

**A REVIEW OF THE GOVERNANCE OF MATERNITY SERVICES AT
SOUTH TIPPERARY GENERAL HOSPITAL.**

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BACKGROUND AND CONTEXT

1. Strong Leadership and Effective Governance go hand in hand.

This review of the governance of maternity services at South Tipperary General Hospital has focussed on the systems and processes for assurance of service quality, risk management and patient safety primarily inside the hospital but also in the Hospital Group structure within which it operates. The effectiveness of the governance arrangements is largely determined by the quality of the leadership and management – both clinical and general – which designs, implements, and oversees those systems and processes and is ultimately responsible and accountable.

The conclusions and recommendations are, therefore, as much about the capacity and capabilities of the leadership and management teams as the governance structures that they operate.

2. Context matters

In making judgements about the leadership and the governance structures and the extent to which assurance can be taken about the quality and safety of services, it is necessary to understand the challenging context in which both units are operating. This contextual backdrop creates a number of key constraints on the effectiveness and efficiency of day to day service delivery yet also points to the significant potential to make improvements going forward.

Before setting out the specific findings, conclusions and recommendations for the unit and the Group, there are four significant elements of contextual reality within which they need to be considered :

The long road to economic recovery

The Health Service in Ireland has endured a very tough period in which financial cuts and restraints have had a significant impact on the size and quality of the healthcare workforce. The number of jobs has been reduced and pay levels cut and whilst the process of recovery and reinvestment is now underway the impact of the cuts is still having a significant impact on day to day service delivery.

Clinical service staffing establishments are often not fully funded resulting in some significant shortages of different types of healthcare professionals and the

pay levels are not competitive in an international labour market for either general managers or healthcare professionals.

At the same time the Acute Hospitals across the country are collectively overspending and the Hospital Groups are being held to account to reduce expenditure.

The unfinished business of the establishment and development of Hospital Groups

Smaller hospitals such as South Tipperary cannot operate in isolation as stand-alone entities either clinically or financially. They simply cannot sustain the breadth and depth of clinical services that the populations they serve require without formal links and networks with bigger, stronger, more specialist units. Likewise, they cannot afford to do everything independently and the connection and sharing of staff and facilities between units enables the available funds to go further.

The role of Hospital Groups in creating and leading networks across and between constituent hospitals is critical. The Groups are themselves going through a process of set up and development.

It is taking a long time. Key posts remain unfilled and operating models are not yet fully established.

The bright spotlight on maternity services following the HIQA Report on Portlaoise and the critical commentary running in the media.

There is an ongoing and critical discussion about maternity services playing out through the media.

This contributes to a culture of fear of getting it wrong amongst some healthcare professionals who can become more cautious or even defensive in the course of their work. If this impacts upon the decisions about the care of patients then high quality appropriate care can be compromised.

This almost constant scrutiny puts pressure on General Managers and their teams when on occasions they may feel it is unfair and unbalanced . This can distract them from a proactive focus on the urgent and important, and there is a risk that they become too reactive to the events happening around them.

The absence of a clear and understood strategy for maternity services across Ireland.

There is a general acceptance amongst those interviewed as part of this review process that the current configuration and governance structure for maternity services across Ireland is not sustainable. A Strategy Group established by the Department of Health is currently working through these questions.

The absence of a widely owned and understood strategic plan allows for speculation and suspicion about what may happen, particularly to smaller units, in the future. This creates a negative environment which absorbs energy which can be better used focussing on day to day service delivery.

3. Resilience and Sustainability are not the same thing.

The future model or models for sustainable, high quality and safe maternity services within the Hospital Groups and across Ireland is beyond the terms of reference of this review. It is a process that ultimately requires the alignment of politicians, public opinion, and professional and expert interests and as such takes time to consider, design, plan, engage and implement. All of this rarely happens in straight lines.

This review focusses on the much shorter term horizon of building resilience in service delivery and governance processes for the here and now.

4. Building resilience in the units goes beyond the local Management Teams and requires action by, and leadership from, the Hospital Groups.

The review process has focussed primarily on what is happening inside the hospital and how it is led, managed and governed. Some of the findings and recommendations can be addressed within the unit but it can't find all the answers itself. The role of the Hospital Group is crucially important both in terms of building effective networks as described above and also in providing direct support and filling some gaps in the unit's operating model. In this way the role of the Group goes beyond oversight and planning and into direct "hands on" responsibility for solving problems.

5. The challenge for smaller hospitals

Having examined the detailed governance arrangements in two units there are some common factors which emerge which other similarly sized hospitals probably face as well.

Staffing

Affording, recruiting, and retaining a clinical and managerial workforce capable of delivering high quality services safely and effectively and populating the governance systems and processes which wrap around them often feels like a day by day struggle.

In that situation the units rely on a relatively small number of key individuals in both clinical and managerial positions to keep the show on the road by working beyond their contractual commitments and carrying a much broader range of responsibilities than their job titles describe. These are not just the most senior people either. This is a great strength in the operation of the units but carries a significant vulnerability if any of those individuals leave or are away.

Networks involving Voluntary Hospitals

Operational resilience in smaller services is strengthened with support from bigger and stronger units which are often Voluntary Hospitals operating in a quite different statutory and governance framework than the HSE public hospitals. The evidence from the two units reviewed is that this is not straightforward. In the former regional HSE structures the patient pathways which ensure higher risk patients go to the bigger, more specialist centres seem to generally work well but there was little evidence of networked staff rotas or other forms of practical, cross site operational support.

In the Group structures, albeit relatively early days, there is little evidence of practical networking in maternity services. There is a lot of talk about it, and some preparation for it, but as yet not much action.

Infrastructure and capital investment

The smaller units share a perception that they are at the back of the queue when it comes to access to funding for capital and this further fuels a suspicion that someone, somewhere is planning to downgrade the sites and adds to the sense of an uncertain future.

KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

South Tipperary General Hospital – key findings and conclusions.

Overall

South Tipperary General Hospital has had a difficult recent history. Eight years ago a number of services which up until then had been delivered in Cashel Hospital were moved to the Clonmel site. It took four years to implement the changes after the decision to do so was made. There remains some fallout from those changes and a number of the senior doctors have not easily integrated into the new corporate structures.

Some parts of the building are not fit for the purpose of delivering high quality and safe care.

The hospital is spending more than its income and yet suffers from shortages in key areas of the workforce.

The General Manager is interim and has been on secondment from St James' Hospital in Dublin for over a year. She is working hard to build an effective system of management and governance and senior colleagues describe the current situation as representing significant progress from where it had been a year ago. The fallout from the Cashel changes has undoubtedly made some of this more difficult to achieve. Also, by its very nature, getting things done as an interim is harder than it is for a substantive and permanent appointee.

The culmination of all these factors has led to the current situation of the highest level of formal governance in the hospital being an Executive Management Team co-chaired by the General Manager and a Consultant Geriatrician. This compromise clouds the key issue of leadership and accountability in the unit.

The senior management team is in a state of change and transition. The team structure is conventional with a Deputy General Manager (with overall responsibility for Quality including complaints), a Clinical Director, a Director of Nursing and a Finance Manager. The Director of Nursing is leaving and an interim appointment is being made. There are questions as to whether the DGM and CD see themselves continuing in their roles for the foreseeable future although neither indicated any intention to stand down.

All of the above adds up to a team which does not look to the rest of the organisation or the outside world as a strong collective of individuals working effectively together with leadership authority.

The general management team supporting the Directors is very shallow and with significant gaps. There is no Operations lead, no Business Manager lead and no Performance lead evident in the structure. The information systems to support performance management and improvement are not well developed.

The General Manager is aware of the gaps and weaknesses in the Director team and supporting structure but has not felt able to do anything about them. Her operating style is to step in herself. There are examples of this in service operational issues, complaint handling, corporate business management and performance management. This is not an effective leadership model, even in the short term.

The governance systems and processes have been largely introduced by the General Manager in the course of the last year. On paper they look quite comprehensive if unnecessarily complicated in places but it is clear that they are immature in their execution.

At the centre of the governance structure is the Quality, Risk and Patient Safety Group which reports upwards into the Executive Management Team. This is chaired by a Consultant Paediatrician and attended by the General Manager. It is acknowledged that the working of the group is still developing. The Corporate Risk Register is considered irregularly at this meeting and updates are received from the Risk Register Management Group.

Overall the governance systems are not as well understood throughout the organisation as they could be.

A number of clinical services, including Obstetrics and Gynaecology have their own Governance Groups which report in to the Quality Risk and Patient Safety Group and a separate Risk Register Management Group.

A Clinical Risk Manager holds most of the governance systems and processes together despite working only 28 hours a week and without a support team. She attends the Executive Management Team and the Quality, Risk and Patient Safety Group, chairs the Risk Register Management Group and supports the individual service Governance Groups. Her responsibilities also include Incident Management and follow through. This is a very broad and deep range

of responsibilities and cannot be undertaken by one part time manager without an experienced and capable support team.

The complaints handling processes are in place under the charge of the Deputy General Manager. This seems to be more administrative than investigative in its function.

There is an active Patient Representative Service User Forum which meets irregularly and is chaired by the Deputy General Manager.

Maternity Services

The maternity service at South Tipperary typically delivers 1100 – 1200 babies a year. Measured by number of births it is the smallest unit in Ireland but when gynaecology activity is considered it is as busy as some other units.

The last published rate of Perinatal Mortality is relatively low and the maternity unit receives high levels of patient satisfaction albeit from small samples surveyed on an infrequent basis. The number of complaints in the unit are small and those that do arise are responded to by staff in the unit very promptly.

The unit operates 24/7 and is led by a Consultant Obstetrician – the only substantive consultant in the unit. There are two locum consultants and the unit is seeking approval for a fourth post. Even if approved, it is thought unlikely that strong and experienced candidates will come forward for the role.

The consultants work a “1 in 3” rota. This is both unsatisfactory and unsustainable. However capable the junior doctors are and however accessible the consultants are when not on site, this model has an inherently higher level of risk than a rota with more consultants would present.

The midwife to births ratio is a healthy 1:32 following the addition of five new posts in the last few months. Whilst this is positive the unit still cannot operate 24/7 shift leaders.

The Obstetricians and the Midwives work well together and meet on a weekly basis to review the functioning of the service and to review individual cases.

The CNM3 Manager is a particularly strong figure in the day to day running of the department and holds a lot of it together. Whilst some question whether

some of the working practices are old fashioned, there is an order and discipline to the unit which in itself brings a resilience.

The sense of strong team working is palpable in the unit. The broader Midwifery leadership team is energetic and positive and just gets on with things. This too adds to the resilience. A large proportion of the staff are local people who have a huge personal commitment to the hospital which means that they frequently turn up to work outside their contracted hours when things are busy. This is such a strength and should not be underestimated or taken for granted.

The formal quality assurance and risk management is built into the Obs/Gynae/SCBU Risk Register which is well constructed and maintained as a live management document. This is undertaken by the Clinical Risk Manager and is excellent practice. There are currently nine red rated risks including those posed by shortages of staff and equipment. It reflects the hand to mouth existence experienced by the unit on a day to day basis. In these circumstances the individuals running the maternity unit do a remarkable job.

There are a number of specific areas requiring immediate attention:

There are no staff fully trained in Bereavement ;

There is an Obstetric/Gynaecology Governance group which meets frequently and is chaired by the Lead Obstetrician. The General Manager or Deputy GM usually attend. The agendas and minutes suggest that the group is very detail and operationally focussed which is necessary but not at the expense of a more strategic overview of the risk areas and risk management strategies. The Executive Management team should review the operation of the group with a view to achieving a more strategic and proactive approach;

A Portlaoise Report self- assessment has been undertaken but it is not a comprehensive or thorough piece of work and should be redone with external support.

Issues for the South/ South West Hospital Group

The Group needs to take immediate action to inject more management capability and capacity into South Tipperary General Hospital. This should be in the areas of Business Management, Performance Management, Information Management and Operational Management.

Also, the process of appointing a substantive General Manager needs to be accelerated. The current interim General Manager is working very hard to make progress but interim status is a constraint in doing so, particularly in relation to building a stronger Executive Team. Pending the outcome of the appointment process the interim General Manager needs more direct support and counsel.

The Group CEO should personally assess whether he is content with an Executive Team co-chaired by the General Manager and a Consultant Geriatrician as an appropriate governance model and if not should take directive action to change it.

It is clear from discussions with the Chair and Chief Executive of the Group that they have a shared determination to make the changes necessary to reconfigure maternity and other services to make them sustainable. The Chair and Chief Executive together can provide very strong leadership of this difficult process. This priority was also identified and supported by the Group Clinical Director and the Chief Academic Officer.

Work should begin without delay to design and operationalise a new Maternity Services Network across the Group with Cork being the central hub. The Group had agreed Terms of Reference for a review of maternity services involving all units in the Group which has been pended whilst this review is undertaken. The Terms of Reference stated that the process could take up to five months. Whilst some of the detail might take months to finalise, some aspects of the design are so obvious (eg Cork being in charge) that implementation should commence without delay. The history of joint working between Waterford and South Tipperary is not as strong as it could have been and South Tipperary has operated pretty much in isolation in terms of its own governance and protocols.

The need for more consultant obstetrician presence at South Tipperary is urgent and immediate support from Cork in this regard would be a good first step to building a meaningful network. If there are cultural, behavioural, operational or

financial barriers to this happening then the Group CEO should pull all relevant parties together and sort it out once and for all.

The Group has adopted an approach to developing its own role with a heavy emphasis on relationship building. The Clinical Director and CEO are undertaking a series of evening meetings with clinicians from all the units on a service by service basis. This is a good process but can lead to a situation where necessary action is talked about a lot over a period of time before it is taken.

The Group seems rightfully clear about its strategic leadership responsibilities and how it will exercise them. The engagement events referred to above are a good place to start. It is also evident that the Group has systems in place to exercise its oversight responsibilities and the formal regular meetings with each unit are an effective mechanism for this. Alongside these processes, the Group needs to establish a model for direct intervention to fill gaps and solve problems in units and needs to develop its own capacity and capability to step directly into local operational issues where necessary. There are some good examples of this already – securing the additional midwives at South Tipperary is one – but it needs to be more systematised.

Some aspects of the Group's own structures still need to be filled and some operating models need to be determined. This is particularly so in the Clinical Directorate where a number of critical posts will drive the networks. This should be accelerated where possible.

Some of the critical processes of incident management , risk management and audit which are undertaken in each unit in the Group before being reported up to Group level could be consolidated and just done once, and better, by integrating the teams horizontally across units and vertically into the Group structure.