CQHHS oversight of the maternity services

Office of the HEALTH OMBUDSMAN

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33. CQHHS oversight of the maternity services

While responsibility for the provision of safe and high quality healthcare sits across all persons engaged within a health service, ultimate responsibility for ensuring that the health service meets this goal sits with the governing body, namely the CQHHS Board and board level committees. The Commission's National Model Clinical Governance Framework notes that there are two key components to board leadership: forward-looking leadership and retrospective accountability.[113] These involve setting the strategic direction, testing the assumptions of health service management, and reviewing performance to ensure that it meets accepted standards.[114] This role in leading strategic planning and ensuring accountability are recognised and reflected in the CQHHS *Clinical Governance Framework 2018–2020*.

During the office's investigation into the various CQHHS maternity services, it became clear that there were areas in which the CQHHS Board could refine its clinical governance leadership to provide a more robust and accountable system. Each of the following areas will be discussed in-turn below:

- transferring of patients in the MGP
- clinical incident management
- trending and benchmarking performance.

33.1 Transferring patients in the midwifery group practice

As discussed throughout this report, MGP is one of the key models for securing continuity of care for pregnant women. To that end there needs to be clear expectations regarding how a woman's care will be managed if her allocated midwife leaves MGP. This set of expectations should be driven by CQHHS to ensure that it implements a consistent policy across the health service catchment.

CQHHS has four MGP-specific policies and procedures, namely:

- *Midwifery Group Practice (MGP): Clinical Governance Requirements*
- *Midwifery Group Practice (MGP): Communication Pathways*
- *Midwifery Group Practice (MGP): Allocation to MGP*
- *Midwifery Group Practice (MGP): Transfer of Care*.

On reviewing the above procedures it became clear that none of them deal with the process and expectations for how a woman's care should be transferred when her allocated MGP midwife leaves the service or becomes unavailable for an extended period of time.

The above situation appears to be a gap in the MGP governance framework, which is particularly important to address as staff from the office, during the visits to Rockhampton, Gladstone and Emerald

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[113] Australian Commission on Safety and Quality in Health Care, *National Model Clinical Governance Framework*, Sydney: ACSQHC; 2017
[114] Ibid

maternity services, were advised that each of these services had experienced recent departures of MGP midwives, with the most extreme case being Emerald where three MGP midwives left within quick succession of one another. When asked about how a midwife's caseload was managed on their departure, staff from the office were given varying accounts of the process and expectations. In Rockhampton it was acknowledged that the transfer of patients and communication about the departure was not handled as well as expected. Without a benchmark or articulated set of expectations for approaching this scenario it is difficult to hold staff accountable for any deficiencies when transferring care.

Given continuity of care is at the centre of the MGP model, it is imperative that there be an established procedure to support the transfer of a woman's care when her allocated MGP midwife ceases with the service. The procedure should be aimed at limiting, as far as practicable, the disruption to the woman and making it clear how her care will be managed going forward. This may include a change in the model of care as in Emerald because there were insufficient MGP midwives to take over the departing midwives' caseloads.

Recommendation 8

To address the above gap in the governance framework I recommend that:

8. Within three months, CQHHS introduces a midwifery group practice procedure outlining the process for transferring a woman's care when her allocated MGP midwife ceases with the service. The procedure should include an outline of the roles and responsibilities of each person involved with the transfer of care and be focused on maintaining continuity of care, where possible.

33.2 Clinical incident management

Despite the issues across the various CQHHS maternity services between 2015 and 2017, the overarching clinical incident management framework at that time was relatively sound in ensuring that incidents were reported, categorised and investigated in line with their relevant SAC classification. The main areas for improvement in the framework are in relation to:

- developing recommendations
- escalating concerns when there are repeat recommendations
- ensuring appropriate oversight of recommendations.

33.2.1 Developing recommendations

33.2.1.1 Clinician engagement and consultation

The CQHHS *Clinical Incident Management Procedure* (CIM procedure) sets out the roles and expectations for managing SAC 1 to SAC 4 incidents from the CQHHS Board to the individual staff member reporting the incident. In relation to the development of recommendations the CIM procedure focuses on SAC 1 incidents, stating that prior to the final incident analysis report being handed over to

the Chief Executive for endorsement, the '*team facilitator and team lead clinician [for the review]* ***may*** *meet with the service area responsible lead to discuss recommendations developed by the team*'.

The CIM procedure is supported by the CQHHS *SAC 1 Recommendation Management Procedure* (SAC 1 procedure), which sets out the expected approach to developing recommendations for SAC 1 incident analysis. This procedure outlines that recommendations should be developed using the SMARTER[115] principles. It also notes that '*seeking input/feedback on proposed recommendations* ***may*** *assist in ensuring that recommendations are appropriate, sufficiently address the risks and facilitate robust uptake by clinical teams.'* As with the CIM procedure, consultation between the incident analysis team and relevant clinicians is not mandatory.

Across all of the visits to the various CQHHS facilities, staff from this office routinely heard that clinicians feel separated from the development of recommendations during the incident analysis process. While the process should be independent from the clinicians involved with the incident, it should not be quarantined from clinician input into the recommendations. This should be occurring early in the process to ensure that the recommendations developed are meaningful, implementable, and supported by the clinicians who will ultimately be responsible for implementing, and working within, the recommendations. Rather than making this step voluntary in the CIM and SAC 1 procedures, consultation on the recommendations should be a mandatory step for all SAC 1 reviews where there will be recommendations. This type of approach is already captured in the SAC 2 incident analysis process where the CIM procedure requires that for a complex review there is '*[collaboration] with all relevant stakeholders and [a] review [of] proposed recommendations*'.

This position is also outlined in Queensland Health's *Best practice guide to clinical incident management* (the guide), which notes that consultation may be beneficial in '*order to ensure that the recommendations are appropriate, the identified risks have been addressed, and there is a high probability to reduce the reoccurrence of this or similar incidents*.' The guide notes that consumers and their families may also have relevant input into the development of recommendations, however, consultation with any party should clearly state that their suggestions and input may not be reflected in the final recommendations for a multitude of reasons.

33.2.1.2 Strength of recommendations

Strong recommendations are a key component of a mature and effective clinical incident management system as they secure the best outcomes in response to incidents that will have the greatest impact on preventing the future recurrence of similar issues. Specifically, the guide defines three strengths of recommendations: high impact or effort, moderate impact or effort, and low impact or effort. When developing recommendations in response to clinical incidents, the guide suggests that health services aim for high effect and low effort changes as these types of recommendations are most likely to succeed in addressing the reasons for the incident and prevent its recurrence. Low effect recommendations are less likely to have any impact on the root cause of the incident and will likely not prevent its recurrence.

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[115] SMARTER recommendations are specific, measurable, accountable, realistic, timely, effective and will be reviewed.

Figure 9, from the guide, provides examples of the types of recommendations falling within each category.

High Effect/ Effort	Architectural/physical plant changes
	Tangible involvement & action by leadership in support of patient safety
	Simplify the process and remove unnecessary steps
	Standardise equipment or process or care maps
	New device with usability testing before purchasing
Moderate Effect/Effort	Checklist/cognitive aid
	Increase in staffing/decrease in workload
	Read back process
	Enhanced documentation/communication
	Software enhancements/modifications
	Eliminate look and sound-a-likes
	Eliminate/reduce distractions (sterile medical environment)
Low Effect/ Effort	Redundancy/double checks
	Warnings and labels
	New procedure/memorandum/policy
	Training
	Additional study/analysis

Figure 9 Examples of types of recommendations and impact

The development of high quality recommendations is an area in which CQHHS could improve its processes. The office reviewed 14 RCA reports relating to SAC 1 maternity incidents from Rockhampton, Gladstone and Emerald for the period May 2015 to January 2018. This review only relates to RCA reports known to the office and excludes HEAPS or clinical reviews. The review analysed how many recommendations and lessons learnt had been made across all of the RCAs and what proportion of them were high, moderate or low quality recommendations. The office used CQHHS' categorisation of the recommendation and where there was none then the office assigned a category based on the guide's criteria. In some instances the office disagreed with CQHHS' assessment of the strength of a recommendation, for example, two recommendations from an Emerald RCA were the preparation of a memo and these were categorised as high control when they are low control in accordance with the guide. In these cases the office used the CQHHS categorisation in its review. The review identified 170 recommendations and lessons learnt across the 14 RCAs. Figure 10 illustrates the proportion of high, moderate and low recommendations made across the 170 total recommendations.

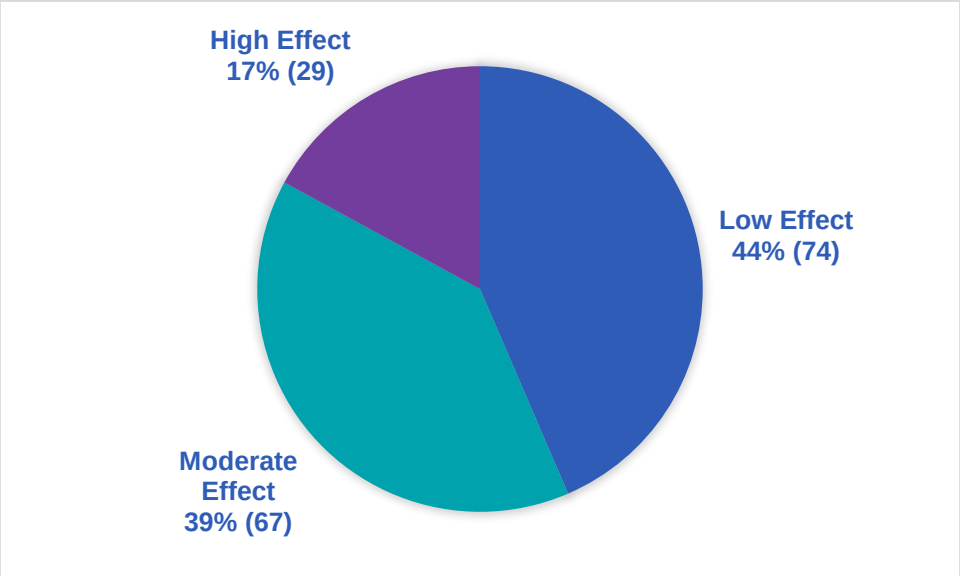

Figure 10 Review of strength of RCA recommendations

The figure above demonstrates that the highest proportion of recommendations of the sample group were low effect, focused on training or the preparation of memos to staff reminding them of their obligation to comply with clinical guidelines and internal processes. The proportion of high to low effect recommendations is not indicative of a strong approach to recommendations development. This is further highlighted by the fact that the 29 high effect recommendations came from only 6 of the 14 RCAs reviewed, with 10 high effect recommendations being from a single RCA. Effectively, a majority of the RCAs completed do not have any high effect recommendations.

The flow on effects of large amounts of moderate or low effect recommendations is that they have a limited potential for impacting on the reasons for the incident. Additionally, the implementation and evaluation cycle for recommendations is time consuming so it should be focused on high effect recommendations. This will ensure that the effort being expended to provide appropriate clinical governance oversight of the recommendation is commensurate with its impact. While there are important learnings in some of the low impact recommendations, CQHHS should consider whether there is scope to take a risk-based approach to the governance applied to a recommendation, so that low effect recommendations are not managed in the same way as high effect recommendations.

Overall, CQHHS must ensure that the recommendations being made across all of the maternity services are efficacious and worthy of the time and effort required to implement, monitor and evaluate them.

Recommendation 9

To secure greater involvement of clinicians in the development of SAC 1 incident recommendations and ensure increased strength in the recommendations being made, I recommend that:

9. CQHHS must:

Recommendation 9

a. within 6 months, develop a clinician consultation process for all recommendations being proposed during a SAC 1 RCA or Human Error and Patient Safety (HEAPS) analysis. This should be a mandatory step in the clinical incident management process. Any relevant procedures, checklists or other policy documents should be amended to reflect the consultation process.

b. within 12 months, introduce a benchmark that for all maternity SAC 1 and serious SAC 2 RCAs, where there are formal recommendations and lessons learnt, 70 per cent of all of the recommendations made must be moderate effect or higher in 80 per cent of all maternity incidents across each calendar year. This should be audited on an ongoing basis as part of the annual maternity audit program.

c. within 12 months, develops as part of its clinical incident management process, a risk-based approach to implementation, evaluation and oversight of low, moderate and high effect recommendations.

33.2.2 Escalating repeat concerns

A strong clinical incident management framework should be capable of identifying repeating issues across incidents, provide for the escalation of repeat concerns to high level CQHHS Board level committees, and develop an appropriate action plan to secure a response to the issues that will, as far as practicable, prevent their recurrence. Historically this was done poorly by CQHHS as is demonstrated by the incidents at the Rockhampton Hospital maternity service between May 2015 and February 2016. Each of the five SAC 1 incidents had a contributory factor relating to the categorisation, identification and/or management of maternal risk. Nevertheless each incident appears to have been taken in isolation, without broader escalation of concerns to the CQHHS executive. Triangulating incidents that are recurring with the same themes is essential to a strong clinical incident management framework. However, at that time the Rockhampton Hospital maternity service and the CQHHS governance structures were immature and required further refinement to properly utilise clinical incident management to drive improvement and address trends holistically.

This escalation feature of a strong clinical incident management framework is particularly important when issues occur in quick succession (as they did in 2015 and 2016) because this does not allow sufficient time for measures to be implemented and evaluated. This timeframe also creates an immediate trend that needs to be addressed at a higher level as it should not wait for the 'implement and evaluate cycle' of individual recommendations in response to individual incidents.

Since 2016, the approach to escalating repeating recommendations has improved. The SAC 1 procedure notes that the CQHHS Maternity Steering Committee receives a quarterly report which includes '*SAC 1 contributory factors and recommendations to assist the committee to identify repeat recommendations and to ensure the escalation of risks occur…*' The SAC 1 procedure also outlines three points during the incident management process during which repeating and recurring recommendations can be escalated, they are during:

- the quality check of the SAC 1 investigation documentation undertaken by the CQHHS Quality and Safety Unit
- the handover meeting when the SAC 1 team presents their final report to the executive
- the recommendation review audit, which involves a thematic review of contributory factors and recommendations from a range of SAC classifications. The report is tabled every six months at the CQHHS Board Safety and Quality Committee and the Patient Safety, Quality and Risk Committee.

Finally, the SAC 1 procedure provides for the review of past recommendations over the preceding 24 months to ascertain whether the same or similar recommendations have been made in response to a similar clinical incident. If such repeating recommendations are identified, they can be escalated at any of the above three stages in the incident review process. At this stage these requirements only apply to SAC 1 recommendations and it would be beneficial for the framework to apply a similar, if not more streamlined, approach to SAC 2 to SAC 4 incidents.

While CQHHS is heading in the right direction with its clinical incident management approach, there is still room for further refinement in the identification and escalation of repeating issues as illustrated by the following case study:

Case study of Patient F

Patient F was a young first time mother who had been receiving shared care through a community service and Rockhampton Hospital. Over the course of two weeks in early January 2018, Patient F attended Rockhampton Hospital on several occasions for various routine and emergent pregnancy-related concerns. Patient F was 36 weeks gestation. During one of the visits, Patient F had an obstetric ultrasound to assess fetal growth. The ultrasound report recorded abnormal results but these were not immediately escalated to the obstetrics team at Rockhampton Hospital; this was a departure from the standard procedure.

Two days after the scan, Patient F's community service contacted the obstetric team at Rockhampton Hospital to escalate the abnormal scan result, which was identified during a routine case conference. Patient F was subsequently transferred to Rockhampton Hospital, where she underwent an intrauterine fetal death ultrasound scan, which confirmed the fetus' death. Patient F delivered the deceased fetus on this same date.

The incident analysis and open disclosure with Patient F's family identified that there was a missed opportunity to recognise Patient F's emerging clinical risk and develop an appropriate management plan in response, which is a theme that was identified during the incident analyses in 2015 and 2016 yet there was no discussion about the escalation of this as a repeating concern.

The case study of Patient F highlights that there are still gaps in the incident management system when responding to repeating themes from the preceding two years. The clinical incident management framework would benefit from taking a more holistic view of repeating concerns, ensuring that not only recommendations from the preceding 24 months are considered but also contributory factors and missed opportunities to ascertain whether there are areas of continuous improvement in the provision of maternity services.

Recommendation 10

To support the continued improvement of the CQHHS clinical incident management framework, I recommend that:

10. Within 12 months, CQHHS evaluates their approach to reviewing and escalating repeating concerns and recommendations for SAC 1 incident analyses. The new approach should include a requirement that for all SAC 1 incident analyses, past recommendations, lessons learnt, contributory factors and missed opportunities from the preceding 24 months are reviewed to ascertain any similarities or repeating issues. Where repeating issues, recommendations or other concerns are identified these should be escalated to the Maternity Steering Committee for action.

33.2.3 Oversight of recommendations

The CQHHS Board and CQHHS Safety and Quality Committee are the peak bodies within the safety and quality governance chain with responsibility for ensuring that recommendations arising from reviews and incidents are appropriately and fulsomely implemented. These two bodies are also responsible for testing the implementation status to ensure that the briefing from lower level safety and quality committees are fair and accurate. When reviewing maternity services across CQHHS, it appeared that this was an area that could be further refined.

Specifically, it was clear from when the CQHHS Board endorsed the recommendations from the internal review into the Gladstone Hospital maternity service that they had significant concerns about the safety of the service and required an assurance from February 2018 onwards. Consequently, at its February 2018 meeting, the CQHHS Board requested a number of additional reporting lines be put in place to closely oversee the recommendation implementation phase, namely:

- two members of the CQHHS Board Safety and Quality Committee receive a monthly update on the progress of the Gladstone Hospital maternity service
- a standing agenda item be added to the CQHHS Board Safety and Quality Committee providing an update on the Gladstone Hospital maternity service
- all recommendations relating to the Gladstone Hospital maternity service be implemented by February 2019.

These were sound measures by the CQHHS Board in securing appropriate oversight of the service, however, in June 2018, with a coronial inquest planned into a maternity incident, it was identified that the Gladstone Hospital maternity service was significantly behind in their implementation of recommendations. In response, the CQHHS Board directed that there be a weekly special meeting of the CQHHS Board Safety and Quality Committee to track the implementation of recommendations, particularly those that were outstanding from the incident, some two years earlier, which was the subject of the coronial inquest.

While the CQHHS Board implemented strong oversight systems in relation to the implementation of the Gladstone Hospital maternity service recommendations, when staff from the office visited the service in October 2018 it was clear that some recommendations were very recent; this issue was discussed

above in section 14.1. When concerns about the recency of some of the measures was discussed with CQHHS, there appeared to be a perception that the measures had been implemented for a longer period of time and were being embedded into practice. Arguably, the mechanisms implemented by the CQHHS Board and its committee should have safeguarded against any perception about the progress of the implementation of recommendations, however, such bodies are reliant on the information being briefed to them if they are not undertaking a sampling exercise to the confirm the veracity of the information being provided and to test the timeline for when actions are occurring.

Recommendation 11

To support the CQHHS Board in testing the veracity of the information being presented throughout the safety and quality governance chain, I recommend that:

11. Within 12 months, CQHHS develops and implements an ongoing qualitative review process for the Maternity Steering Committee and the CQHHS Board Safety and Quality Committee in relation to the reporting of the recommendation status, including implementation and escalation of repeating recommendations. The review should be:
    a. targeted at ensuring the accuracy of reporting from committees in the safety and quality governance chain in relation to: implemented recommendations, repeat recommendations, and reviewing the effectiveness of the evaluation of implemented recommendations
    b. risk based[116] in line with criteria developed by CQHHS to guide the identification of the sample of recommendations and repeat issues to be reviewed; where possible the audited recommendations should come from a range of SAC classifications.

33.3 Trending and benchmarking

The CQHHS *Clinical Governance Framework 2018–2020* sets clear expectations that CQHHS will *'[promote a] culture of learning from adverse events (including near misses) and [seek] to strengthen safety [systems] and processes, in order to build a culture that fosters learning from mistakes and aims relentlessly to eliminate preventable harm.*' The clinical governance framework will also use incidents to identify trends and '*problem sense*' to drive continuous improvement.

To achieve the above goal, CQHHS has a number of measures aimed at tracking, trending and benchmarking its maternity services, including:

- monthly reporting to the CQHHS Board and CQHHS Safety and Quality Committee on key performance indicators and performance measures for the maternity service, including individual scorecards for each maternity service. This is underpinned by the *Safety and Quality Performance*

[116] The Institute of Internal of Internal Auditors explains that a risk based internal audit '*aims to deliver increased value through effective and relevant internal auditing. It does this through a combination of aspects, approaches and techniques into a single audit while focussing on areas of highest risk to customers, stakeholders, organisation, community and the environment.'* The Institute of Internal Auditors, *White Paper – Integrated Risk-Based Internal Auditing*, July 2016.

Reporting and Monitoring procedure, which sets out clear expectations for performance reporting across CQHHS

- quarterly reporting to the Maternity Steering Committee on all SAC 1 contributory factors and recommendations to assist with the identification of trends
- morbidity and mortality meetings across the network, which examine data and explore themes to drive system improvements
- *Patient on Our Shoulder*, which is a quality and safety newsletter disseminated to staff that highlights key themes or areas of improvement and new safety and quality initiatives
- patient safety notices, which are disseminated across CQHHS after serious incidents to ensure any broader learnings are shared outside of the facility in which the incident occurred.

The above are just some of the measures implemented by CQHHS to routinely track the performance of the maternity service and identify trends or issues as they emerge, enabling a more agile response to preventing serious clinical incidents. When reviewing the myriad of measures CQHHS has in place to monitor performance, it was clear that this has been an area of focus for the health service, with some measures demonstrating sophistication and maturity beyond the expected capability of a health service of its size. One particularly impressive example was from Rockhampton Hospital and is outlined in the case study below.

Case study of control charts

In response to the incidents in the Rockhampton Hospital maternity service in 2015 and 2016, the service wanted to be able to generate real-time data in relation to a series of key performance measures. Previously the service had been relying on the Queensland Health state-wide perinatal data collection, which occurs quarterly and has a six to eight week lag time between the end of the quarter and release of the data, which results in a consistently historical safety and quality snapshot. To obtain a more current picture of the performance data a midwife would manually collate and generate monthly data, taking on average 16 hours to complete the data capture.

To streamline the process staff in the maternity service undertook a project to develop control charts[117] for key performance measures across the maternity service. Initially they developed a list of key performance measures that were aligned with the perinatal data indicators and the Women's Healthcare Australasia clinical indicators. The list was distributed to staff for consultation and as a result of the consultation further performance measures were added.

With a settled list of indicators, staff developed 34 control charts relating to various key performances measures. Each chart has a central line, which is the baseline expectation for performance, and upper and lower control limits setting the acceptable deviations from the central

[117] '*The control chart is a graph used to study how a process changes over time. Data are plotted in time order. A control chart always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. These lines are determined from historical data. By comparing current data to these lines, you can draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation).*' – https://asq.org/quality-resources/control-chart

Case study of control charts

line. Figure 11 below is an example of a control chart, which was used by CQHHS in a poster submission for a health conference.

During the stakeholder visit in October 2018, staff from the office were also advised that where there is three consistent quarters of improvement in key performance measures, the control line and upper and lower control limits are adjusted to meet the improved performance; resulting in a continuously improving benchmark for the key performance measure. Further, if performance is exceeding upper or lower control limits then this can be investigated promptly to ascertain whether corrective measures are required, or to determine what improvements have resulted in consistently higher performance.

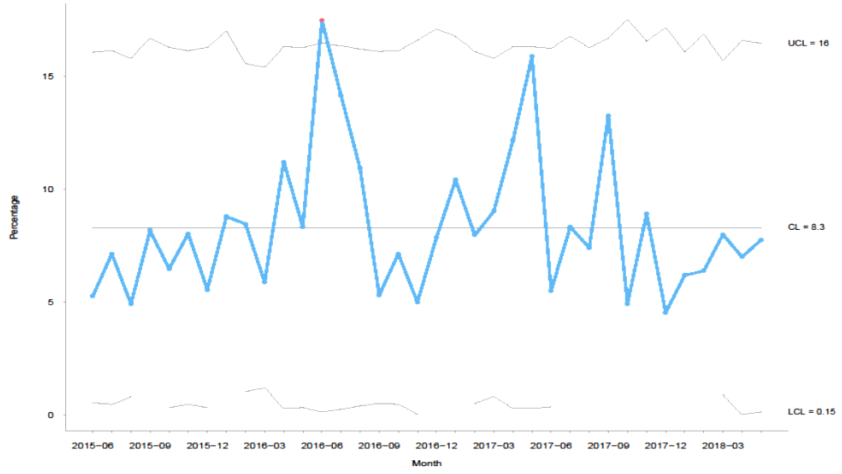

Figure 11 Example control chart from CQHHS

Due to the work done setting up the control charts, and the alignment with existing data capturing processes, the preparation of the monthly data now takes on average 20 minutes. This makes the preparation of data more manageable within the busy clinical environment and provides the CQHHS Board and CQHHS Board Safety and Quality Committee with a monthly up-to-date snapshot of how the maternity service is tracking against key performance measures.

After a three month trial at Rockhampton Hospital the control charts were rolled out to all maternity services across CQHHS. To provide more meaningful data for smaller maternity services, the control charts are prepared quarterly.

Now that CQHHS has embedded its tracking and trending of key performance measures and SAC 1 and, to a lesser extent, SAC 2 incidents, it is important for focussed trending to occur in relation to SAC 3 and 4 incidents. These generally make up the largest bulk of incidents in a health service and are the greatest resource for landscape scanning to identify where the next major adverse incident may occur. Given CQHHS' demonstrated understanding of and commitment to trend analysis and performance reporting I do not consider it necessary to make a recommendation in relation to SAC 3 and 4 trend analysis as I am confident that this will start to occur as the performance reporting processes continue to mature.

34. Adverse comment submission

CQHHS' adverse comment submission made 36 comments in relation to this report. The office accepted a majority of these comments and welcomed CQHHS' input into the accuracy of the information being reported and the appropriateness of the recommendations being made. Accepted comments have been incorporated into the report and are not separately identifiable.

Commentary was provided in relation to three recommendations (outlined below) and on considering CQHHS' submission I have decided to retain the recommendations for the following reasons:

- In relation to the recommendation requiring a staff survey be completed at Gladstone Hospital (recommendation 4a), CQHHS are of the view that this recommendation is unnecessary because they completed a similar staff survey in June 2018 and have a baseline of staff views. However, given that this survey was completed a year ago; the significant changes in the executive leadership at the hospital; and new processes that have been implemented within the maternity service to start to address some of the concerns highlighted by this report, it seems appropriate that a new baseline is ascertained to inform both an evaluation of the last 12 months and what is required moving forward. Accordingly, I am continuing to make this recommendation to support Gladstone Hospital's understanding of its current safety and quality landscape.
- CQHHS consider that the technical recommendation proposed for Emerald Hospital (recommendation 6) in relation to their epidural service is not necessary as they have completed a follow-up audit and confirmed that the service is safe. This report does not contend that the epidural service is unsafe, rather I am recommending a follow-up audit and action plan to address the considerable deficiencies identified with the recordkeeping when the first audit of the service was completed. No evidence has been provided to demonstrate that the gaps in recordkeeping have improved or are otherwise being addressed. It is therefore appropriate for this recommendation to be retained.
- Regarding this office's oversight of the implementation of the review recommendations in Theodore MPHS, CQHHS has queried the need for this recommendation given the work that has been done to improve and embed recommendation management across the Gladstone and Banana region. While I acknowledge the work undertaken by CQHHS to improve its oversight of recommendation implementation, I consider recommendation 7 is still necessary given the protracted period during which the review recommendations were not progressed, despite this coinciding with the improvements to the management of recommendations. I note that CQHHS has not disputed this office's conclusion that no progress had been made towards implementing the recommendations in Theodore to date. This suggests that this is an area that requires independent oversight to ensure the recommendations are fulsomely implemented.

In addition to the above, CQHHS flagged that some of the patients may be identifiable from the case studies due to the small communities within which they live. While I appreciate CQHHS' concern for the privacy of its patients, the case studies are derived from complaints to this office and all complainants have agreed for their stories to be shared as de-identified case studies in an effort to improve healthcare for mothers and babies across CQHHS. As such, I am satisfied that the privacy of all individuals referenced within the patient stories has been appropriately managed.

35. Conclusion and recommendations

After two years of difficulty between 2015 and 2017, marked by external reviews, leadership instability, safety concerns, and outmoded maternity services, CQHHS is clearly rebuilding itself stronger, with a more coordinated and focused strategic vision that aims to provide great care to all Central Queenslanders. There are undoubtedly still challenges to overcome within the maternity service, as has been highlighted throughout this report, but CQHHS has demonstrated the innovation, energy and commitment to keep driving the health service forward to meet and exceed those challenges.

The Rockhampton Hospital maternity service was a significant focus for CQHHS for a number of years due to the safety concerns in 2015, but now that it is a safe and high quality service providing leadership across the CQHHS maternity services, it is time for equal attention to be paid to Gladstone, Emerald and Biloela. The Gladstone Hospital maternity service is facing significant difficulties as the busiest Level 3 maternity service in Queensland. It will require excellent leadership to improve the safety and quality culture and grow the service over the short to medium term. The Emerald and Biloela Hospital maternity services are facing the same problems as most rural maternity services across Queensland in relation to recruitment and retention of suitably qualified and senior clinicians. It will be vital for CQHHS to develop and drive a robust recruitment strategy. In Theodore there is work to be done to rebuild the relationship with the community and design a Level 1 maternity service that suits the community's needs and meets the CSCF requirements. This is no small body of work and will require renewed energy by the CQHHS executive to deliver high quality services across its catchment.

The recommendations made throughout this report are aimed at supporting CQHHS and the individual maternity services in their refinement and improvement journey. While there were some tragic incidents that led to my office's investigation, the impacts of which cannot be forgotten, the opportunity for my office to partner with CQHHS to continuously improve the maternity service is a valuable outcome. I am of the view that overall, the advancements made across the planned birthing services in CQHHS would prevent, as far as practicable, the recurrence of the issues highlighted through the incidents. In any instances where there are still safety improvements to be made, my recommendations should assist CQHHS and its individual maternity services to address these gaps going forward.

The strong stakeholder collaboration undertaken during the investigation and adverse comment process of this report will be maintained throughout the recommendations monitoring phase and has been built into the recommendations monitoring plan (see **Appendix 4**). Through these recommendations and CQHHS' own initiatives, I am confident that the provision of maternity services across CQHHS, at any level of service, will continue to improve to meet the community's needs.

35.1 Full list of recommendations

No.	Recommendation
1	Within 30 days, the CQHHS *Maternity Risk Assessment Tool (Initial Midwife Assessment)* procedure be updated to explicitly require an initial midwifery assessment tool be completed for all women transferring into the service.
2	In relation to the telephone enquiry service the Gladstone Hospital maternity service must:

No.	Recommendation
	a. within 30 days make it mandatory to record in Riskman all instances where there has been some type of corrective action needed to be taken in response to telephone advice, including follow-up care needing to be provided to the woman, and/or discussions with individual staff members, whether formal or informal, about the appropriateness of the advice provided. This incident recording is to occur regardless of any other clinical outcomes. b. within three months: i. review all incidents of any SAC classification level for the period 1 January 2016 to 30 October 2018 where a telephone enquiry encounter was part of the care ii. prepare a report to the CQHHS Safety and Quality Committee on the outcome of the review, including a summary of each incident and any deficiencies with the telephone enquiry advice provided iii. develop a coordinated action plan, for endorsement by the CQHHS Safety and Quality Committee, to address the identified key issues and root causes for the repeated concerns with the telephone enquiry service. This action plan may include measures that have already been implemented. c. provide the CQHHS Safety and Quality Committee with a quarterly report covering: i. any incidents of any SAC classification level that involve the telephone enquiry service ii. a status update from the midwifery unit manager on the number of occasions within the quarter on which she has had to either provide follow-up care after reviewing a telephone enquiry advice and/or have a formal or informal performance discussion with a midwife about the telephone enquiry advice provided. The first quarter of reporting should commence within 30 days of endorsement of the action plan referred to in recommendation 2b. This reporting must continue for four quarters. Any ongoing issues with the telephone enquiry service should be addressed through the standard safety and quality escalation pathways.
3	Within three months the Gladstone Hospital emergency department: a. establishes a mandatory process for placing an alert on a women's file where they are pregnant or potentially pregnant and have: i. self-discharged against medical advice ii. not waited to see a clinician iii. left after treatment commenced.

No.	Recommendation
	b. establishes a KPI benchmark for compliance, audit schedule and review process for the mandatory alert outlined in 3a above that reports quarterly to the Quality and Safety Committee in relation to: i. all incidents relating to the care and management of pregnant or potentially pregnant women in the emergency department ii. compliance rates with the policies and processes related to the care and management of pregnancy or potential pregnancy related presentations to the emergency department. Any adverse issues or trends identified in relation to the care and management of pregnancy related presentations in the emergency department are to be escalated to the CQHHS Safety and Quality Committee and CQHHS Board in accordance with the existing governance framework.
4	In relation to safety and quality leadership and culture that the Gladstone Hospital maternity service must: a. within three months complete a staff survey seeking staff views on what they understand is the safety and quality culture and safety and quality leadership within the maternity service. The results of this survey should inform the kaizen workshop referred to in recommendation 4b. b. within six months run kaizen workshops and plan for evaluation of the outcomes of those workshops. At least one session should focus on leadership and the safety and quality culture.
5	Within 12 months the Gladstone and Banana Shire Business Unit: a. maps out all of the clinical governance committees across Gladstone and Banana Shire, including their reporting lines upwards and downwards through the governance chain b. reviews how the existing committee structure could be streamlined, including reviewing the terms of reference for each committee to ascertain overlap, and presents a paper to the Gladstone and Banana Senior Leadership Team on the review and any recommended changes c. develops a diagram to demonstrate the final committee structure, including reporting relationships between the committees.
6	Within three months, the Emerald Hospital maternity service: a. undertakes a chart audit of all epidurals performed since the previous audit. This process should include setting benchmarks for the expected completion of key areas of the epidural process e.g. 80 per cent of all charts audited have a fully documented post anaesthetic review process and provision of the information booklet

No.	Recommendation
	b. develops an action plan for any identified areas for improvement from the audit, if any. The action plan, if any, should include a process for evaluating the effectiveness of the measures once they are implemented c. presents the outcomes from the audit and any action plan to the Maternity Steering Committee.
7	CQHHS provides six monthly status reports to the office on the implementation of the internal review recommendations until all recommendations are implemented and their fully implemented status is confirmed by the office.
8	Within three months, CQHHS introduces a midwifery group practice procedure outlining the process for transferring a woman's care when her allocated MGP midwife ceases with the service. The procedure should include an outline of the roles and responsibilities of each person involved with the transfer of care and be focused on maintaining continuity of care, where possible.
9	CQHHS must: a. within 6 months, develop a clinician consultation process for all recommendations being proposed during a SAC 1 RCA or Human Error and Patient Safety (HEAPS) analysis. This should be a mandatory step in the clinical incident management process. Any relevant procedures, checklists or other policy documents should be amended to reflect the consultation process. b. within 12 months, introduce a benchmark that for all maternity SAC 1 and serious SAC 2 RCAs, where there are formal recommendations and lessons learnt, 70 per cent of all of the recommendations made must be moderate effect or higher in 80 per cent of all maternity incidents across each calendar year. This should be audited on an ongoing basis as part of the annual maternity audit program. c. within 12 months, develops as part of its clinical incident management process, a risk-based approach to implementation, evaluation and oversight of low, moderate and high effect recommendations.
10	Within 12 months, CQHHS evaluates their approach to reviewing and escalating repeating concerns and recommendations for SAC 1 incident analyses. The new approach should include a requirement that for all SAC 1 incident analyses, past recommendations, lessons learnt, contributory factors and missed opportunities from the preceding 24 months are reviewed to ascertain any similarities or repeating issues. Where repeating issues, recommendations or other concerns are identified these should be escalated to the Maternity Steering Committee for action.
11	Within 12 months, CQHHS develops and implements an ongoing qualitative review process for the Maternity Steering Committee and the CQHHS Board Safety and Quality Committee in relation to the reporting of the recommendation status, including implementation and escalation of repeating recommendations. The review should be: a. targeted at ensuring the accuracy of reporting from committees in the safety and quality governance chain in relation to: implemented recommendations, repeat

No.	Recommendation
	recommendations, and reviewing the effectiveness of the evaluation of implemented recommendations b. risk based[118] in line with criteria developed by CQHHS to guide the identification of the sample of recommendations and repeat issues to be reviewed; where possible the audited recommendations should come from a range of SAC classifications.

[118] The Institute of Internal of Internal Auditors explains that a risk based internal audit '*aims to deliver increased value through effective and relevant internal auditing. It does this through a combination of aspects, approaches and techniques into a single audit while focussing on areas of highest risk to customers, stakeholders, organisation, community and the environment.'* The Institute of Internal Auditors, *White Paper – Integrated Risk-Based Internal Auditing*, July 2016.