ACKNOWLEDGEMENTS

The Risk Assessment Team wish to acknowledge the contribution of all stakeholders who gave freely of their time to inform this risk assessment process. Their valuable contribution ensured that the process was both inclusive and efficient.

EXECUTIVE SUMMARY

In June 2015, NSW Kids and Families were approached by Northern NSW Local Health District (NNSW LHD) to consider partnering with GIO, the current service provider for health liability claims for Treasury Managed Fund, to assess the change in the maternity service configuration at the Murwillumbah District Hospital (MDH).

The change in the maternity service configuration at MDH was made by NNSW LHD in response to the reduction of available General Practitioner/Visiting Medical Officers (GP VMOs) for the neonatal roster which provided neonatal support to MDH. NNSW LHD made the decision that women from the midwifery group practice at MDH should be transferred to The Tweed Hospital (TTH) for labour and birth care.

In response to this request NSW Kids and Families suggested that a formal detailed risk assessment process be undertaken in line with the Australian/New Zealand Standard AS/NZ ISO 31000:2009 Risk Management - Principles and Guidelines, to explore the current and potential model/s of maternity care that could be safely provided at MDH. This process is recommended by NSW Ministry of Health prior to the introduction of a new service or when an existing service undergoes significant changes. The main objective for conducting this formal process is to identify actual and potential threats or weaknesses in a proposed service in order to maximise safety and minimise the likelihood of adverse outcomes to patient care.

Since 2004, GIO’s Operational Risk Management Team has facilitated a number of formal risk assessments for proposed maternity models of care within NSW and use the Australian/New Zealand Standard AS/NZ ISO 31000:2009 Risk Management - Principles and Guidelines as the standard to assess changes in maternity services.

NNSW LHD endorsed the risk assessment approach as outlined in the Terms of Reference communicated on 8 July 2015. The risk assessment for MDH was facilitated by Kate Robinson, Clinical Risk Advisor, TMF Client Management GIO; Associate Professor Michael Nicholl, Senior Clinical Advisor, Obstetrics NSW Kids and Families and Cathy Adams, Chair NSW Maternity Risk Network (the Team).
The Team engaged with a range of stakeholders (nominated by NNSW LHD) from the Tweed Byron Health Service Group (TBHSG) including clinicians, LHD Executive and consumers and undertook a two-step process for the risk assessment. Firstly, the current service (‘bypass’ for birth except an elective caesarean section operating list per week and the back transfer of women and their babies from The Tweed Hospital for postnatal care) was risk assessed against the previous model (the ‘Tweed Valley Birthing Service’ – (TVBS), a midwifery group practice model operating at MDH, and in addition an elective caesarean section operating list each week and the back transfer of women and their babies from The Tweed Hospital for postnatal care). Secondly, a level 2 Maternity service with a level 1 Neonatal service* was risk assessed against the current service. This approach was deemed appropriate given the lack of GP obstetrics at the MDH for the last 6 years. A level 2 Maternity / level 1 Neonatal service is the highest level of capability possible without GP Obstetric care.

The appended GIO Risk Assessment Report details the threats, current controls and possible additional controls identified in the risk assessment process. Based on the risk assessment undertaken, and in relation to the Report and the Terms of Reference, five recommendations have been identified by the Team for consideration by NNSW LHD.

**RECOMMENDATIONS**

**Recommendation 1:**
That NNSW LHD consider ceasing the elective lower segment caesarean section operating suite list currently performed at MDH.

**Recommendation 2:**
That NNSW LHD consider designating MDH as a level 2 Maternity service with a level 1 Neonatal service. Given the possible service configurations under this service capability level this would include a review of the current GP VMO contractual arrangements and consideration of a GP Shared Care Liaison midwifery position.

**Recommendation 3:**
That NNSW LHD consider developing a Clinical Services Plan for MDH and a Maternity Services Plan for the TBHSG or the LHD.

**Recommendation 4:**
That NNSW LHD considers the development of a well-articulated communication strategy for birthing services available across the Tweed Valley, including the location and pathways for access, with consistent messaging for both the community and staff. Such a strategy should include engagement of the wider GP community and Primary Health Network and not limited to the GP VMOs contracted to MDH.

**Recommendation 5:**
That NNSW LHD consider timely feedback to all stakeholders in relation to the GIO Risk Assessment Report.
A Level 2 Maternity service provides planned care for:
Women with no identified risks or those identified as category A and some women identified as category B following consultation with a suitably qualified clinician e.g. obstetrician, GP and the development of a management plan.

Antenatal care in either a shared care arrangement or by midwives in consultation with medical officers within the Tiered Network when required.

Labour and birth ≥ 37⁺⁰ weeks gestation.

Care provided by a multidisciplinary team or by midwives in a stand-alone unit or publicly funded homebirth service (in consultation with medical officers within the Tiered Network when required).

Postnatal care provided by midwives. Ideally this care should be provided in the home unless:
- The clinical needs of the mother and/or newborn require an inpatient stay
- Staffing or maternal location require an inpatient stay.

EMERGENCY CARE: Emergency caesarean section may be considered in situations where suitably qualified staff are available and the risks of maternal transfer are considered too great.

RISK CATEGORIES: When a variance from normal is identified during a woman’s care, the level of consultation requires one or more actions from across the following three categories:
- Category A: Discussion with a colleague; midwife, medical practitioner and/or other health care provider; and/or
- Category B: Consultation with a medical practitioner and/or other health care provider; and/or
- Category C: Referral of the woman or her baby to a medical practitioner for specialist care

A Level 1 Neonatal Service provides planned care for:
Immediate newborn care for those ≥ 37⁺⁰ weeks gestation where the mother had no identified risks and those identified as category A.

Ongoing care of preterm and convalescing newborns ≥ 36⁺⁰ weeks corrected age and having full care by the mother.

BACKGROUND

NSW Kids and Families were approached by Northern New South Wales Local Health District (NNSW LHD) to consider partnering with GIO to assess the change in the maternity service configuration at the Murwillumbah District Hospital (MDH). The change in the maternity service configuration at MDH was made by NNSW LHD in response to the reduction of available General Practitioner/Visiting Medical Officers (GP VMOs) for the neonatal roster which provided neonatal support to MDH. NNSW LHD made the decision that women booked at MDH for maternity care should be transferred to The Tweed Hospital (TTH) for labour and birth care.

Murwillumbah District Hospital is a local community level 3 rural hospital within the NNSW LHD. The hospital was established in 1903 and the current hospital building was completed and opened in 1939. Over the years, the hospital has undergone a variety of additions and facility upgrades, which includes the establishment of a rehabilitation unit, modernisation of the operating facilities and recent refurbishment of the emergency department.

The hospital serves the local population of approximately 20,000 and is a facility of the Tweed Byron Health Services Group within the NNSW LHD. The hospital has an Emergency Department, Operating Suite, Day Surgery and Recovery Unit, Medical Ward, General Surgical/Orthopaedic Ward, Children’s Ward, Assessment and Rehabilitation Ward, Women’s Care Unit and Nursery. It is well supported by the local community and volunteers from the hospital Auxiliary, Coffee Shop and Pink Ladies.

Historically the maternity service at MDH operated with specialist obstetricians supported by GPs who had skills in paediatrics, anaesthetics and surgery. The past decade has seen a shift from a specialist obstetric model to a GP Obstetrician model and in more recent years a move to midwifery group practice. The midwifery group practice has operated in collaboration with the MDH maternity service and local GP VMOs for the past six years. This most recent model of care was supported by a VMO neonatal roster. A recent change in these arrangements triggered a modification in service delivery which has resulted in women in the midwifery group practice, Tweed Valley Birthing Service (TVBS), transferring to The Tweed Hospital for labour and birth care. The distance between MDH and TTH is approximately 30 kilometres.
METHODOLOGY

The NSW Ministry of Health recommends a formal risk assessment is undertaken prior to the introduction of a new service or when an existing service undergoes significant changes. The main objective for conducting this formal process is to identify actual and potential threats or weaknesses in a proposed service in order to maximise safety and minimise the likelihood of adverse outcomes to patient care.

Since 2004, GIO’s (the current service provider for health liability claims for Treasury Managed Fund) Operational Risk Management Team has facilitated a number of formal risk assessments for proposed maternity models of care within NSW and use the Australian/New Zealand Standard AS/NZ ISO 31000:2009 Risk Management - Principles and Guidelines as the standard to assess changes in maternity services, small or large (see following link).


The Terms of Reference were developed by NSW Kids and Families in collaboration with NNSW LHD. NNSW LHD endorsed the Terms of Reference for the formal risk assessment on 8th July 2015 (see Appendix 1).

The Risk Assessment was facilitated by Kate Robinson, Clinical Risk Advisor, TMF Client Management GIO; Associate Professor Michael Nicholl, Senior Clinical Advisor, Obstetrics NSW Kids and Families and Cathy Adams, Chair NSW Maternity Risk Network (the ‘Team’). In attendance, on the second visit from NSW Kids and Families were Deb Matha, Manager Maternal and Newborn Unit and Sarah Wyatt, Analyst Maternal and Newborn Unit. The face to face meetings took place over two separate visits on the following dates.

On 25th June 2015 (9am – 4.30pm) on-site interviews had been arranged by NNSW LHD for the Team to meet with selected stakeholders. The purpose was to gain a broad understanding about how maternity services at MDH previously operated compared with the recent changes and to establish the risk assessment framework;

On 16th July (13.30pm – 5.45pm) and 17th July 2015 (9am – 4.30pm) the formal risk assessment was undertaken by the Team with stakeholders. Over these two days, the Team undertook a two-step process. Firstly, the current service (‘bypass’ for birth except an elective caesarean section operating list per week and the back transfer of women and their babies from The Tweed Hospital for postnatal care) was risk assessed against the previous model (the ‘Tweed Valley Birthing Service’ (TVBS), a midwifery group
practice model operating at MDH, and in addition an elective caesarean section operating list each week and the back transfer of women and their babies from The Tweed Hospital for postnatal care). Secondly, a level 2 Maternity service with a level 1 Neonatal service was risk assessed against the current service. This approach was deemed appropriate given the lack of GP obstetrics at the MDH for the last 6 years. A level 2 maternity / level 1 Neonatal service is the highest level of capability possible without GP Obstetric care.

The attendance list for those stakeholders who participated in the on-site interviews and the formal risk assessment is appended at Appendix 2.

**PROCESS OF RISK ASSESSMENT**

The process of risk assessment is robust and detailed in order to closely examine all the elements of the current service and the controls that are currently in place to mitigate risk. The process then extends to examine the potential or actual risk that the proposed change will pose. The current controls may be sufficient to mitigate any risk or additional controls may need to be considered in order to mitigate the proposed change.

The strengths of this process are that all stakeholders of the model (including consumers) are engaged in a process where open communication is facilitated and issues raised are considered constructively. It is an effective process to elicit what actually happens in a service from an operational perspective, which is at times, different to what we think may happen. The collaborative engagement between all members can ensure that the proposed model of care is as safe and efficient as possible.

An additional strength is that this is a systematic process that assists in the identification of risks to a proposed change and prioritises risk in relation to its consequence and likelihood.

- This systematic approach ensures that each aspect of the service (including sustainability, financial viability and responsiveness to consumer expectations) is considered in a measured manner so that all aspects can be made transparent and then risk assessed.
- To enable this to occur, detailed process mapping is undertaken which commences from when the woman accesses pregnancy care and will follow her through to the end of the postnatal period. The process for Murwillumbah District Hospital, therefore, would not examine just the neonatal roster but all systems related to the care of women in the service. This can also be positive in identifying existing systems issues that could be made more efficient and effective.

The process is proactive in its approach, attempting to predict the impact of the risk before it takes place.
FINDINGS OF THE RISK ASSESSMENT

The findings of the risk assessment are detailed in the GIO Risk Assessment Report in Appendix 3. In summary, there were a total of 76 threats identified. Each threat was assessed and allocated a Consequence (C), Likelihood (L) and Risk (R) rating in accordance with the NSW Health Risk Matrix. The findings of the risk assessment were further synthesised by the Team, in order to provide a response to the eleven questions posed in the Terms of Reference. Subsequently, the Team has identified five recommendations for consideration by NNSW LHD.

Terms of Reference (ToR) 1. What is the risk of changed neonatal roster?
There were no ‘extreme’ risks identified with the changed neonatal roster per se. The primary resuscitation of neonates at vaginal birth has previously been with the attending midwife and with rapid response calls dealt with through the hospital-wide emergency response system with back-up from the neonatal roster. However, the continuation of an elective lower segment caesarean section (LSCS) operating suite list on a Tuesday, with notional neonatal cover until Friday, poses a significant organisational risk. The accountability for patient care and escalation pathways for neonates born by elective LSCS are neither well-articulated nor communicated with evidence of work-arounds by the staff.

Likewise, the same issue regarding accountability and escalation pathways neither being well articulated nor communicated applies for the babies of women transferred to MDH for postnatal care. The changed neonatal roster did not trigger the implementation of additional controls around neonatal care for this group of neonates apart from the cessation of normal birth ing on site.

The perception that mothers birthed by, and neonates born by, elective LSCS are at lower risk than neonates and mothers birthing normally does not appear to have been challenged prior to this risk assessment. The Team were of the opinion that low probabilities or risks have been overweighted (i.e. the risk of normal labour and birth) and moderate and high probabilities or risks (i.e. the risk to mother and neonate with elective LSCS) have been underweighted in the decision to maintain an elective caesarean list but cease normal birthing.

Recommendation 1:
That NNSW LHD consider ceasing the elective lower segment caesarean section operating suite list currently performed at MDH.

ToR 2. What current controls are in place e.g. midwives skills and training for neonatal resuscitation?
With respect to neonatal resuscitation the current controls that exist include: mandatory FONT education for midwives and additional skills and drills on an ad hoc basis; hospital wide emergency response system with targeted training for Emergency Department staff; neonatal escalation of care flow chart; and, paediatrician clinical on-call roster distributed to the Tweed Valley Birthing Service (TVBS) midwives on a weekly basis. There is no identified ongoing skills and training for the GP VMOs on the neonatal roster apart from continuing professional education opportunities as they arise. There did not appear to be any deficiencies with respect to equipment required to support immediate neonatal resuscitation. The current controls would be considered the minimum requirement for maternity service providing care to women without identified risk factors.

ToR 3. What controls need to be added to mitigate identified risks e.g. additional neonatal training for midwives, equipment, referral pathways for escalation of care if baby requires ongoing care?

With respect to neonatal resuscitation possible additional controls identified by the stakeholders included: Paediatric CNC engagement with the maternity service; funded Advanced Life Support in Obstetrics (ALSO) training; return of advanced neonatal resuscitation training; dedicated clinical midwifery educator position; availability of face-to-face education hours; formalised skills and drills training; and graded assertiveness training.

Whilst there is a neonatal escalation of care flow chart, there is an opportunity to better articulate the accountability for neonatal care and escalation pathways for all neonates cared for at MDH regardless of mode of birth, model of care, place of birth or day of week.

ToR 4. What are the risks with extending the homebirth service – what are current controls/identify possible additional controls?

Local understanding of service capacity and demand would be required to fully appreciate the impact on the Mullumbimby and District War Memorial Hospital Home Birth Service. Additional controls that consider workforce volume and skills, local geography and community expectations would be required. It is important to recognise that a homebirth model of care is not sought after by all women and market testing with the two communities would need to be undertaken. In addition, there would need to be a willingness and capacity of the midwifery staff to engage with such a service.

Currently, maternity services in the LHD are not planned across the LHD or Health Service Groups (Tweed -Byron Health Services Group and Richmond-Clarence Health Service Group). The absence of an LHD or Health Service Group Maternity Services Plan and a Clinical Services Plan for MDH has meant that service planning appears to have been reactive to local circumstances rather than a co-ordinated strategic approach.
ToR 5. What are the workforce requirements to sustain a safe service within current and proposed changes to the maternity model of care?

There is a requirement for a minimum of 4.0 FTE (+1.0 FTE for leave relief) to establish a midwifery group practice roster with the total complement of FTE dependent on the total number of births. Most models plan for 38-40 births per FTE per year. Medical and allied health workforce requirements will be dependent on the chosen model of care. A level 2 Maternity service may have care provided by a multidisciplinary team or by midwives in a stand-alone unit or publically funded homebirth service (in consultation with medical officers within the Tiered Network when required).

Midwifery workforce requirements could also be informed by the statewide tool (Birthrate Plus) which considers volume and acuity of maternity presentations.

The GIO Risk Assessment Report appended, would indicate that MDH with its current core services could support a level 2 Maternity service with a level 1 Neonatal service. The workforce requirements for a level 2 Maternity service with a level 1 Neonatal service would be dependent on the model of care chosen, given that there are a number of possible configurations for a model of care within this service capability level. With the withdrawal over time of specialist obstetricians, GP obstetricians and more recently GP VMOs willing to engage in the neonatal roster, there are limitations to the feasibility of some of the model of care options that could be considered at MDH.

Possible configurations might include:

- Midwifery group practice operating under similar business rules of existing services elsewhere in NSW (stand-alone or a TVBS that includes MDH and TTH);
- GP obstetrician care for low risk women at term which may include emergency caesarean section (where there is a staffed operating theatre available on site) but not elective procedures;
- Shared antenatal care arrangement between hospital based midwives and GPs;
- Publicly funded homebirth service;
- Ambulatory antenatal and postnatal care for women with no identified risk factors;
- Postnatal care for newborns born at ≥ 37+0 weeks gestation with the care provided by the mother.

A level 2 Maternity service with a level 1 Neonatal service would exclude:

- Models of care that include planned caesarean section, induction of labour, instrumental birth, vaginal birth after caesarean section, or the requirement for continuous electronic fetal monitoring (EFM);
Models of care that include babies requiring routine monitoring or additional support including convalescing babies.

Models of care that would require further investigation at this service capability level include:

- Privately Practising Eligible Midwives requiring a collaborative arrangement.

**Recommendation 2:**

That NNSW LHD consider designating MDH as a level 2 Maternity service with a level 1 Neonatal service. Given the possible service configurations under this service capability level this would include a review of the current GP VMO contractual arrangements and consideration of a GP Shared Care Liaison midwifery position.

**ToR 6. What are the risks of creating a TVBS that includes MDH and The Tweed Hospital?**

The proposed model of midwifery care would need to be clearly articulated in order to identify actual and potential risks. The Team considers that there are the following three possible options:

1. the establishment of a midwifery group practice at TTH in addition to the existing TVBS at MDH;
2. two midwifery group practices e.g. TVBS and TTH MGP existing under a single management structure;
3. a single management structure governing one midwifery group practice operating across the Tweed Valley responsive to where women reside, their level of risk and their preference for place of birth.

The creation of a TVBS that includes MDH and TTH would need to be the subject of a separate risk assessment. Such a risk assessment would consider changes affecting the community, antenatal care, labour and birth care, postnatal care, neonatal care, core services and transport considerations including Ambulance Service NSW. In the absence of a formal risk assessment the following potential risks could be foreshadowed:

- Underutilisation of one or more of the models;
- Underutilisation of staffing resources if the models do not reach capacity for numbers of women accessing these models;
- Midwifery workforce at TTH would need to be allocated from existing resources to staff the model which may impact on current service delivery;
- Midwifery Management structure would need to provide oversight of both models across two sites;
- The models of care would need to be clearly articulated for eligibility criteria, consultation, referral and escalation pathways to ensure the right women are in the right model cared for by the right people;
• There is currently limited provision of antenatal care by midwives at TTH which would require some skills and knowledge development;
• Loss of activity for the GPs providing antenatal care may create tensions and lack of confidence with the proposed models.

ToR 7. What is the impact of the current model in terms of cost effectiveness?
During the risk assessment process it became apparent that the current service arrangements are resulting in a number of inefficiencies. Due to the decreased activity, the core midwives at MDH are not working to their full scope of practice and are providing more general nursing care to non-maternity patients. The implications of decreased exposure to maternity care will have cost implications for reskilling and training within the maternity context.

Whilst it is difficult to quantify direct cost implications there is a more obvious effect on the productivity of the existing staff establishment for TVBS and core midwifery staff. For example, the original TVBS model did not include continuity of carer at TTH for labour and birth care. The current change has resulted in the TVBS midwife needing to travel to TTH more frequently to provide labour and birth care for a reducing number of women.

ToR 8. In terms of risk, is there another more contemporary model of care?
Models of care that could be considered are listed above in response to question 5. Most contemporary models of care require a high level of collaboration between all stakeholders within the facility and with the Tiered Network. The features most consistent in these models are a shared vision, high levels of communication, an understanding of other’s professional needs and mutual respect.

The absence of a Clinical Services Plan for MDH, together with the absence of a Maternity Services Plan for the Health Services Group or the LHD combined with recent adverse media has resulted in a lack of focus on the model of care at MDH. A reorientation on the existing strengths of the services at MDH incorporating the required features for collaboration may support the development of more contemporary models of care.

Recommendation 3:
That NNSW LHD considers developing a Clinical Services Plan for MDH and a Maternity Services Plan for the Tweed Byron Health Services Group or the LHD.

ToR 9. Within risk framework is there an option of the MGP midwives continuing care of their mothers when their clinical risk changes?
The GIO Risk Assessment Report appended would indicate that MDH with its current core services could provide a level 2 Maternity service with a level 1 Neonatal service. Therefore, there is an option of MGP midwives birthing normal risk women at MDH and also for them continuing care at TTH for women who develop risk factors. To achieve this, a formal risk assessment of the changed model would be required in addition to a high level of collaboration as described in the response to ToR 8.

**ToR 10. Are there any unforeseen risks that need immediate mitigation / escalation?**

Only one extreme risk was identified during the risk assessment process. This risk was related to the cessation of birthing at MDH and the feeling of disempowerment of women with respect to their place of birth. Normally a risk assessment process such as this would be expected to reveal significant threats of a clinical and/or operational nature. This risk assessment however has uncovered an unforeseen reputational risk to the organisation with the apparent disengagement of significant parts of the community.

The cessation of birthing at MDH appeared to the community to be sudden and inexplicable despite the LHD communications at the time. The development of a well-articulated communication strategy for birthing services available across the Tweed Valley, including the location and pathways for access, with consistent messaging would assist with regaining community support and confidence.

**Recommendation 4:**

That NNSW LHD considers the development of a well-articulated communication strategy for birthing services available across the Tweed Valley, including the location and pathways for access, with consistent messaging for both the community and staff. Such a strategy should include engagement of the wider GP community and Primary Health Network and not limited to the GP VMOs contracted to MDH.

**Recommendation 5:**

That NNSW LHD considers timely feedback to all stakeholders in relation to the GIO risk assessment report.

**ToR 11. What would be the impact of performing all elective Lower Segment Caesarean Section (LSCS) at TTH?**

The GIO Risk Assessment Report appended would indicate that MDH with its current core services could provide a level 2 Maternity service with a level 1 Neonatal service. From a risk perspective, the provision of ELSCS at MDH is beyond the current service capability of the facility. Performing all elective LSCS at TTH would reduce the clinical risk exposure at the MDH but would have operational implications at TTH. Such implications were not able to be assessed fully during this review.
APPENDIX 1 TERMS OF REFERENCE

Tweed Byron Health Service Group Maternity Services Risk Assessment

Context

The NSW Ministry of Health recommends a formal risk assessment is undertaken prior to the introduction of a new service or when an existing service undergoes significant changes. The main objective for conducting this formal process is to identify actual and potential threats or weaknesses in a proposed service in order to maximise safety and minimise the likelihood of adverse outcomes to women and babies.

Since 2004, GIO's (the current service provider for health liability claims for Treasury Managed Fund) Operational Risk Management Team has facilitated a number of formal risk assessments for proposed maternity models of care within NSW and use the Australian/New Zealand Standard AS/NZ ISO 31000:2009 Risk Management - Principles and Guidelines as the standard to assess changes in maternity services, small or large (see link below).


It is proposed that the Risk Assessment would be facilitated by Kate Robinson, Clinical Risk Advisor, TMF Client Management GIO; A/Professor Michael Nicholl, Senior Clinical Advisor, Obstetrics NSW Kids and Families and Cathy Adams, Northern Sydney LHD Network Manager Midwifery Practice.

Process of Risk Assessment

- The process is robust and detailed in order to closely examine all the elements of the current service and the controls that are currently in place to mitigate risk. The process then extends to examine the potential or actual risk that the proposed change will pose. The current controls may be sufficient to mitigate any risk or additional controls need to be considered in order to mitigate the proposed change.
- The strengths of this process are that all stakeholders of the model (including consumers) are engaged in a process where open communication is facilitated and issues raised are considered constructively. It is an effective process to elicit what actually happens in a service from an operational perspective that which is at times different to what we think may happen. The collaborative engagement between all members can ensure that the proposed model of care is as safe and efficient as possible.
An additional strength is that this is a systematic process that assists in the identification of risks to a proposed change and prioritises risk in relation to its consequence and likelihood.

- This systematic approach ensures that each aspect of the service (including sustainability, financial viability and responsiveness to consumer expectations) is considered in a measured manner so that all aspects can be made transparent and then risk assessed.
- To enable this to occur, detailed process mapping is undertaken which commences from when the women accesses pregnancy care and will follow her through to the end of the postnatal period. The process for Murwillumbah, for example, would not examine just the paediatric roster but all systems related to the care of women in the service. This can also be positive in identifying existing systems issues that could be made more efficient and effective.

- The process is proactive in its approach, attempting to predict the impact of the risk before it takes place.

**Process Mapping:**

- Map the current services at Murwillumbah District Hospital as they are.
- Map actual and potential proposed changes to the model which would include for example, actual change to Paediatric support roster; proposed change to current Mullumbimby and District War Memorial Hospital home birth service by extension of geographic boundary to include Murwillumbah; explore potential for a caseload midwifery model of care to provide care for women who reside in Murwillumbah district.
- Risk assess all the proposed changes which would include:
  - What is the risk of changed neonatal roster?
  - What current controls are in place e.g. midwives skills and training for neonatal resuscitation?
  - What controls need to be added to mitigate identified risks e.g. additional neonatal training for midwives, equipment, referral pathways for escalation of care if baby requires ongoing care
  - What are the risks with extending the home birth service – what are current controls/identify possible additional controls
  - What are the workforce requirements to sustain a safe service within current and proposed changes to the maternity model of care?
  - What are the risks of creating a TVBS that includes MDH and The Tweed Hospital?
  - What is the impact of the current mode in terms of cost effectiveness?
  - In terms of risk, is there another more contemporary model of care?
o Within risk framework is there an option of the MGP midwives continuing care of their mothers when their clinical risk changes?
o Are there any unforeseen risks that need immediate mitigation / escalation?
o What would be the impact of performing all elective LSCS at TTH?

  - Consequence and likelihood of this occurrence = risk rating by matrix

- Identify all the risks identified as high and prioritise these into the final matrix table for the Risk Assessment Summary Report.

Outcome of the Risk Assessment:

- A Risk Assessment Summary Report prepared for Mr Chris Crawford, Chief Executive, Local Health District which will include: the matrix table, which captures all the information from the risk assessment process and an executive summary of the risk priorities and process steps that would need to be in place to support the current service and proposed changes to model/s of care.

Suggested Attendees for the Risk Assessment could include:

- Executive Director, TBHSG. Executive Sponsor
- EO DON Mullumbimby as senior nursing midwifery admin representative.
- Network Director Obstetrics
- Paediatric Representative/s
- Midwifery Unit Manager from Murwillumbah
- Midwifery Unit Manager TTH
- CMC NNSW LHD
- TVBS midwives (all)
- Murwillumbah ‘core’ midwives from the Maternity service
- Consumer representative (Sally Cusack)
- Mother representative (Rachel Bryant)
- Ambulance representative (for part of the discussion at least) (Wayne McKenna).

Final document as per email from B. Loughnane Executive Director Tweed Byron Health Service Group 8th July 2015.
## APPENDIX 2 ATTENDANCE LIST

### Context Discussion - Thursday 25th June 2015

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Hospital/Organisation</th>
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<tr>
<td>Cheryl Colley</td>
<td>MUM WCU</td>
<td>Murwillumbah District Hospital</td>
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<tr>
<td>Julie Young</td>
<td>CMS TVBS</td>
<td>Murwillumbah District Hospital</td>
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<td>Hayley van Cuylenburg</td>
<td>CMS TVBS</td>
<td>Murwillumbah District Hospital</td>
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<td>Linda Shaw</td>
<td>RM TVBS</td>
<td>Murwillumbah District Hospital</td>
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<tr>
<td>Judy Hamilton</td>
<td>CMS TVBS</td>
<td>Murwillumbah District Hospital</td>
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<tr>
<td>Bernadette Loughnane</td>
<td>ED</td>
<td>Tweed Byron Health Service Group</td>
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<tr>
<td>Suzanne Weir</td>
<td>A/CMC</td>
<td>NNSW Local Health District</td>
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<tr>
<td>Geeta Sales</td>
<td>Director OB GYN</td>
<td>Tweed Byron Health Service Group</td>
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<tr>
<td>Jenny Shaw</td>
<td>A/DONM</td>
<td>Tweed Hospital &amp; Murwillumbah District Hospital</td>
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<tr>
<td>Caroline Chandler</td>
<td>CMS TVBS</td>
<td>Murwillumbah District Hospital</td>
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<tr>
<td>Rachel Bryant</td>
<td>Consumer</td>
<td>Murwillumbah</td>
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<tr>
<td>Sally Cusack</td>
<td>Consumer</td>
<td>Byron Bay</td>
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<tr>
<td>Rob Davies</td>
<td>Network ED Director</td>
<td>Murwillumbah District Hospital</td>
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<tr>
<td>Dr John Moran</td>
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<td>Jane Crawford</td>
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</tr>
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<td>David McMaster</td>
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<td>Thomas Ratoni</td>
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<td>Deb Matha</td>
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<tr>
<td>Sarah Wyatt</td>
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<td>Jane Crawford</td>
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APPENDIX 3 GIO TMF RISK ASSESSMENT REPORT

See attachment – GIO TMF Risk Assessment Report – Murwillumbah Hospital