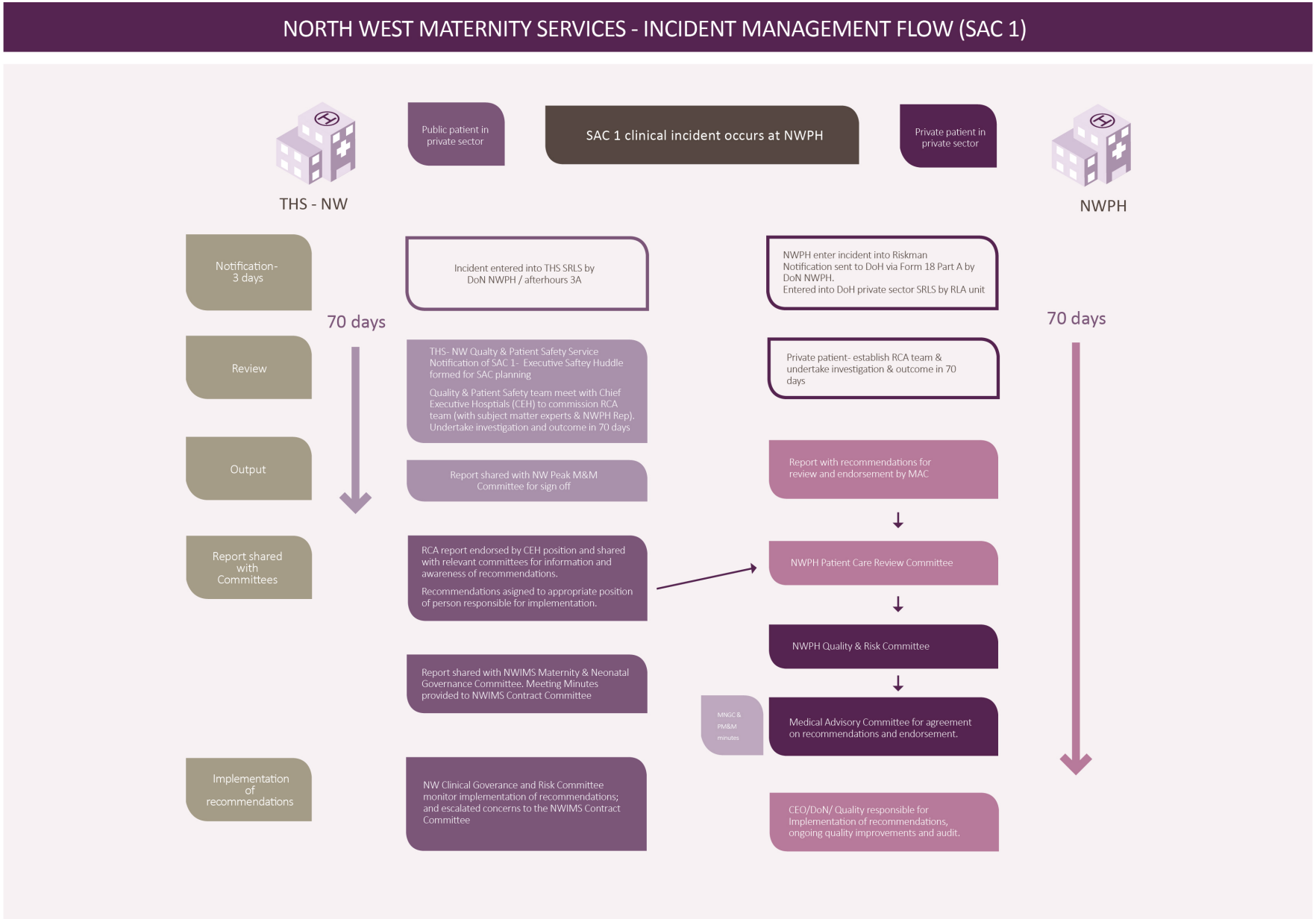

Figure 13: Incident Management Flow for SAC 1 Incidents

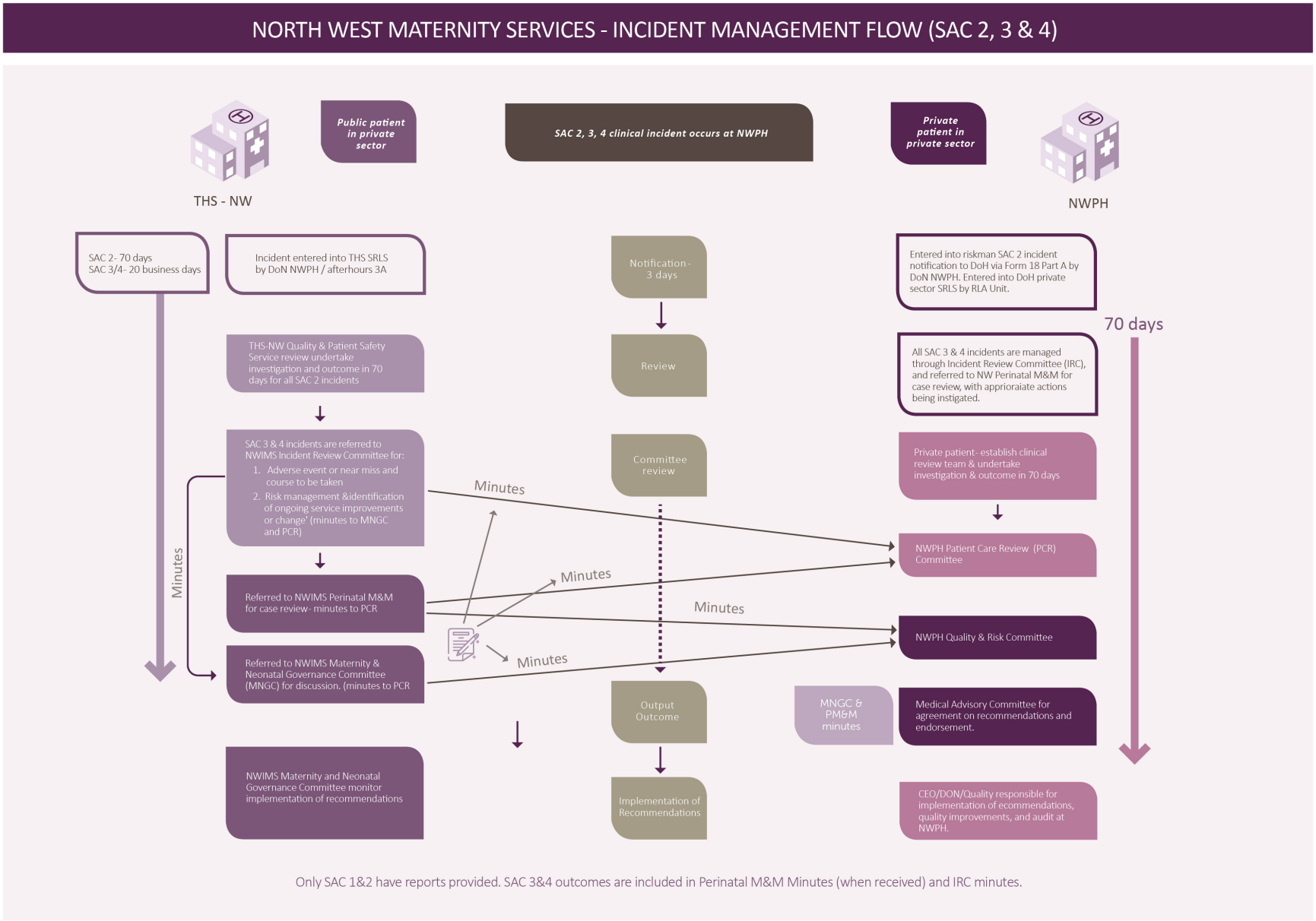

Figure 14: Incident Management Flow for SAC 2, 3, And 4 Incidents

Credentialing - medical staff

The appointments and credentialing of senior medical practitioners working within the NWIMS is undertaken by both the THS Medical and Dental Appointments Advisory Committee (MDAAC) and the NWPH Medical Advisory Committee (MAC).

Medical practitioners appointed through the THS, providing clinical services to maternity patients and infants within the NWPH (predominantly obstetricians, paediatricians and anaesthetists) are required to submit an application for clinical privileges to the NWPH MAC for consideration.

Re-credentialing of medical staff occurs every five years. Evidence provided through documents and interviews suggests that credentialing practices are in line with relevant standards.

Credentialing - midwifery staff

Since the establishment of the MGP model, the NWPH MAC has taken the decision to credential midwives working on the maternity ward as per the requirements set out in *Annexure N Model Criteria Midwifery Group Practice* (refer to textbox over page) under the NWPH's HealtheCare By-Laws. While it is noted that credentialing of midwives is a requirement of the contract, some staff raised concerns regarding the approach being taken.

Requirements include being able to demonstrate the equivalent of 3-years full-time post registration experience as a Registered Midwife and evidence of current competence to provide pregnancy, labour, birth and postnatal care. Credentialing is undertaken on an annual basis.

The review team noted that while the MAC had requested the advice of specialist obstetricians on the credentialing of MGP midwives, this had been declined. Further, there are no provisions within the terms of reference of the MAC to seek midwifery input on the credentialing of midwives, and neither does the MAC credential NWPH midwives, including those participating on the KYM program.

In the past review of the MGP, midwives credentials has been undertaken by a subcommittee consisting of the NWPH DON, with obstetric input from the private obstetrician however this was proving difficult when a conflict of interest arise, and THS obstetricians did not consider their role was to review MGP midwives practice on the private hospital MAC.

In 2020 concerns regarding safety and quality were raised by the medical staff to the AMA which ultimately delayed the credentialing of 2 midwives. If MGP midwives are not credentialed, they are unable to practice midwifery at NWPH.

Many of the MGP midwives expressed concern regarding the credentialing process, particularly with respect to the different standard which appears to be set for MGP midwives compared with other midwives working under different models of care within the north west of the state.

It is noted that Annexure N refers to the ANMC Competency Standard (2006) which is no longer in use and while much of the content has remained unchanged, this has been superseded by the Nursing and Midwifery Board of Australia - Midwife Standards for Practice.

The local credentialing process should not create further burden of proof/evidence or restrict a midwife from what they are professionally endorsed and registered to provide. Many of the other requirements listed in Annexure N duplicate those already met through THS employment requirements or the legal scope of practice through the professional qualification and registration body.

Ultimately, the credentialing process for MGP midwives and subsequent audits of compliance with NWPH policies and procedures has been a source of significant tension between the NWPH, obstetricians and the MGP midwives.

A registered midwife employed by the THS will have already met all the required standards of competency and is required to continue to provide evidence to AHPRA for recency of practice in addition to using the NMBA decision making framework regarding their individual skill set within the legal midwifery scope of practice.

Credentialing to perform the work midwives have been employed to do should not require providing additional evidence beyond having met the requirements mentioned above.

A service that choses to have additional criteria must ensure that a fair and equitable process can be demonstrated with the same expectations for all professions across all employment situations.

Concerns regarding an individual practitioner should have a clear governance and supportive review process within or connected to the service. This includes fair performance management and reporting processes, (including reporting to the professional regulation body), as well as capacity for independent review of practice when required.

ANNEXURE N Model Criteria Midwifery Group Practice (MGP)

An applicant seeking to be identified as a practitioner within Midwifery Group Practice (MGP) must be able to meet all the requirements to practice in Australia as per the Australian and Midwifery Council National Competency Standards for the Midwife (2006) including: being able to demonstrate the equivalent of three (3) years full time post registration experience as a midwife and evidence of current competence to provide pregnancy, labour, birth and postnatal care, through professional practice review: and have an approved qualification required for practice across the continuum of midwifery care.

- Practice for at least three years across the continuum of midwifery care, ie: demonstrates competency and proficiency as a midwife in:
    - Antenatal,
    - Labour, birth
    - Postnatal care
    - Lactation and infant feeding

  consistent with the Australian Nursing and Midwifery Council National Competency Standards for the Midwife (2006), within the previous 5 years.

- Demonstrates understanding of and evidence of commitment to continuity of carer models of midwifery care.

- Demonstrates and shows evidence of ability to work effectively within a multidisciplinary team with consistent adherence to ACM National Midwifery Guidelines for Consultation and Referral (2008).

- Demonstrates commitment to ongoing professional development and evidence of capacity to meet the Australian College of Midwives Midwifery Practice Review (Credentialing) process within 12 months of commencement of the model of care.

- Demonstrates and shows evidence of effective written and verbal communication skills.

- Evidence of current employment with the Tasmanian Health Service (THS) as a registered midwife within the THS-North West midwifery group practice program (mandatory requirement).

[Source: Healthe Care]

Clinical communication

There were a number of issues identified across NWIMS with respect to clinical communication. The impacts of multiple models of care operating within a complex service structure, present a number of inherent challenges for clinical staff in ensuring communication optimises patient safety. Many staff raised issues with respect to clinical handover practices, in particular and the continuum for care planning, in the context of a multitude of care providers being involved in one women's pregnancy. There are clearly opportunities to strengthen clinical handover processes and

promote more collaborative, interprofessional communication across the service.

The review team also heard that the NWPH's admission paperwork was very cumbersome, difficult for some women to finish and was therefore required to be completed when the women booked in for admission. The NWRH midwives articulated their frustration with respect to having to duplicate the admission information due to the requirement to input the woman's details, history and admission into the Obstetrix system in addition to the THS record. It was reported that there were often delays in processing clinical information into the maternity database used across NWIMS (Obstetrix). One reason provided for this was inadequate training for locums on the use of the Obstetrix system and its processes.

The review team were informed of many instances where communication and clinical documentation was problematic due to delays in uploading data into Obstetrix.

Summary of key issues

While broadly speaking, the elements of a clinical governance framework were in place, there was significant evidence to support the lack of integration, with duplication of committee structures, lengthy times for investigation and lack of reporting back to relevant staff members.

The structure of clinical services, delivered across multiple sites, involving different models of care (which is to be encouraged), but under a complex leadership and governance structure has presented significant challenges to ensuring the delivery of safe care, despite the best efforts of individual clinicians. Many clinicians (medical, midwifery and others) currently working in the service raised concerns with the review team about their capacity to deliver safe care.

It is clear that many of the issues identified in this chapter have been longstanding, evidenced by multiple prior reviews and while it is acknowledged that significant effort and progress has been made to address some issues, a number of other issues remain unresolved.

In giving consideration to these issues, the review team is firmly of the view that simply tweaking the service or committee structure will not address the underlying structural and governance issues and more fundamental changes are required.

After careful consideration, the review team recommend that public maternity services should move to a single governance structure and that this is best placed under the governance of the Tasmanian Health System. It is recognised that this cannot practically be achieved while the existing public private contract is in place and transition arrangements will need to occur with consideration given to all parties.

That said, it is hoped that moving the governance of all public maternity services under the Tasmanian Health Service will support a more fully integrated public maternity service across the state, thereby ensuring equitable and seamless access to high quality and safe patient care for all women and infants, regardless of postcode.

It is also intended that the implementation of this recommendation will increase opportunities for public maternity services in the north west of the state to better connect with existing expertise at a state and national level, including in the areas of policy development, clinical practice and clinical governance functions.

Recommendations

A one employer and single governance structure, under the Tasmanian Health Service, be implemented for the provision of all public maternity services in the north west of the state. This aligns with the delivery of public maternity services elsewhere in the state and provides opportunities to move toward a more fully integrated and networked statewide service. (R1)

The committee and clinical governance arrangements be strengthened in line with the future service direction. The review team is of the view that the issues identified in this report are of such complexity, that simply restructuring the existing committees will not address the underlying issues. (R7)

The contract committee membership to be reviewed with the aim to separate operational management from contractual functions. It is suggested that the THS be represented by someone from within the DoH (albeit with contributions and advice from the relevant Executive). (R8)

Credentialing arrangements of midwives to be reviewed and endorsed by the ACM professional body. These should remain in line with existing registration requirements regarding Midwifery scope of practice through NMBA and AHPRA. (R9)

Handover processes across the service be strengthened. This should include establishing shared rules for documentation of management plans, alignment of clinical care pathways with shared forms for all models of care across sites. (R10)

Chapter five: Workforce

This chapter provides information and data about the current clinical workforce supporting the delivery of maternity services. The review team acknowledge the inherent challenges in recruiting and retaining a clinical workforce within regional areas, including the north west of Tasmania.

Medical workforce

Obstetrics

Specialist obstetricians, as well as junior medical staff are employed or contracted through the THS-NW to provide clinical care to public patients admitted to the maternity unit. **Table 11** shows the current obstetric workforce.

Position	FTE/Sessions	Employer
SENIOR MEDICAL STAFF		
Staff specialist (Clinical Lead)	1.0FTE	THS N/NW
Staff specialist	1.0FTE	THS N/NW
Staff specialist	1.0FTE	VACANT
Staff specialist	1.0FTE	VACANT
Staff specialist	1.0FTE	VACANT
Visiting Medical Officer		Private practice
Senior medical staff total **headcount**	6	
JUNIOR MEDICAL STAFF		
Registrar	1.0FTE	THS N/NW
Registrar	1.0FTE	Seconded from RHH
Registrar	1.0FTE	Seconded from RHH
Resident Medical Officer	1.0FTE	Seconded from RHH
Junior medical staff total **headcount**	4	

Table 11: Obstetric Medical Workforce

It is noted that the previous Clinical Lead retired in 2020 and the interim Clinical Lead was on extended leave from the period March through to November 2020.

The senior medical workforce has almost entirely changed over during the last five years, exacerbating issues in retaining a stable medical workforce. In the interim, senior obstetric vacancies have been managed through the engagement of short-term locums.

The three vacant positions have recently been recruited to and the successful applicants are due to commence in early - mid 2021. This is viewed as a unique opportunity to consolidate and stablise the senior medical workforce for the service going forward.

Private obstetric services to private maternity patients at the NWPH are provided through a single obstetrician.

The NWPH is accredited with RANZCOG for registrar training with trainees on rotation for up to 12 months from RHH. The service is also accredited for the RANZCOG Diploma.

Anaesthetics

Table 12 (below) shows the current anaesthetics medical workforce. All anaesthetists are contracted or employed through the THS-NW to provide services to public patients. As previously identified in this report, there are no private anaesthetic services

Position	FTE/Sessions	Employer
SENIOR MEDICAL STAFF		
Staff specialist (Clinical Lead)	1.0FTE	THS N/NW
Staff specialist	1.0FTE	THS N/NW
Staff specialist	1.0FTE	THS N/NW
Staff specialist	1.0FTE	THS N/NW
Staff specialist	1.0FTE	THS N/NW
Staff specialist	1.0FTE	THS N/NW
Staff specialist	1.0FTE	THS N/NW
Staff specialist	1.0FTE	THS N/NW
Staff specialist	1.0FTE	THS N/NW
Staff specialist	1.0FTE	THS N/NW
Staff specialist	1.0FTE	THS N/NW
Senior medical staff total **headcount**	11	
JUNIOR MEDICAL STAFF		
Registrar	1.0FTE	THS N/NW
Registrar	1.0FTE	THS N/NW
Registrar	1.0FTE	THS N/NW
Registrar	1.0FTE	THS N/NW
Resident Medical Officer	1.0FTE	THS N/NW
Junior medical staff total **headcount**	5	

Table 12: Anaesthetics medical workforce

at NWPH. The NWPH have advertised for this service but to date have been unsuccessful.

The lack of an anaesthetist willing to provide services to a private obstetric patient requiring an epidural or caesarian section is problematic. The review team were advised that in the event that a private patient requires anaesthetics services, the patient's classification is changed from private to public status. It is unclear what implications this has on the woman's choice, the private obstetrician nor on the NWPH meeting its contractual obligations. This issue was identified in previous reviews and remains unresolved.

The anaesthetics roster has anaesthetists covering an emergency service within the NWRH in addition to being available for epidurals and emergency obstetric cases in the NWPH. The multiple demands on the on-call anaesthetist have at times, led to delays in providing anaesthetics services within the NWPH. The current system relies on telephoning potentially available (but off duty) anaesthetists to assist. While there was no available data to assess the frequency of this, the review team formed the view that a more systematic response through the provision of a second on call anaesthetist was required.

Somewhat tellingly, the review team were informed that given concerns expressed by anaesthetists with respect to proximity and levels of additional support in the NWPH operating theatres after hours, consultant anaesthetists provide Level 1 (direct) supervision of registrars who are called to the operating theatres of the NWPH after hours.

Midwifery workforce

Tables 13 a and b show the midwifery staffing levels across the different services/models of care within the NWIMS, in addition to the administrative staffing. Several issues were identified during the consultation process with respect to the midwifery workforce.

Issues were noted whereby women admitted under the MGP model of care to the Huon Ward, often had to wait for routine care to be provided once MGP midwives were on duty, rather than being offered care by the core NWPH midwives on duty. This is particularly problematic when MGP midwives have been working late with labouring women the night before. Several reasons were provided for this including the rostering arrangements for the MGP midwives, staffing levels of the NWPH core midwives, as well as reflecting somewhat dysfunctional silos within the service. This practice does also not reflect the philosophy of woman centred care as described in professional and regulatory frameworks.

Midwife title	Grade	FTE funded	Head count	Comment
Assistant Director of Nursing	8	1	1	
Nurse Unit Manager	7	1	1	
Clinical Nurse /Midwifery Educator	6	1.06	1	
Clinical Nurse Consultant ECM / Lactation Consultant	6	1	1	
NWRH BURNIE ANTENATAL CLINIC				
Clinical Coordinator/s	5	1	1	Located at NWRH ANC
Antenatal midwives (Burnie)	Grade 3/4	4		NWRH ANC 10.29 FTE for ANC/ECM and MGP; Filled at 8.92 FTE
Antenatal midwives (Burnie)	Grade 3 - casual	0.84		
Admin support – business hours	Band 2	2	4	
MERSEY ANTENATAL CLINIC				
Antenatal midwives	Grade 3/4	8.24 combined	4	8.24 FTE and filled at 6.43 FTE
Antenatal midwives	Grade 3/4			
Admin support – business hours	Band 3	0.4	1	
Admin support – business hours	Band 2	2	3	
Admin support – business hours	Band 2 casual		2	
MIDWIFERY GROUP PRACTICE				
MGP Midwives (NWRH)	Grade 3/4	5	Was 5, down to 3.5	Funded to 5.0FTE; Filled at 3.5FTE
MGP Midwives (MCH)	Grade 3/4	3	4	Funded to 3.0FTE; Filled at 2.38 FTE
MGP Advanced Practice Program	Grade 3	0.84	1	
EXTENDED CARE MIDWIFERY				
ECM Midwives (MCH)	Grade 4	1.49	2	Funded to 1.49 FTE; Filled at 1.37 FTE
ECM Midwives (NWRH)	Grade 4	1.29	2	Included in the 10.29 FTE NWRH ANC

Table 13a: Midwifery workforce - THS employed

Midwife title	Level	FTE funded	Head count	Comment
NORTH WEST PRIVATE HOSPITAL				
Nurse Unit Manager	3	1	2	Job-share arrangement
Clinical Nurse Educator	3	0.6	1	
Core Nurse (private)	2	5.2	7	
Core Nurse (private)	1	9	14	
Core nurse (private) <1 year post grad	1	2.3	3	
KYM midwives	2	0.11	0	All core midwives can work in the KYM scheme but 1 midwife has 1 day per fortnight allocated for administration related to KYM
Credentialed MGP Midwives				Minimum 3 years post graduate, all are THS employed midwives
SCN Registered Nurse (NICU Certificate)		1.8	2	
SCN Registered Nurse (no certificate)				
SCN Enrolled Nurse		0.5	1	
After-hours Nurse Manager with midwifery quals		0	0	
Admin support – business hours		1	2	
Admin support – after hours		0.7	4	
Other – casual midwives		0	10	

Table 13b: Midwifery workforce - NWPH employed

The only THS employed midwives that have access to the full scope of midwifery practice are those involved in the MGP. THS employed midwives not involved in the MGP provide antenatal and postnatal services only. Some THS employed midwives have sought an additional contract through the NWPH to provide midwifery care on the ward, thereby enabling access to intrapartum care

This has particularly impacted the MCH based midwives, who since the closure of birthing services at the hospital, have a restricted scope of practice limited to only antenatal and postnatal phases of care, without opportunities for involvement in intrapartum care. This is seen as highly problematic not just in terms of skills maintenance for current midwives, but also the implications for the future midwifery workforce.

A proportion of senior midwives across all models of care employed by both the THS and the NWPH are close to retirement. Issues identified elsewhere in this report have led to many seeking early retirement or part time work, with little evidence of succession planning across the service.

There is an urgent need to address issues limiting opportunities for midwives to practice at the full scope of practice, workplace issues causing premature attrition of the midwifery workforce and to develop a robust plan to meet training and workforce needs.

Leadership and management

The leadership and management structure of the NWIMS reflects the dual organisational structure and reporting lines. As such there are two distinct management structures.

The leadership structure at the NWPH comprises a CEO and DON, with the latter responsible for clinical governance of the hospital. Within the maternity services there is a NUM position currently shared by two midwives who were appointed to the role in mid-2020.

Within the NWIMS, there is also a shared NUM position, with two midwives also appointed to those roles in early 2020.

The previous clinical lead in obstetrics retired in mid 2020 and her replacement, acting in the position has been on extended leave since March 2020, only just returning to the role on a part-time basis in November 2020.

It was noted that the Level 5 position within the MGP has been ceased with the NUM currently reporting directly to the DON. The

review team is of the view that the lack of the Grade 5 position has significantly impacted the capacity of management to address operational and professional issues emerging within the service. This includes:

- clinical coordination,
- oversight for safe care planning for all aspects of clinical care within a midwifery scope
- having an accessible experienced midwifery leader reporting and ensuring the service is meeting expected levels of care and documentation,
- providing a leadership presence across the governance structures to assist with the development of multidisciplinary partnerships and communication.

One of the central issues of this review has been the inherent tensions between obstetricians and the MGP midwives particularly with respect to who is clinically responsible for women choosing midwifery led models of care. While it is acknowledged that this tension is not unique to NWIMS nor Tasmania, it has been exacerbated by the lack of effective leadership or clinical champions, the lack of integrated clinical governance structures; and ultimately the physical setting in which the care is being delivered. In many settings, MGP models of care are offered in physically distinct spaces. In these settings, women who require medical referral or obstetric intervention are transferred to other clinical spaces.

From the midwifery point of view, the autonomy of midwifery practice is not supported by having expectations that the medical team will be responsible for the management of labour and birth care. The requirement to report (when not outside of ACM guidelines for referral and consultation) is at odds with the rights of midwives to practice as a recognised profession (that women choose as a model of care).

This is distinct from maintaining safe communication and collegiality and collaboration (all critical for safe patient care) versus “responsibility” or control over clinical decision making.

On the other hand, there is a strongly held view that any woman *admitted* to NWPH for intrapartum care, ultimately falls under the clinical responsibility of the on-call obstetrician. These opposing positions have been the source of significant interprofessional conflict. While as stated above, this issue is not unique to NWIMS, it is undoubtedly complex and requires effective and collaborative leadership to resolve.

Workforce culture

More broadly, one of the most compelling and concerning findings of this review was the impacts of workforce culture on individual staff and arguably, on the delivery of safe and high-quality maternity services.

There was evidence of a poor safety culture with the hallmark features of fragmented services, frequently operating within professional and organisational silos; evidence of blaming across services, lack of clear and transparent accountability at all levels of the service; and multiple conflicts between different groups, as depicted in the textbox to the right.

Public / private

Obstetricians / midwives

Obstetricians /MGP

Anaesthetists / NWPH

NWRH antenatal / Mersey antenatal

THS midwives / NWPH midwives

THS Executive / NWPH Executive

LGH / MCH

The presence of conflictual relationships in healthcare is not unique, is well reported in the literature and quite common in resource constrained environments where there is competition for finite resources.

Conflict is also not unique in maternity services where there are often opposing views about optimal models of care (as per the example provided in the section above). That said, the level of conflict and distress among the workforce in the NWIMS was very concerning.

While in some instances, this was more overt than others, the prevalence of conflict was pervasive. The potential negative impacts on safe patient care are difficult to measure but conflict is well reported in the literature as a risk factor for the delivery of safe care.

Just as concerning was evidence that suggests that working in this service is harming people. During the review process, the team interviewed over 60 people, from all parts of the service, including clinical and non-clinical staff, leadership, management and administrative staff, as well as receiving a number of written submissions. Some of the interviews were difficult to hear. No group seemed to be spared from distress and there were too many distressed staff to ignore. There was evidence of high attrition of staff. The erosion of trust between professional and management groups across the services was profound.

The review team formed the impression that in the main, there were committed and well intentioned clinical and non-clinical staff trying to work in a very challenging environment.

The textbox overpage with some quotes from staff provides a flavour of the comments made during the review process. Comments like these were pervasive throughout interviews, reflecting a very worrying workforce culture.

"If this is the culture, it is so unfair, so unjust for the mothers and community [in the north west], and it is careless of us to continue like this."

"I am no longer a real midwife."

"I don't ever want to be involved in maternity services again."

"There has been so much grief and loss." [referring to the service]

"We can't find a common ground to work kindly and respectfully with each other."

There were also a number of comments made during interviews, suggesting occurrences of poor behaviour by some staff members. It is important to note that the focus of the review and therefore the lines of enquiry by the review team was on systems and processes and not on individuals. Instances of poor behaviour is arguably not surprising, given the very significant stressors combined with a lack of support.

There is clearly a significant amount of work to be done. To not take any action risks further depleting an already very fragile workforce, but more importantly fails to address issues that are known to negatively contribute to poor patient safety.

Structural changes to the service with a single organisational structure and reporting lines will provide a foundation. However, a body of work is also required to build a just culture and to promote constructive and collaborative teamwork across the service.

Education and training

The NWRH (including NWPH) is accredited as a training site for RANZCOG. In addition to the two registrars who are on rotation as part of the RANZCOG Tasmanian Integrated Training Program, there is also an unaccredited registrar and junior medical officers. While the review team had requested to speak with registrars as part of the review process, they were advised that the registrars were "too stressed". The reasons for this were not made clear and is of itself a concern. The review team noted that while registrars rotating to the north west value the mix of clinical experience, particularly opportunities for gynaecological surgery, supervision has been raised as an issue in the past. Supervision issues have

been raised previously as part of the accreditation process with RANZCOG.

The NWPH is also accredited by ANZCA for anaesthetic training. Registrars are usually in their first year of training and require Level one supervision for LUSCS for at least 6 months and often up to 12 months. For epidural, trainees require direct supervision until deemed competent, potentially performing up to 10 epidurals under direct supervision. Level 1 supervision is provided for all after hours LUSCS, given concerns held by supervising anaesthetists being called to theatres for emergency caesarean sections at the NWPH after hours.

Midwifery training is also provided in the north west. The review team was advised of issues regarding the governance of student midwives at the NWPH, with reports of refusal of THS NW employed nurse educators allowed a presence on the delivery suite. It was also reported that THS student midwives exposure to intrapartum care was more limited compared with those student midwives engaged in the NWPH. The implications for the restricted scope of practice for THS non MGP new graduate midwives on choice of place of employment was dealt with an earlier section.

Recommendations

A body of work is undertaken to address workplace cultural issues identified in this report with the aim of unifying the service. It is acknowledged that significant investment is required to build a workplace culture reflecting the shared values and build the capacity for all staff to work collaboratively across the maternity service to deliver high quality, safe patient care. (R2)

Appointments to the senior positions of THS clinical leads (Head of Department and Midwifery DON) to be progressed as soon as practicable. These positions will require significant support at all levels of the service. (R11)

The Grade 5 position for the Midwifery Group Practice be reinstituted and recruitment progressed. (R12)

Midwives on the north west are engaged and supported through secondment arrangements to work at other sites within Tasmania. This might include for example, allowing for a block of 4 weeks every 3 years to practice at other midwifery service sites. This is in addition to engagement with other professional development activities. (R13)

Work arrangements for midwives be reviewed to encourage and support the capacity to work across the full scope of practice. (R14)

Succession planning for the obstetric, anaesthetic and midwifery workforce be undertaken. This will involve a comprehensive understanding of the demographics of the workforce and planning for the future. (R15)

APPENDICES

Purpose of this review

The Secretary is seeking to:

- Understand, based on evidence, the quality, safety and management of the integrated maternity services in the North West Tasmania
- Maintain public confidence in the maternity services provided to the region
- Understand the viability of the integrated midwifery service model for the women of Tasmania
- Identify inconsistencies between the contract and the *Health Service Establishment Regulations 2011*

Scope of this review

The scope of the review is the adequacy and appropriateness of accountability arrangements, including the culture, systems and procedures that apply to maternity providers, which ensure quality and safety in maternity services.

Using primarily an in-depth study of document reviews, interviews and observations techniques, the reviewers will explore the following:

1. Antenatal care related to childbirth
   - 1.1. Options for antenatal care – private patients NWPH, and public patients NWIMS
   - 1.2. Services provided at Mersey Community Hospital, North West Private Hospital
   - 1.3. Operation of services, staffing (public MGP/private) and client access
   - 1.4. Provision of private Obstetrician practice/s – services and client access
   - 1.5. Access to services for mothers from rural and remote areas, ie: Queenstown, Zeehan etc
   - 1.6. Culture/systems/processes in place for identification of high-risk pregnancies, pathway for referral to specialist care, instigation of higher thresholds (ie: from 30 weeks) for monitoring and escalation of care when required
   - 1.7. Integration of care across the region

2. Intrapartum Care at North West Private Hospital
   - 2.1. Patient information re accessing medical/hospital services after hours – all patients
   - 2.2. Systems in place for uncomplicated pregnancy – public/private services and differences
   - 2.3. Systems and processes to access timely surgical intervention, and access to critical workforce – private/public Obstetricians, anaesthetists, theatre staff.
   - 2.4. Immediate emergency care systems and processes, workforce knowledge
   - 2.5. Access to North West Regional Hospital intensive care for mothers, support person and family:
     - 2.5.1. Describe systems and processes for adult and paediatric escalation to higher level care at LGH/RHH within the maternity services
   - 2.6. Access to neonatal special care nursery:
     - 2.6.1. Systems/procedures for initiations of specialist review and escalation of care to LGH/RHH
     - 2.6.2. Referral processes, decision making and arrangements for transport for best patient outcomes
     - 2.6.3. Staffing of this unit
   - 2.7. Processes for admission and care of a mother admitted with a baby immediately following childbirth

2.8. Processes for reporting stillbirths and adverse outcomes

3. Postnatal care at North West Private Hospital
   - 3.1. Care processes for care of the mother post normal childbirth by midwifery and obstetric team and care of the baby by the paediatric team
   - 3.2. Barriers accessing additional workforce such as access to lactation consultants, social workers
   - 3.3. Systems for discharge criteria, referrals and patient information
   - 3.4. Systems/processes for readmission for treatment and management of breastfeeding complications and/or other neonatal or maternal complications

4. Governance (North West Integrated Midwifery Service (NWIMS)
   - 4.1. North West Private Hospital Maternity Care Policy including criteria in accordance with HSE Regulations 2011 Sch 2, Part 2, Clause 3: and Contract requirements for NWIMS
   - 4.2. Maternity environment - accommodation, number of single rooms, share rooms, rooming-in policies, beds/neonatal costs
   - 4.3. Appropriate critical clinical equipment, emergency equipment available to support the service
   - 4.4. Access to operating theatres and the necessary staffing for obstetric surgical procedures
   - 4.5. Clinical Committee Governance Structure - appropriate TOR with clear roles and responsibilities, clinical leadership, exploring the following:
     - 4.5.1. Contract (refer 9 Contractual obligations)
     - 4.5.2. Credentialing processes - NWPH MAC / THS Clinical Governance
     - 4.5.3. General integrated midwifery services, workforce issues, quality improvements, monitoring
     - 4.5.4. Perinatal mortality and morbidity
     - 4.5.5. Incident management and review
     - 4.5.6. Education and training
   - 4.6. Information systems to track patient journey, incident reporting
   - 4.7. Policies, procedures, and protocols (refer 8 Clinical Protocols)

5. Workforce
   - 5.1. Clinical Medical Care
     - 5.1.1. Obstetrician/Gynaecologists, Paediatricians, Anaesthetists
     - 5.1.2. Access to neonatal specialists
     - 5.1.3. Credentialing requirements
     - 5.1.4. Trainees
     - 5.1.5. FTEs - appropriate resourcing across public and private maternity services
   - 5.2. Tasmanian Health Service Midwifery Group Practice
     - 5.2.1. Midwifery FTE
     - 5.2.2. NWPH midwifery staff FTE
     - 5.2.3. Credentialing and requirements for ongoing competency
     - 5.2.4. Education and training
   - 5.3. Access
     - 5.3.1. Access to midwifery workforce (THS MGP and ambulatory services) and MGP rostering for on-call
     - 5.3.2. Access to medical workforce (anaesthetists, obstetricians, paediatricians), rostering, on-site requirements, access requirements, (ie: within 30 minutes of hospital), V/C phone with LGH/RHH)
     - 5.3.3. NWPH Special Care Nursery - paediatricians, neonatologist, neonatal trained nursing/midwifery staff
   - 5.4. Workforce Culture
     - 5.4.1. Clinical and professional culture of maternity services in the North West, ie: do clinical relationships impede the delivery of safe/quality maternity services

6. Data and Monitoring
   - 6.1. Compliance against policy, protocols
   - 6.2. Auditing requirements as required by the Regulations

7. Support Services
   - 7.1. NWRH - Anaesthetists
   - 7.2. NWRH - ICU staffing - Intensivists
   - 7.3. Pathology, radiology
   - 7.4. Neonatal Intensive Paediatric Care Unit (transfer/ deteriorating patient processes)
   - 7.5. Neonatal Emergency Transport Service (transfer/deteriorating patient processes)

8. Clinical Protocols
   - 8.1. Midwifery, antenatal, birth and postnatal practice
   - 8.2. Midwifery Group Practice
   - 8.3. Neonatal care
   - 8.4. Clinical communication and engagement with O&G team, re patient progress/issues and escalation of care

9. Contractual obligations
   - 9.1. Contractual obligations for each of the parties involved in delivering maternity services and are these systematically implemented
   - 9.2. Contract alignment with the Health Service Establishments Act 2006 and Health Service Establishments Regulations 2011

Appendix B: List of source documents

Review of North West Private Hospital – Maternity Services, 2013

Follow- up review of North West Private Hospital – Maternity Services, 2015

Internal North West Integrated Maternity Services Review, 2018

RLA Unit, Analysis of 2013/2015 Review Status Recommendations

Licence Certificate North West Private Hospital

Conditions of Contract - THS and Healthe Care Burnie Pty Ltd

THS Organisational Chart

NWPH Organisational Chart

NWPH Maternity Care Policy

NWIMS Governance Diagram

NWIMS Contract Management Meeting Terms of Reference

NWIMS Contract Management Meeting minutes

NWIMS Maternal, Women's and Neonatal Governance Committee Terms of Reference

NWIMS Maternal, Women's and Neonatal Governance Committee minutes

NWIMS Perinatal Morbidity and Mortality Committee Terms of Reference

NWIMS Perinatal Morbidity and Mortality Committee Minutes

NWIMS Incident Review Committee Terms of Reference

NWIMS Incident Review Committee minutes

NWPH Committee Structure Diagram

NWPH Medical Advisory Committee, Terms of Reference and membership list

NWPH Medical Advisory Committee minutes

NWPH Quality and Risk Governance Committee, Terms of Reference

NWPH Quality and Risk Governance Committee minutes

NWPH Patient Care Review Committee, Terms of Reference

NWPH Patient Care Review Committee, minutes

THS North West Clinical Governance and Risk Committee, Terms of Reference

THS North West Clinical Governance and Risk Committee, minutes

THS North West Peak Mortality and Morbidity Committee, Terms of Reference

THS North West Peak Mortality and Morbidity Committee, minutes

NWIMS Clinical Policies and Procedures

NWPH Maternity Service Clinical Policies and Procedures

Nursing and Midwifery Board, Midwifery Standards for Practice

MET Service Agreement June 2017

THS – Midwifery Group Practice

Incident Reporting Policy/Procedures

THS – Birthrate Plus in Tasmania, 2019

COAG Health Council, Woman-centred care, Strategic directions for Australian maternity services, 2019

National Maternity Services Capability Framework, 2013

National Guidance of Collaborative Maternity care, 2010

RANZCOG College Guidelines

- Models of Care
- Neonatal Resuscitation
- Management of PPH

Appendix C: List of those who contributed to the review process

Over 60 individuals, comprising health service executive, clinical and non-clinical staff were interviewed by review team members or provided written submissions during the review process. They included:

- Deputy Secretary, Clinical Quality, Regulation and Accreditation/CMO
- Chief Nurse and Midwifery Officer
- Manager, Regulation, Licensing and Accreditation
- Assistant Director of Nursing, Regulation, Licensing and Accreditation
- General Manager, Legal Services
- Director- Health Workforce Planning
- Chief Executive Hospitals North/North West
- Executive Director of Nursing/Midwifery - North West
- Director Quality Improvement North / North West
- Nurse Manager – Patient Safety THS North West
- Quality Patient Safety THS North West
- Executive Director Medical Services THS North West
- Patient Quality Safety Consultant THS North West
- Co-NUMs THS-NW Maternity Service THS North West
- Visiting Medical Officers and Staff Specialists (including recently retired) Obstetrics and Gynaecology
- Staff Specialists, Anaesthetics,
- Staff Specialist, Paediatrics
- Registrars, Anaesthetics
- Chief Executive Officer, NWPH
- Director of Nursing, NWPH
- Chair, Medical Advisory Council, NWPH
- Private Obstetrician, NWPH
- Quality and Staff Development Manager, NWPH
- Co-NUMs NWPH Maternity Service
- Midwife NWPH KYM Scheme
- Midwives, NWPH
- Educator THS NWIMS
- ECM Coordinator NWIMS
- Nursing and Midwifery Staff ANC NWRH
- Nursing and Midwifery Staff ANC MCH
- Nursing and Midwifery Staff ECM NWRH
- Nursing and Midwifery Staff ECM MCH
- THS new Graduates/Students
- ANC clerical and administrative staff
- Staff Specialist Paediatrics, THS South
- Staff Specialists, NICU, THS South
- CNC, Neonatal and Paediatric Retrieval Service (NPETS), THS South
- NUM, NPICU, THS South
- Director, Aero-Medical and Medical Retrieval, Tasmanian Ambulance

The review team would like to take this opportunity to thank all staff who participated in meetings and interviews for their time and contributions to the review process.