A REVIEW OF THE GOVERNANCE OF MATERNITY SERVICES AT CAVAN/MONAGHAN 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 Cavan / Monaghan 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 Cavan/Monaghan 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

Cavan / Monaghan Hospital – key findings and conclusions.

Overall

The hospital at Cavan has a generally fit for purpose infrastructure overall and is quite well maintained.

The unit is overspending in the current year even though there are some shortages in key areas of the clinical workforce. The management structure is very light and is hugely dependent on a small number of key individuals working beyond what can reasonably be expected based on the job description and contract of employment.

When the management team is faced with issues and problems there is a need to react and respond which draws in the key individuals and the reactive work can displace the proactive management of urgent and important business.

The General Manager has worked there for a number of years in different roles and knows the place inside out. She provides strong leadership to the management team, gets involved with the right things at the right time, and sets a tone by her example of leadership based on care and compassion. She makes the best of the too few senior managers at her disposal.

The senior management team is not permanent and stable. The Director of Nursing is only temporary, there are two Clinical Directors. One CD post is responsible for Women’s and Children’s services and the postholder is planning to stand down from the role. There is some suggestion that the General Manager also plans to move on. If the CD and GM do not continue in their roles then this poses a significant risk to the organisation as both are highly capable and senior colleagues in the hospital have great confidence in them.

There is a very strong commitment to Cavan hospital from a large number of staff who are from the county and have lived and worked there for a long time. In this spirit, there are many examples of staff coming in on days off when the place is busy and going beyond the call of duty.

The governance structures are generally well designed and very well maintained and managed. Everyone seems to understand how it works and the quality of documentation and process management is outstanding.
There are no gaps in the governance structures which cause any alarm although the population of the groups and committees places a big demand on a thinly stretched management team.

The Executive Management Team is chaired by the General Manager and is supported by an Operational Management Team chaired by the Assistant General Manager. The Quality and Safety Executive Committee chaired by the Clinical Director for Women’s and Children’s services is the key forum for quality, risk and patient safety matters and reports directly into the Executive Management Team. The process of escalation is effective and the minutes of the Executive Management Team show a strong focus and action regarding quality, risk and patient safety.

Between September 2013 and January 2014 the Management Team undertook a self-assessment measuring against the Safer, Better Healthcare Standards. This produced 102 actions required. As at March 2015, 89 had been completed and 13 remained overdue which included upgrading the Emergency Department with a Paediatric waiting room, completing a training schedule on consent and compiling a risk register in three service areas (not Women’s which is done). This process is both realistic and meaningful. It is tempting to think that these are just tick box exercises but the evidence is there that this is much more than that.

The management culture is quite performance focussed and driven by the data in a positive way.

**Maternity Services**

The cluster of four serious incidents in maternity services in 30 months has hit the place hard. All four have been or are being investigated and this review has kept completely separate from those processes. As a consequence of these incidents there is a very bright and critical media spotlight on the hospital. This is impacting on the mood and morale of members of the maternity team and it was described how it is affecting clinical risk assessments and decisions. One consultant obstetrician described how a colleague locum consultant chose to leave the organisation because of this.

There is a Consultant Led Unit and a Midwife Led Unit. Out of 1800 births in 2014 only 130 were in the MLU even though it is a very high quality facility
with two birthing suites. Although it was not really talked about in interviews it is clear to see that there are different views between the obstetricians and the midwives about the models of care. This gets in the way of effective multi-disciplinary working which in turn presents a risk that individual decisions about care are not as considered and balanced as they should be. Last year some 130 cases which began in the MLU were transferred to the CLU and less than a handful transferred back. The doctors are very much in charge.

Whilst the hospital leaflet outlining the choice of care options compares the CLU and MLU in a balanced way, in practice the GPs refer even low risk pregnancies to the CLU in most cases.

The consultant establishment is four posts with proposals for a fifth. Only one post is substantively filled and active at present and two others are filled by locums. A third locum consultant has left and a process is in place to recruit a replacement. This is clearly inadequate both in terms of capacity and capability. Covering a 24 hour service with consultants working a “one in three” is unsatisfactory and not sustainable. The fifth consultant is required before the service can begin to provide foetal anomaly scans at 20 weeks.

The midwife to births ratio is 1:40 and the unit is hiring five more midwives to work towards a ratio of 1:37 and to enable full 24/7 cover and shift leadership. The most senior midwife is an Assistant Director of Nursing. She is not a member of the Operational Management Team and feels professionally isolated and unsupported. There is evidence to suggest that this is the case.

The statistical comparisons for the maternity service are positive. The perinatal mortality rate is below the Ireland average and is lower than most other units with a similar number of births. The percentage of newborn babies with an Apgar score of less than 5 measured at the 5 minute test is impressively low. Whilst too much assurance should not be drawn from the statistics alone these are very encouraging measures.

There is a maternity services network between Cavan and Monaghan and Drogheda. The protocols for higher risk pregnancies to go to Drogheda or to Dublin for more specialist care are acknowledged to work well.

Quality, risk management and patient safety in Maternity is in the first instance the business of the Women’s Health Clinical Governance Committee. This is chaired by the Lead Obstetrician and is attended by the General Manager. Its
work is based on a well-constructed and balanced Women’s Health Risk Register which is maintained and up to date. The key red rated risks are the shortages of midwives and consultants, the locum doctors not being familiar with hospital procedures, and the lack of capability and capacity to undertake foetal anomaly scans. These issues are consistent with the findings in this review process. It does not however explicitly address the risk and of ineffective multidisciplinary working.

The hospital has undertaken a very thorough assessment of its own services following the Portlaoise report. Out of 53 recommendations and areas of non-compliance identified in this report, 25 are relevant for the hospital and they all have been or are being implemented.

Likewise, the hospital’s own assessment in April 2015 against the recommendations from the Savita Halappanavar report show only one outstanding issue – communication on clinical handovers. Achieving this standard is made difficult by the shortage of consultants.

The processes for self-assessment against the Portlaoise and Savita Halappanavar report recommendations are comprehensive and substantial and are regularly refreshed. The outcomes are considered all the way through the Women’s Clinical Governance Committee to the Executive Management Team.

In addition to the formality of the Clinical Governance Committee, the General Manager chairs a weekly audit meeting in the maternity unit which examines and assesses the previous week’s cases which were out of the ordinary. This meeting is highly effective and is attended by the leaders of all staff groups in the unit.

There is a very good Bereavement service provided part time by a nurse from the Special Care Baby Unit.

The patient representative who contributed to the Review process was positive in her support of what the hospital was trying to do and also very aware of some of the difficulties of effective multi-disciplinary working and clinical networking which she had observed at first hand.
Incident Management and Complaints

The hospital has a dedicated Quality and Patient Safety Manager who is a member of the Operational Management Team and is the guardian of the hospital’s core risk management processes and procedures. Upon inspection, these processes look thorough and appropriate.

The incident management and reporting systems and complaints processes are in accordance with relevant HSE policies and guidance and feed into the National Incident Management System through the Local Incident Management Forum which is chaired by the General Manager.

A large part of the General Manager’s time and focus is in this area and she deals personally with complainants and families. This is excellent practice.

An Open Disclosure Policy is being implemented and good progress was noted.

Summary of Conclusions

Overall, the systems and processes for the assurance of quality, risk, and patient safety are well established and effective at Cavan and Monaghan.

The hospital’s biggest challenge is coping with staff shortages in critical areas including obstetricians and midwives on the one hand and a committed level of expenditure in excess of available funding on the other hand.

The staff shortage problem in these areas is exacerbated by some of the evident strains in multidisciplinary working in the maternity unit and the inability to fill posts substantively meaning there is an ongoing dependency on locum doctors who have not been trained in the system and who are unfamiliar with the hospital’s ways of working. All this means that the services lack the level of resilience required to give confidence that high standards of care can be consistently maintained as and when key individuals come and go and when demand pressures spike.

The management structures are very thin and lack both breadth and depth in some key functional areas.
In these circumstances the Executive Team do remarkably well to achieve the positive results that they do. They can do this because there are a number of very strong individuals in key roles who hold the whole thing together and because the governance systems and processes are well designed and embedded. Also, the organisation responds well to the style and approach of the General Manager.

**Building Resilience**

There is not much more that the hospital can do for itself to build greater resilience in its governance systems and processes.

The relationship and ways of working between the Midwife Led Unit and the Consultant Led Unit needs revisiting and reconciling. This should be undertaken by the GM supported by the Executive team as a matter of urgency.

The Assistant Director of Nursing for Midwifery should join the Operational Management Team.
Issues for the RCSI Group

The Group is very actively engaged at Cavan both through the formality of its operating model of monthly performance meetings and informally through ongoing communication and connection between the Group CEO and Hospital GM and their respective senior teams.

The agendas for the monthly meetings cover a broad range of issues from strategy, to quality, to finance, to day to day operational issues. The communication on serious incidents, operational failings and inquiries and investigations is very thorough and appropriate.

The Group CEO has been in post for six months and has set out a very clear vision and operating model for the future. The Chair and CEO seem to enjoy a mutually supportive working relationship.

A challenge for the Group is to populate the organisational structure more quickly and for new appointees to hit the ground running. This is particularly important in the new Clinical Directorate model. The proposal for cross-group Clinical Directors should enable more rapid progress to be made with the establishment of clinical networks. These networks are the single most important factor in building greater resilience in the smaller units.

A single maternity network across the RCSI Group operating to a single set of standards within a single governance structure and able to make appointments to and manage the clinical workforce will represent significant progress.

In the past, in the former regional structures, Cavan has been loosely networked with Our Lady of Lourdes Hospital Drogheda and the patient pathway to ensure higher risk cases are directed to the bigger and stronger units seem to have worked effectively and continues to do so. However, the clinical teams across the two sites have not come together in any practical sense over and above talking to each other about common issues. This missed opportunity for more joint working and integration has exacerbated the professional isolation of both the Obstetricians and Midwives at Cavan.

In the new Group structure the Rotunda Hospital becomes the biggest and strongest maternity unit in the Group. The Clinical Staff at Cavan are very positive about the potential networking with the Rotunda and this will undoubtedly be an urgent priority for the Group Clinical Director with responsibility for Women’s Services. However, as yet very little has been done
in terms of practical action (such as consultant support) and a more directive approach from the Group would be beneficial. It is not necessary to wait for a full network design to be agreed before beginning with some easy and practical means of support.

The Group CEO has a good vision for the future design of a sustainable Maternity Services configuration, but it is important to act now on building resilience for the period until a more sustainable solution is agreed and implemented.

The Group should consider carefully why better integration and networking did not happen in the former structures and ensure that whatever cultural, behavioural, financial and practical barriers existed are worked through and do not prevent progress in the new Group structure. This will require full and frank discussions between all the relevant parties.

The Group should also consider how it can bolster the managerial and administrative capacity and capability in the smaller units such as Cavan. However good and reliable the systems and processes are in the smaller units, the dependency on a small number of key individuals to operate them presents a risk to their reliability. At present Cavan Hospital runs its own stand-alone systems, such as risk management, audit and incident management. The output of these processes is reported upwards into the Group, where they are reviewed and overseen by the Group’s own processes and people. Consideration should be given to the vertical integration of those teams so that duplication is eliminated and scarce expertise is brought together into a more resilient critical mass.