Clinical: Women's Health
Proactive Release: 11 September 2019

COUNTIES MANUKAU HEALTH

2nd September 2019

[redacted]

Email: [redacted]

Dear [redacted]

**Official Information Act (1982) Request**

I write in response to your Official Information Act request, dated 07 August 2019. You requested the following information:

- **A copy of a report that covered maternity and birthing services and included the views of doctors/ clinicians.**
    - **I believe this was an internal report and authored or co-authored by John Tait, and was finished in 2018 or 2019.**

We are providing a copy of a Report (**attached**) that we believe is the one you refer to. This report is the result of a review and visit to our Women's Health services at CM Health. Our Chief Medical Officer commissioned this in late 2018, and received the report in March 2019. This was completed for CM Health by Dr John Tait, (Chief Medical Officer and a Consultant Obstetrician and Gynaecologist at Capital and Coast DHB).

The visit to the Women's Health Services had a focus on the Obstetrics and Gynaecology medical workforce, and the services they provide at CM Health. This enabled us to receive an external and expert opinion on the medical workforce capacity issues faced by the service at that time.

Subsequent to the report, the Clinical Director for Women's Health confirmed an Action Plan, which incorporated recommendations from this report, as well as other service initiatives. As a result of beginning to implement the plan, there has now been good progress on completing many of the recommended changes since the report was written. We are providing a copy of the Action Plan, including progress-to-date (**attached**), to demonstrate that progress has been made.

Concurrently, the Women's Health Service has been working with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) regarding ongoing Training Accreditation. In relation to this, a visit in April 2019 by Dr Devenish also informed the Women's Health Action Plan, and is referenced in the Action Plan. We are providing a copy of that letter (**attached**), to note the assessment and feedback received.

I trust this information satisfactorily answers your query. If you are not satisfied with this response you are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act.

Please note that this response or an edited version of this may be published on the Counties Manukau DHB website.

Yours sincerely,

Fepulea'i Margie Apa
Chief Executive Officer
**Counties Manukau Health**

Gloria Johnson
Chief Medical Officer – CM Health

Dear Gloria

Thank you for asking me to visit The Women's Health Service at Counties Manukau. I visited on 3 days and spoke to SMO's from Obstetrics and Gynaecology, Anaesthesia, General Surgery, management and nursing staff. This is the final report incorporating the feedback received.

Counties Manukau Women's Health Service is unique in New Zealand. It is the busiest service, has the most pathology, looks after women with significant obesity issues and has a variety of demographics.

The SMOs who work in the service are dedicated, hardworking and competent. However, there was significant emotional distress amongst those interviewed. A series of adverse outcomes, the loss of a colleague, resignation of two senior colleagues and the relentless nature of 'on call' has resulted in a very disillusioned workforce.

At present the total FTE is 21.61, the on-call roster is 1 in 16, and there are 12.5 gynaecological operating lists per week.

I note since the review that Women's Health has appointed four new specialists starting December, February and two in March 2019, and further advertising was in progress.

**Update 6/3/19:** Further successful interviews. Now progressing the appointment process for three further SMOs (with some years of experience); one as an initial FTC.

**OBSTETRICS ISSUES**

Although the birth rate has dropped from a high of 8,225 to 7,816, the absolute number of obesity 2and 3 patients has gone up from 726 to 885. Over 50% of patients booked have a BMI of 35 or greater. The other interesting fact is the timing of emergency LUSCS. Last year 611 were performed between 8am and 5pm; 337 between 5pm and 10pn; and 593 between 10pm and 8am.

In that later group 265 were classified obese 1, 2 or 3. This is a large number of high risk women that have their LUSCS when the rest of the hospital is at its lowest staffing levels.

Another issue is the lack of a team structure with regards to inpatient obstetric care. The care is provided by the on-call team changing daily, which runs the risk of a lack of continuity of care and potentially a lack of decision making.

With the on-call arrangements, there appears to be a reluctance to call the back-up person because they will be working the next shift.

I gather prior to Christmas a separate dedicated weekend on-call SMO system was put in place to avoid this. For weekdays, clinical duties are cancelled the following day if the second on-call has been required to work during the night.

At present there are also a number of junior registrars, which is compounding the feeling of "relentlessness" of work when the SMO is on-call.

The Diabetic Clinic is a major issue. They are overwhelmed by the demand. They do not have the resource to follow the guidelines, which is adding to the stress of those working in the clinic. They are

continually worried that they will miss something. Apart from lack of staff they also have concerns about lack of space to see the patients.

**GYNAECOLOGY**

The Acute Gynaecology service is also run by the on-call team. Again the risk of this is lack of continuity with no one person or team taking responsibility for the care of the individual patient. This can result in a delay in treatment.

There are also concerns about accessing acute theatres although there is work happening around that.

One of the major issues from the gynaecologists is the lack of control over their operating lists. The service is also concerned about the unmet need for patients with pelvic pain and uro-gynaecology as they do not often meet the criteria to be seen in clinic. This particularly affects those specialists with an interest in these clinical areas.

The demand on elective services also means that patients are admitted acutely and operated on acutely, which puts added pressure on the acute services.

There is also a concern about the lack of outsourcing and the fact that what outsourcing there is goes to a non-staff member.

Update: Additional resource has since been provided for outsourcing. This has commenced with working through a back-log of outpatient hysteroscopy cases (200). A procurement process has now commenced for use of a private facility with anaesthetic and nursing staff for use by DHB employed Gynaecologists and trainees.

**GENERAL ISSUES**

There have been issues with rostering and leave. The roster is only coming out the Friday before the next week, and difficulty in getting leave, plus multiple last minute changes. There have been a series of rostered changes with the current employee not coping. Additional support has been provided by NRA, and the job is being scoped to determine whether additional FTE is required. The master roster is not up-to-date, with leave or swaps.

**Update:** This has reached a point of crisis with now clinical safety issues rather than just frustrations (incorrect after hour's roster and delay in finding corrected individual). This has been elevated through NRA, and to the CMO, and further assistance is being sort. This has been added to the DHB risk register.

There is a feeling of no time to think, rushing from one gap to another.

The lack of resource for the Clinical Director has resulted in her spending considerable time on sorting out rosters, fire-fighting, etc. with having limited time to strategise and increase her visibility to the Service.

The concerns with accreditation for training positions with RANZCOG was raised on several occasions. The last report from RANZCOG also raised that possibility with the next reaccreditation visit due in January 2020.

**RECOMMENDATIONS:**

- Implementing the recommendations of the 2012 Report.
- A team structure to look after obstetrics and gynaecology in patients with the aim of improving continuity of care. This will require a dedicated project manager.
- More support for rostering and leave provision. This has the potential to move from frustration to having an effect on clinical safety.
- An Anaesthetic Consultant on-site after hours.
- Expand on the audits of the outcomes for those pregnant women with BMIs of over 50. At the same time look at trying to reduce the number of emergency LUSCS done between 10pm and 8am.
- The Diabetic Clinic needs more resource, both in staff and physical space.
- All day elective LUSCS lists should be implemented.
- Outsourcing of gynaecological electives if possible should be to those gynaecologists who are employed by Counties Manukau. Exploring the possibilities of hiring facilities from private hospitals and using Counties Manukau staff, including registrars, to ensure their operating numbers are adequate.
- Gynaecologists should have more control over the operating list, taking into account clinical priority and waiting time. An effort should be made to address the unmet need for patients with pelvic pain and uro-gynaecological symptoms.
- A job-sizing exercise for SMOs, ensuring that they get adequate non-clinical time.
- Adequate resource to support the Clinical Director, to enable the Clinical Director to have time to strategise and increase her visibility to the Service

Counties Manukau is in a unique position that in it could be a centre for excellence for the management of obesity related problems in women's health. Closer liaison with the University of Auckland may help attain that goal.

The SMO's who I spoke to are dedicated and hard-working who are committed to their service. They need more administrative support to realise their potential.

My final comment is that I found it quite distressing to see the emotional distress of my colleagues, and I hope change can happen to alleviate this distress.

**Kindest regards**
**John Tait**
**MB, BS FRANZCOG FRCOG**

**05/03/2019**

**Refer over**

**APPENDIX A**

A list of potential quick wins:

1. Ventouse equipment in delivery suite. [redacted] would be the contact. Cell saver availability
2. All-day elective LUSCS lists
3. Rosters and leave allocation in a timely manner
4. More input from SMO's into their gynae lists
5. Clinical Nurse Specialist (CNS) in EPAC Clinic, to provide some continuity of care
6. Three SMO's to continue on the weekends
7. More resource for the Diabetic Antenatal Clinic
8. Social Worker resource for perinatal losses
9. Clinical input into the outsourcing of gynaecological patients
10. Support for a Pre-term Birth Clinic

I think the important ones are 1,2,3,4 and 9.

**WOMEN'S HEALTH SERVICE REPORT**

| | Issue | Recommendation | Current situation | Workplan | Proposed completion date | Complete |
|---|---|---|---|---|---|---|
| 1 | Concern that the maternity review of 2012 recommendations had not been fully implemented. | **Implementing the recommendations of the 2012 report.** | Majority of the recommendations were in relation to care in the community and much has been achieved with work still on-going (MQSG and MSGG). | Maternity Strategic Governance Group (MSGG) to present update to ELT Sept 2019. | September 2019 | |
| 2 | Lack of team structure to provide inpatient continuity of care to complex antenatal patients (maternity ward) and complex gynaecology patients (GCU) | **A team structure to look after obstetric and gynaecology inpatients with the aim of improving continuity of care. This will require a dedicated project manager.** | Rostering of SMOs to the daily Maty and GCU ward rounds. This was set up using a dedicated group of SMOs interested in these clinical areas, but over time it has become open to a wider group of SMOs resulting in a range of management plans. | i. [redacted] employed by Women s Health April to September 2019 at 0.5FTE as a "Change Manager" to look at this and other projects within the service.<br><br>ii. Reinstitute Wednesday morning meetings to discuss complex antenatal and gynaecology patients. | Sep-19<br><br>ii. Complex case discussions commenced April 2019. | **Yes** |
| 3 | With the SMO second on-call arrangements there appears to be a reluctance to call the back-up person because they will be working the next shift.<br><br>There have been issues with rostering and leave. The roster only coming out the Friday before the next week and difficulty in getting leave plus multiple last minute changes. There have been a series of rostered changes with the current employee not coping. Additional support has been provided by NRA and the job is being scoped to determine whether additional FTE is required. The master roster is not up to date with leave or swaps. | **More support for rostering and leave provision. This has the potential to move from frustration to having an effect on clinical safety.** | Immediately prior to Christmas 2018 a separate dedicated weekend on-call SMO system was put in place to avoid this. For week days, clinical duties are cancelled the following day if the second – on call has been required to work during the night.<br><br>Current rostering system is disfunctional.<br><br>NRA have job-sized rostering position and believe this to be 1.7 FTE, so 0.7 more than the current FTE. | Indepenndent second-on-call system at weekends<br><br>Change manager to review daily rostering process; looking at replacing multiple manual activities to electronic to avoid errors. Sharepoint and other options being explored. | Dec 2018<br><br>September 2019 | **Yes** |
| 4 | There is a large number of high risk women that having caesarean sections (CS) afterhours when the rest of the hospital is at its lowest staffing levels. | **An anaesthetic consultant on site after hours** | On-call anaesthetic SMO overnight | | Update May 2019 | **Yes 14/5/19** |
| 5 | Although the birth rate has dropped from a high of 8,225 to 7,816, the absolute number of obesity 2and 3 patients has gone up from 726 to 885. Over 50% of patients booked have a BMI of 35 or greater. Timing of emergency CS is a concern. Last year 611 were performed between 8am and 5pm; 337 between 5pm and 10pn; and 593 between 10pm and 8am. | **Expand on the audits of the outcomes for those pregnant women with BMIs of over 50. At the same time look at trying to reduce the number of emergency CS done between 10pm and 8am.** | Currently no local guideline regarding induction of labour (IOL) or elective CS in obese women. | Review of the last 12 months of data by [redacted] presented at the Women s Health update day 1/5/19.<br>Reviewed by May '19 OCPG - recommendations to be added to the Obesity guideline and signed off by the controlled document group 9/7/19 noting that caesareans in women with morbid obesity may still happen out of hours and resources and skilled clinicians are required at all times for this service. | Jul-19 | **Yes** |
| 6 | The Diabetic Clinic is a major issue. They are overwhelmed by the demand. They do not have the resource to follow the guidelines, which is adding to the stress of those working in the clinic. They are continually worried that they will miss something. Apart from lack of staff they also have concerns about lack of space to see the patients. | **The Diabetic Clinic needs more resource both in staff and physical space** | Two new SMOs have been employed since this review (with an interest in diabetes) in-part to work in the GDM clinic .<br>Obstetric diabetes lead reinstated [redacted] with her request to review handing this over in December 2019 - [redacted] new SMO commencing with DiP interest and experience | i. Under review, proposals to be developed by [redacted] engaged as a project manager to assess current situation - report completed.<br><br>Decision made to engage KA<br><br>ii. Review of additional clinic space in Mangere (for low risk women) plus exploring module 10 clinics on Thursday mornings (am clinics also have a lower DNA rate)<br><br>iii. Additional clinic space from portable building to adjoin Module 10. | May 2019<br><br>August 2019<br><br>Dec 2019<br><br>Feb 2020<br>Sept 2019<br><br>2020 | |
| 7 | Inadequate number of caesarean section lists. | **All day elective LUSCS lists should be implemented.** | Over-run of elective caesarean lists on a regular basis. Insufficient lists - recently gained a Wednesday afternoon list. Mon, Tue, Thur and Friday remain half day lists (excluding PH and theatre shut-down days). | [redacted] completed: reviewing theatre flow for elective caesareans (daily overruns). To present report to acute theatre team with solutions.<br><br>Decision to increase to all day theatre lists Tuesday, Wednesday and Thursday | Meeting 21/05/19<br><br>June 2019 | **Yes** |

**WOMEN'S HEALTH SERVICE REPORT**

| | Issue | Recommendation | Current situation | Workplan | Proposed completion date | Complete |
|---|---|---|---|---|---|---|
| 8 | The service is also concerned about the unmet need for patients with pelvic pain and urogynaecology as they do not often meet the criteria to be seen in clinic. This particularly affects those specialists with an interest in these clinical areas. | **Outsourcing of gynaecological electives if possible should be to those gynaecologists who are employed by Counties Manukau. Exploring the possibilities of hiring facilities from private hospitals and using Counties Manuakau staff, including registrars, to ensure their operating numbers are adequate.** | Due to limited theatre capacity, P3 urogynaecology and pelvic pain patients are not seen as FSAs as they would not receive surgery in the required timeframe. | Additional resource has since been provided for outsourcing. This has commenced with working through a back-log of outpatient hysteroscopy cases (218 referred - some declined case eg performed in private/ acutely, no-longer required, uncontactable or requesting GA expect 150 completed cases by end May 2019 ).<br><br>A procurement process has now commenced for use of a private facility with anaesthetic and nursing staff for use by DHB employed Gynaecologists and trainees.<br><br>Saturday operating at MSC being explored - supported by CMH O&G and Anaesthetic SMOs and trainees<br>Pessary clinics run by women s health physiotherapists are being explored to help with the unmet urogynaecology need. | **Completed end May 2019.**<br><br>Contract to be finalised for 48 cases - surgery commences 29th August .<br><br>October 2019<br><br>Oct-19 | |
| 9 | One of the major issues from the gynaecologists is the lack of control over their operating lists. | **Gynaecologists should have more control over the operaitng list taking into account clinical priority and waiting time.** | i. Gynaecologists not involved in booking lists and often operate on women they meet for the first time on the day of surgery.<br><br>ii. Dictated to by theatre team (cube) that TLHs will only be performed on all day lists with no consultation. | i. Operating surgeon to be able to agree list 2 weeks out and see all patients in pre assessment clinic.<br><br>ii. Meet with anaesthes a regarding TLH cases - discussed at Anaesthetic GG on 14 May 2019. [redacted] will look futher into cube data.<br>to attend TOG and cube meeting.<br>Discussed option of Saturday operating at MSC - surgica;l services and anaesthetics in consideration. | May 2019<br><br>May 2019<br><br>June 2019<br><br>June 2019 | **Yes** |
| 10 | Low SMO morale | **A job sizing exercise for SMOs ensuring that they get adequate non-clinical time** | Current difficult roster situation, business after hours and lack of team structure.<br>Some improvement since Dr T it s visit with employment of 4 new SMOs and 3 additional registrars. | Change Manager employed April to September 2019 to look at daily rostering and leave, team structure and after hours roster. [redacted] will work closely with the SMO team. ASMS are aware. Job sizing will be required as part of this process.<br><br>Engagement with allied health looking at a women s health psychologist for staff and patient s | September 2019<br><br>October 2019 | |
| 11 | The lack of resource for the Clinical Director has resulted in her spending considerable time on sorting out rosters, fire-fighting, etc with having limited time to strategise and increase her visibility to the Service. | **Provide adequate resource to support the Clinical Director** | Lack of resource; fire fighting | Change Managers [redacted] for Ward [redacted] for SMO roster and model of care work<br>Working alongside CD | September 2019 but may need ongoing support for future projects | |
| **Additional items in the report but no specific Tait recommendations** | | | | | | |
| 12 | At present there are also a number of junior registrars which is compounding the feeling of "relentlessness" of work when the SMO is on duty | **No specific Tait recommendation** | Registrars employed through NRA regionally, with few step-up positions available in the region. Currently CM Health have an over-allocation of two registrars to function in this way. | Application made through NRA for an SHO tier of four doctors to assist transition from HO to registrar. This equates to the number of first year RANZCOG trainees joining CM Health each year. Approval granted to commence 2 positions in December 2019 and a further 2 in June 2020. | December 2019 and June 2020 | **Yes (funding approved)** |
| 13 | The concerns with accreditation for training positions with RANZCOG was raised on several occasions. The last report from RANZCOG also raised that possibility with the next reaccreditation visit due in January 2020. | **No specific Tait recommendation** | [redacted] for a RANZCOG pre-accreditation visit by O&G Colleague,<br>Dr. Devenish, on 3rd April 2019 | See Devenish report recommendations, including a later re-accreditation visit with January being soon after registrar change-over and a high leave period - this has been endorsed by RANZCOG. Overall a positive report. | **RANZCOG reaccreditaiton visit March 2020** | |

**April 3 Visit to Middlemore**

Dear Sarah Tout,

Thank you for the opportunity to visit your department.

It was a pleasure to meet the SMOs Registrars and Administrative staff. The discussion of current training and rostering challenges was very helpful in achieving an overview of the current progress towards Accreditation in 2020.

I believe there re no major obstacles to achieving this; and I congratulate all on the efforts made and innovations instigated.

I would suggest a re-accreditation visit in March 2020, when the new senior and junior doctor appointments will have had sufficient time to become established in their positions. This will also allow sufficient time to consolidate changes currently planned.

I believe the Accreditation standards will be met within this timeline

My impression is that the culture of the unit is excellent, and in particular it is one open to change and reflective thinking. Training is a priority, and junior staff report a very positive supportive and enabling culture. They report all senior staff are approachable.

I understand [redacted] is a newly appointed change manager, who will fully evaluate potential roster changes, and help optimize working arrangements to best facilitate training amongst other priorities.

Todays' conversations have resulted in the following suggestions

**Education**
Registrar Education Sessions might be aligned to the RANZCOG curriculum, and a year or two-year program of topics be arranged in advance. This can help to optimize examination preparations. A nominated SMO might join the session for all or part of the time each week. This is desirable to enable experienced input to topics. Relevant Practice SAQ/ OSCE questions could be discussed at the end of the session.

An accessible lap box trainer could be made available within the reg room/ unit, but not locked away after hours. It is also desirable that all trainees have their own lap box trainer.

Attendance at the MDMs surgical complication and audit meetings is useful learning for trainees.

The Fellows now carry pagers for an hour, to enable reg attendance at the hour-long dedicated registrar teaching sessions on Wed morning.

**Surgical Training**
Yr 4 upwards report good access to surgical cases, including additional lists picked up whenever available. Future outsourcing may also extend surgical opportunities.

Yr 1 & 2 trainees can access acute surgeries, but mainly concentrate on acquiring the necessary OB and GYN acute skills.

There are imposed limitations to surgical access due to Anesthetic shortages, and Anesthetic working systems. The full surgical time should be utilized by the team, as anesthetists are aware of the lists planned. This system should minimize case cancellations on the day.

The recently introduced Surgical Buddies allows regular exposure to nominated SMO's lists and cases/ complications can be discussed in this forum

Whilst pre-admission visits are under SHO care, the opportunity to access case details through an electronic portal exists when the roster is available ahead of time.

The surgical buddy system enables a loose team structure for gynaecology. The trainees are able to discuss pre and post op matters with the appropriate SMO. Such loose team structure may be more and difficult, and potentially associated with more downsides in obstetrics. OB given the significant acuity and high workload of the service, which requires on-site SMOs, and a shorter working week.

Post-acute call acute patient results are discussed with the SMO of the day as necessary. This is a pragmatic solution, and ensures discussion is possible with an on-site SMO in person.

**Roster**
An effort is being made since templates were finalized in March. There is a persistent issue with errors in this template, which means last minute changes occur. This should be remedied, as there is a loss in confidence when these oversights mean last minute changes to the roster are frequently required.

**IHA**
sign offs for Colposcopy and USS have always been completed in a timely fashion to date, and the new week long block for Colposcopy clinics and Ultrasound training off-site is very advantageous to training.

Feedback re: Trainee progress is through Training Supervisors, and credentialing is completed at the 3-monthly Assessment times. Some registrars do not know about the credentialing outcomes
Comment re: the inability to provide a senior buddy when on-call last year because of the more junior mix will resolve over this year. Of necessity the on-call SMOs have been available on the floor in-lieu in this capacity.
Ongoing opportunities for trainees to debrief re their working experiences may be a further welcome addition with the surgical buddy systems
Additional TS will be available at the end of the year to optimize trainee to TS ratios.
A Cultural Competence course will be accessed for trainees requiring this over 2019.

Congratulations on all progress made and your future plans.
Kind Regards,

Celia Devenish. MB BS MRCOG FRANZCOG

Clinical Senior Lecturer
Department of Women's and Children's Health (Dunedin)