The WACS CAG is pleased to have this opportunity to provide this response to the Government’s Green Paper regarding Maternity Services.

Please note: one CAG member did not endorse this final submission.

Background

The WACS CAG welcomes the opportunity to respond to the Maternity element of the Green Paper.

Maternity is a 24/7 service with highly unpredictable acuity and workload issues. Even with the very best care it is impossible to completely determine when a woman will start in labour. Spontaneous delivery of a foetus can occur at any stage during a period of some 36 weeks (6 weeks gestation to 42 weeks gestation). Labour can be a rapidly changing dynamic situation with a wide variation in outcomes. Poor outcomes cannot be completely controlled or predicted and individual patient circumstances can deteriorate rapidly from a simple to highly complex situation. Maternity services therefore require flexibility in their service delivery and a rapid and efficient transport system.

The WACS CAG supports the concept of a “hub and spoke” service model with the more highly complex cases been dealt with on a more regular basis by higher role delineation centres. Care must be taken to retain a minimum skill base at the lower delineation centres to ensure that life threatening emergencies, when they arise, can be treated with appropriate skill and that all units have the ability to instigate treatments that will stabilise the patient’s condition prior to transfer to a higher role delineation.

For Obstetricians, surgical skills and in particular some gynaecology surgical skills are important in the safe delivery of women at a Maternity service level 4 and above. They are also a prerequisite of recruiting a FRANZCOG.

University Education is one of Tasmania’s major success stories and Tasmania “punches far above its weight” when compared to other states with larger populations. There is strong evidence to show that educating medical students and young Doctors in rural areas improves recruitment and retention. It is extremely important that the state government continues to support these educational activities. Results in terms of recruitment and retention make take years to come to fruition. There is lack of kudos associated with this
support but its continuation is vital to Tasmania’s future ability to attract a stable medical workforce. The delivery of clinical services and education and training must not and cannot be separated.

Obstetrics and Gynaecology services in Tasmania are all deeply committed to education and training for Speciality Training, RMO’s, Medical Students and Midwives. We value the close working relationship we have with the University of Tasmania and the Rural Clinical Schools. Any proposed changes in service model must consider the impact on our ability to continue to achieve high standards in education and training and the benefits that follow in terms of recruitment.

Maternity services across Tasmania consult Professional Guidelines and the National Maternity Capability Framework documents for the development of staffing levels. Individual units develop clinical guidelines according to best practice and evidence based practice; this process is more consistent in some units than others. There may be benefit in adopting a statewide approach to the development of further guidelines.

### Service Profile

#### Current Service Overview

Based on the Service Descriptions provided in the draft Tasmanian Role Delineation Framework (TRDF) the WACS CAG believes that the following levels of service are currently being provided in Tasmania:

- Royal Hobart Hospital – Level 6
- Launceston General Hospital – Level 5
- North West Private Hospital (providing public services) – Level 4
- Mersey Community Hospital – Level 2/3

#### Royal Hobart Hospital (RHH)

- The Maternity Service at RHH is the tertiary referral unit for Tasmania, providing maternity services at Level 6 and is closely linked to the statewide Level 6 Neonatology Service. Babies identified with a cardiac condition are referred in utero to interstate providers for management.
- This unit takes patients of all complexity as it is supported on a 24 hour basis by all the specialist services including the Intensive Care Unit, Coronary Care Unit, Neurosurgical Unit, Specialist Medical and Interventional Imaging and all the surgical and medical subspecialties.
- This unit is supported by 6 full time Staff Specialist Obstetricians and Gynaecologists, supported by 9 Registrars and 6 Resident Medical Officers. Visiting Medical

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1 National Maternity Services Capability Framework
Practitioners also provide some outpatient services as well as participate in the on call service.

- This Unit is well supported by specialist services such as genetics, renal medicine, and the specialist High Risk Antenatal Clinic serves the function of a state-wide Maternal Fetal Medicine (MFM) service. Although there are no MFM Subspecialists in the department, there are 2 obstetricians with a special interest in this area supported by the Feto-Maternal imaging service etc. Prenatal counselling and diagnosis is carried out in this unit. The antenatal complex care clinic is a multidisciplinary clinic providing obstetric, psychological and social care for socially disadvantaged women.

- This unit has very close links with specialised MFM services in Melbourne, Sydney and Adelaide so that women with pregnancies affected by conditions requiring treatments that are not available in Tasmania can be referred to the appropriate centres for care.

- This Unit works closely with the Maternity Services at LGH, MCH and the NWPH. There are good channels of communication and patients referred to the High Risk Clinic for assessment and on-going care are discussed monthly at the Perinatal Management Group meetings. In-utero transfers are carried out according to the guidelines set out by the Statewide Neonatal Service and the Tasmanian Ambulance Service. Where possible, transfers of such mothers should be to the location which will be able to provide them with the most appropriate care, as close to home or as convenient as is possible.

- This unit is designated as the co-ordinator for the Tasmanian specialist O&G training programme (ITP) and is responsible for the statewide supervision of trainees and has close links with RANZCOG. It is responsible for providing the state-wide video linked ITP training formal teaching programme. This unit also provides training for RMO’s, diploma candidates and midwives.

**Launceston General Hospital Queen Victoria Maternity Unit (LGH)**

- This unit delivers a 24 hour maternity service that provides comprehensive specialist services, including, but not restricted to, midwifery, obstetric, mental health and surgical care for women with high-risk and complex needs.

- This unit has capacity to provide Maternity services at Level 5 but also provides care to singleton neonates from 30 weeks- who do not have intrauterine growth restriction and twins from 32 weeks gestation and is supported by a Level 5 Neonatal Service. There are approximately 1600-1700 deliveries a year.

- This unit is supported on a 24 hour basis by specialist services including the Intensive Care Unit, the Coronary Care Unit, Interventional Imaging and surgical, anaesthetic and medical subspecialties.

- This unit is staffed by 3 FTE Staff specialists Obstetrician and Gynaecologists (one 0.3 University) supported by 3 Visiting Medical Officers providing outpatient, inpatient and on-call cover. There are 6 accredited registrar positions (2 Senior and 4 ITP) and 5 RMO positions.

- Low risk maternity patients are cared for in midwifery led models of care or in shared care models with general practitioners. High risk patients are cared for in medical
antenatal clinics with a specialty service for twins and a multidisciplinary service for endocrine and diabetic patients. Foetal diagnostic services are offered.

- This Unit has well developed links with the RHH and interstate units at the Royal Hospital for Women and Monash Medical Centre when required.
- This unit provides training for FRANZCOG trainees and, Diploma and Advanced Diploma candidates and midwives.
- It should be noted that any changes to current services provided at the MCH could possibly increase demand at LGH and the NWPH and therefore review of services requirements and resources will need to be considered.

**North West Private Hospital (NWPH)**

- In this unit the Public service is contracted out to a private provider (NWPH).
- This unit serves an area of low socio economic status and in consequence many of the Obstetric patients that deliver at NWPH would be classed as “Level 4” and some as “Level 5”.
- The wide geographical nature of the area (Queenstown is a 3-4 hour drive from NWPH and King Island a one hour by plane and 30 min car journey away) necessitates the relative proximity of a maternity unit able to deliver the majority of these patients. All patients are assessed as per antenatal risk management to determine which patients are appropriate for delivery at NWPH and which high risk patients should deliver at a more appropriate Level 5 or Level 6 site.
- This unit is supported by 3 full time Staff Specialists, 4 Registrars and 2 RMO’s and 1 VMO. The service currently has the required facilities and staff to deliver care at Level 4 as defined by the framework. A Staff Specialist post remains vacant at the present time. The unit has a competent Obstetric and Midwifery workforce with a current service load that is capable of maintaining skills.
- This unit is supported by a level 4 ICU, according to the framework. This unit provides care for neonates greater than 32 weeks with neonates between 32-34 weeks discussed with RHH to determine whether or not these babies should be transferred or may safely remain. These practices do not align with the proposed role delineation framework.
- Educationally the unit has been successful and is accredited by RANZCOG for specialist training for the next 4 years. The unit has 2 established rotations for RANZCOG trainees, one with RHH and the other with Sunshine Hospital. It is recognised for training in RANZCOG Diploma and Advanced diploma.
- This unit provides training for midwives.
- Any changes to current role delineation of services on the North-West would necessitate a robust community education program providing clear, concise information about the provision and delivery of safe high quality maternity services.
Mersey Community Hospital (MCH)

- This unit is currently funded by the Federal Government.
- This unit has the facilities and staff to deliver care at between Levels 2 - 4 as defined by the role delineation framework. The service is supported by 2 full time Staff Specialists and by 2 Registrars who all work on a 1 in 2 roster. Three Anaesthetists provide anaesthetic cover on a 1 in 3 roster; recruitment to both the Obstetric service and the Anaesthetic service is problematic. There is a mismatch between the framework and the current model as follows:
  - Anaesthetic services at MCH are delivered by a Fellow of the College of Anaesthetists; this is consistent with a Level 4 rather than a Level 3.
  - Obstetric services are delivered by a FRANZCOG which is commensurate with a Level 4 not a Level 3 service, as is the presence of a registrar or RMO 24/7.
  - Neonatal services are a Level 2-3.
  - There is a risk management process that identifies high risk patients to allow only moderately complex patients to be delivered at MCH. However the substantial barrier to Level 3 for MCH is the paediatric support which is currently on site 8-5 but only available from Burnie out of hours (a journey of 40 plus minutes) which is not compliant with RANZCOG standards (2014).
  - This unit provides training for midwives.
- If service provision at MCH is reduced there is potential for Federal funding to be reduced. State funding will be required for the service reallocation.

Outreach Services

- The following antenatal and postnatal community services are supported financially by TasReach and DHHS, and clinically by MCH, LGH and RHH. They are equivalent to Level 1 services:

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<thead>
<tr>
<th>North West</th>
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<th>South</th>
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<tr>
<td>Smithton</td>
<td>George Town</td>
<td>Huonville</td>
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<tr>
<td>King Island</td>
<td>Beaconsfield</td>
<td>Brighton</td>
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<td>Queenstown</td>
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<td>Kingborough</td>
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<td>Scottsdale</td>
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Specialised Midwifery services

- All 3 regions provide specific antenatal and postnatal community services to Aboriginal and Torres Strait Islander women funded through New Directions: Mothers and Babies Services\(^2\) (previously known as National Partnership Agreement on Indigenous Early Childhood Development (NPA IECD)).

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\(^2\) Australian Government - Department of Health- Aboriginal & Torres Strait Islander Health
### Proposed Service Overview

The WACS CAG believes that to meet future demands for maternity services the following levels of service are required in Tasmania:

- Royal Hobart Hospital – Level 6
- Launceston General Hospital – Level 5
- North West Private Hospital – Level 4
- Mersey Community Hospital – Not defined – see options page 15 and not on following page.

### Please Note:

There was not a CAG consensus with the proposed role delineation for MCH.

The preferred role delineation of the medical staff (obstetric, anaesthetic and paediatric) staff was Level 1, whilst that of the midwifery staff was Level 2-3.

### Recommendation 1:

That the attached amendments to the Maternity Service Profile be accepted for the final version of the TRDF (Attachment A).

### Service Description – Levels 1 to 6

- Please see Service Description within the TRDF.
- Tasmania has always suffered from lack of critical mass due to the small population in a relatively large geographical area. There needs to be some flexibility built into the framework to allow the services as described above to address the needs of the community whilst adhering to the following principles of care: care that is safe, effective, reliable, sustainable, efficient and close to home when possible.
- The WACS CAG notes the similarity of the TRDF to frameworks that are already established in other states. Although the CAG recognises the benefits of adherence to a national framework the geography of Tasmanian is unique as a result of its isolation, a circumferential water barrier, low population density, unpredictable adverse weather conditions and inadequate internal transport networks. Consequently there is a need for careful consideration regarding highly specialised services which should be reflected in the role delineation framework.
- The service description is focused on the gestation of the Neonate and has only vague references to the needs of the mother.
- The proposed definitions of low, moderate and high Obstetric complexity needs further elucidation. Obstetric complexity cannot be defined by the same model used for surgical complexity.
- Maternity care is a unique speciality with a philosophy that recognises childbirth as a natural event. This philosophy is supported by national policy that supports the autonomy of pregnant mothers in choosing a model of care that is most suited to their needs. There is no recognition in the Tasmanian role delineation framework (TRDF) of
alternative and innovative models of care such as home birth or stand-alone midwifery units.

- There needs to be some recognition of the established extensive outreach network that is integral to the delivery of safe Maternity services in remote areas and the requirement for close collaboration with a robust primary care service.

**Suggested Service Improvements**

- Whilst RHH is the obvious recipient of in-utero transfers of women with threatened preterm labour, consideration should be given to LGH being the location for transfers for women with threatened preterm labour above 30 weeks gestation.
- There needs to be a reflection of the further development of alternate models of Midwifery care across all sites i.e. RHH models of care have been realigned to accommodate the needs of women with normal risk pregnancies with the introduction of the case load Midwifery Group Practice to those with High Risks, specific medical problems such as Diabetes in Pregnancy, Perinatal Mental Health and those with complex psychosocial needs.
- Clinical guidelines and Models of Care have been changed and may need to change further to accommodate the rising acuity of women, especially with regards to the rising incidence of obesity.
- There needs to be comprehensive care plans in place for all patients to minimise admissions.

**Recommendation 2:**
The TRDF needs to reflect the unique circumstances of Tasmanian Maternity Services and the geographical population distribution. Consider the development of alternative models of midwifery care across all sites that are in alignment with the philosophy of maternity care and the principles of the Green Paper.

**Service Requirements – Levels 1 to 6**

- Please see Service Requirements within the TRDF.

Please refer to narrative within the Current Service Overview.

**Requirements**

- Level 5 requirements dictate that only Level 5 and above unit requires a dedicated birthing suite.
- Level 5 requirements imply that only Level 5 units and above deliver training to Midwives and Specialists. The support of Level 4 units in terms of training of Midwifery and Specialist education is necessary across Australia but especially so in Tasmania with its low birthing numbers.

**Recommendation 3:** All units that birth should have a dedicated birth suite. Level 4 units and above should deliver training to midwives and provide specialist education.
Improvements

- **Communication:** The channels of communication for patient transfers and handover of care needs to improve. This is a work in progress involving the Tasmanian Ambulance Service and Lead Clinicians from the 3 regional areas.
- **Transport:** An efficient, rapid and timely transfer system would be essential. Considerable support for displaced patients; in terms of low cost travel and accommodation for them and their families.
- **GP Shared Care:** Currently not well provided in all areas for but improving.
- Not all sites have the facilities for remote CTG access.

Service volumes

- Tasmania has always suffered from lack of critical mass due to the small population in a relatively large geographical area. Hence, it is also difficult to maintain a full subspecialist MFM service at RHH which is sustainable for training and accreditation purposes.
- There is also a small but significant number of women delivering in the private sector who would benefit from a subspecialist MFM service.
  - A solution would be to appoint 1 full time MFM subspecialist at RHH, supported by the 2 existing obstetricians with a special interest in this area, whilst maintaining strong links with a mainland FMF unit.
  - There may also be an opportunity to rotate these specialists in order to maintain skills in this area.
- There needs to be some recognition that some skills although essential to a particular service maybe impossible to maintain due to low patient numbers.
- Innovative collaborative working arrangements between services are necessary to maintain these skills for patients in whom the seriousness of their condition does not permit safe transfer.
- Although actual patient numbers with a specific condition may be low, uncertainties in the diagnostic process in specific areas may involve disruption for large numbers of patients and their families; these areas are not addressed by the current framework.
- **MCH-** The inability to recruit and retain Medical Staff in anaesthetics, paediatrics and obstetrics is caused by low service volumes and the onerous nature of the rosters. Delivery numbers have progressively fallen over the last 5 years exacerbating this situation.

Demand

The birth rate in Tasmania is slowly falling but patient acuity in terms of obesity, diabetes, hypertension, maternal age and an increased percentage of first time mothers are rising. These mothers require a minimum of Level 4 care as defined by the framework.
**Recommendation 4**
Ambulance Tasmania requires substantial improvements in infrastructure and funding to meet the needs of the service.

**Workforce Requirements – Levels 3 to 6**

- Please see Workforce Requirements within the TRDF.

Please refer to narrative within the Current Service Overview.

**Requirements**

- Level 4 units that are accredited for training must have a minimum of 2 RMO’s in addition to the registrar grade (RANZCOG accreditation standard).

**Services with Key dependencies**

- At MCH the service is heavily dependent on locums for both anaesthetics and obstetrics, provided at some considerable cost and with clinical governance issues that have been highlighted by some incidents.
- A 2 year recruitment programme has not provided a single permanent staff specialist and has only managed to fill one registrar position.
- Both the staff specialists and registrars work on a 1 in 2 roster and therefore the service is highly dependent on these individuals this has been a cause of some incidents. On the other hand Midwifery recruitment is buoyant.
- Midwifery staffing at NWPH is to be determined by the model used by HealtheCare, however despite extensive effort the unit, is unable to recruit even though this model demands fewer midwives than other recognised staffing models.

**Available Guidelines**

- There are no current guidelines for Obstetric staffing available apart from the RANZCOG 2014 statement that “staffing must be appropriate to clinical demand”.
- Obstetric workload is onerous in terms of out-of-hours workload.

**Recommendation 5:**
Level 4 services have the ability to deliver specialist Obstetric training and loss of these training position will effect Tasmania’s ability to train tomorrow’s specialist.
Minimum recommendations for specialist rosters are 1 in 4 (without prospective cover)

- The medical staffing structures at RHH are adequate to support the complex nature of obstetric care.
  - Except when the unit needs to provide medical staff for retrieval from referring hospitals or to transfer complex patients to a mainland hospital. This is a very rare occurrence for maternity patients but more common in neonatology.
- Midwifery staffing levels can be determined by using an evidenced based staffing resource tool such as “Birth-rate Plus” which is the internationally accepted tool.
**Recommendation 6:**
A purpose fit staffing resource tool should be considered by Tasmania public hospitals to determine midwife staffing levels

RHH should have the staffing to enable their development into statewide Maternal Fetal Medicine services encompassing development of pathways, audit and review of complex patients

- Over the last 3 years, the models of care at RHH have been reviewed with the resultant development of the Midwifery Group Practice, more midwifery satellite clinics to provide low risk antenatal care closer to home, more involvement of midwives in antenatal clinics to allow for more concentration of medical staffing resources in the more complex and high risk clinics.
- The development of the Fetal-Maternal Unit has also changed the way women with high risk pregnancies are monitored, allowing for more outpatient based monitoring and scanning of women with high risk pregnancies.

**Support Service Requirements – Levels 1 to 6**

- Please see Support Service Requirements within the TRDF.

**Appropriateness**

- The support services listed are basic services and as such are appropriate; however there are some support services listed under service requirements which is an inconsistency that should be addressed.

**Improvements**

- There is no mention of key support services such as cardiology, urology, renal medicine, colorectal surgery or neurology and neurosurgery.
- The framework for Gynaecology also needs to be considered in the Maternity framework.
- The ability to perform a lifesaving intra-partum hysterectomy is essential for all units that are a Maternity Service Level 4 and above.
- Level 3 – 6 Maternity Services require a pharmacy support service of level 3 and above according to the Maternity Services TRDF draft. Level 5 pharmacy services are required for level 5 and 6 maternity services. Level 3 and above pharmacy services are defined as providing ‘medications and clinical services for inpatients’ and the clinical service include; ‘drug information, drug monitoring, drug utilisation evaluation, adverse drug reaction reporting, patient education and support’. The RHH and LGH do not provide a ward based inpatient clinical pharmacy service. Clinical services are provided on an adhoc referral basis only.
- Maternity inpatient facilities should have access to a mother-baby unit model to cater for the needs of mothers with mild to moderate mental health problems.
• Recruitment of FRANZCOG obstetricians will not be possible to a gynaecology service any less than a Level 5.

**Recommendation 7:**
Maternity services are provided with a level of pharmacy support commensurate with their role delineation level.

**Recommendation 8:**
Interlinking of services needs to be carefully considered

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**Tasmanian Clinical Service Profile Considerations**

**Gaps, issues or barriers that need to be considered to ensure the successful implementation of the Tasmanian Clinical Service Profile (TCSP)**

1. **Issues**

   • Acceptance by clinicians, and the population of areas where services will be decommissioned on safety grounds.
   • There needs to be an open and honest discussion about the access to safe maternity care in the regional centres.
   • Linkages between the Northwest, the North and to the South requires review to support a safe and sustainable maternity service across the state, including the remote outreach areas.

2. **Gaps**

   • The current Ambulance Tasmania do not have the resources to support hospitals to meet the current service demands.

**Recommendation 8:**
There needs to be support services (ie accommodation) for families required to travel to access services away from their home region

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• Communication gaps with private share/care women, GP share/care and privately practicing midwives.
• Robust intra hospital transfer processes including consistent statewide guidelines, policies and documentation.
• Increased opportunities for advice on future lifestyle behaviours. There is a varied amount of access to support services including:
  o Perinatal Mental Health services available
  o Social worker
  o Continence advisors
  o Child Protection Services Liaison Officer
Lactation Consultants – This service caters for inpatients and outpatients with breastfeeding issues or concerns and is able to give advice regarding breast abscess and its management.

3. Information Technology Systems

The following IT systems are used differently at all sites and impacts upon referral and transfer of care:

- Obstetrix database; and
- Digital Medical Record system.

**Recommendation 9:**
There needs to be a consistent statewide approach to Information Technology Systems.

4. As regards midwifery services

- Under the National Maternity Services Plan³
  - Access Priority 1.2.2 requires “… jurisdictions to develop consistent approaches to the provision of clinical privileging within public maternity services, to enable admitting and practice rights for eligible midwives and medical practitioners…”
  - Access Priority 1.2.4 requires all jurisdictions to investigate options for the provision of publically funded home birthing. Suggest Tasmania investigates home birthing under a collaborative care model such as Midwifery Group Practice.

- Immersion in water for women in labour.

- Communication gaps and alignment between hospital services and Child Protection Services.
  - This includes onsite access for all acute services to a Child Protection Liaison Officer, streamlining of referral and feedback processes.
  - In addition the families who are vulnerable, but not at risk of harm, have limited support through the Child Protection Services.
  - These families are at risk if supports are not present.

- Perinatal Mental Health services have access difficulties with appropriate community resources. –
  - The Mother and Baby Unit (private facility) is located in Hobart however referral to service is complicated and not conducive to ease of transfer for public women.
  - This service is not close or easily accessible for North and North West mothers.

- Access to Medical and Allied Health services allows for early intervention and referral, but there are insufficient allied health services within acute settings and the community including Social work Physiotherapists, Nutrition services.
  - This problem is particularly difficult in relation to access to dietetic services for diabetic and bariatric pregnant women.

Reduction of obesity and diabetes must be a prime directive of a modern health service and Maternity Services have a unique window opportunity to influence.

The LGH and NWPH provide care that does not align with the proposed role delineation framework.

- The Australian Woman Held Pregnancy Record (an initiative of the National Maternity Services Plan) suggested schedule of routine antenatal care recommends:
  - primiparous women have 11 antenatal visits
  - multiparous women have 8 antenatal visits. Many women (particularly in the NW currently exceed these recommendations).

5. **Service Duplication**

- There are areas of service duplication where the woman has chosen a private or general practice shared care.
  - As a consequence women can receive either Obstetric or Midwifery care in a public obstetric service, a public general practice, a private midwifery service or private obstetric service which can lead to multiple unnecessary antenatal visits.
  - Due to the configuration of record systems there may be more visits than clinically indicated.
  - Women access both imaging and pathology in the private and public sector and there is difficulty tracking results from the both the public and the private sector.

- As a consequence there is the risk of re-ordering the same imaging and tests. Women should be given information about choices for pregnancy care at the time that the pregnancy is confirmed. This information will assist women to determine their preferred model of care and so minimise or avoid over-servicing and/or duplication.

- Due to the lack of integration between acute services and Child Health and Parenting Services (CHaPS) there can be service duplication when women and their newborn baby are discharged home.
  - Streamlining communications, processes and documentation may alleviate this issue.
  - The transfer of care processes to CHaPS is complicated and can result in both under and over service delivery.

6. **Integration of services across regions/hospital campuses**

- There must be clinical leadership in the engagement of the public and politicians. Any reason to rationalise, change or decommission services should be led by strong and evidence based clinical outcomes and adhering to a philosophy of service improvement rather than cost cutting.

- Based on evidenced based practice and research collaborative and robust primary and secondary outpatient services and support must be offered to pregnant, birthing and postnatal women, and provided in a way the woman and her family understand.

- Pregnancy may be the first time a woman and her family have accessed health care and it is an ideal time to increase their health literacy and knowledge. Tasmania midwives
offer this in the acute and community settings (dependent upon the level of that service) including:
  o Early Pregnancy Assessment Service which prevents repeat presentations to the Emergency Department and ensures the timely management of threatened miscarriage, miscarriage and ectopic pregnancy.
  o Normal risk clinics (in acute and satellite/outreach settings).
  o Midwifery led models of care such as Midwifery Group Practice, Know Your Midwife, TEAMS and Satellite Clinics.
  o All practice within the Australian College of Midwives National Guidelines for Consultation and Referral Guidelines\(^4\) which enables referral to medical practitioners and early intervention with moderate and high risk conditions that develop within pregnancy.
  o High risk clinics that have a multidisciplinary team approach – includes women with endocrine, bariatric care, multiple birth and other co-morbidities.
  o Provision of a foetal maternal service for high risk obstetrics (Level 6 only) – Plans care to minimise admissions.
  o Young pregnant mothers clinics.
  o Aboriginal and Torres Strait Islander women clinics.
  o Complex Care Clinic for pregnant women affected by the use of drugs and/or alcohol.
  o 24 hour telephone counselling service with midwife and/or consultant.
  o 24 hour service at the Maternity Unit to triage, manage and treat urgent pregnancy related complications such as bleeding pregnancy or pre-term labour.
  o 24 hour provision of midwifery and specialist consultant care including pregnancy triage service.
  o At home care and support for postnatal women - extended midwifery service.

7. **Support needs to ensure patient access to services**

- The National Maternity Services Plan priority areas include:
  o Improving choices and information about maternity care
  o Maintenance of existing high standards of safety and quality
  o Supporting collaborative maternity workforce
  o Improving access to maternity services for:
    ▪ Rural and remote women
    ▪ Aboriginal and Torres Strait Islander women

- There are unique and integral support services for women and children's health care that have not been included in the proposed framework.
  o These include Aboriginal and Torres Strait Islander support workers
  o Lactation Consultants; and
  o Child Health and Parenting Services (CHaPS) who provide care after discharge from the acute settings of maternity and paediatric services. Consideration to

\(^4\) Australian College of Midwives [http://issuu.com/austcollegemidwives/docs/guidelines2013/1](http://issuu.com/austcollegemidwives/docs/guidelines2013/1)
include CHaPS in the proposed role delineation framework as a support or within paediatric services framework.

**Recommendation 10:**
Consistency of care should be implemented across the spectrum of maternity services

- In November 2012, the Standing Council on Health of the Council of Australian Governments agreed that all Australian jurisdictions support the WHO/UNICEF Baby Friendly Health Initiative (BFHI) and its ten steps to successful breastfeeding for health services. They encouraged all public and private hospitals to implement the ten steps to successful breastfeeding and to work towards or maintain their BFHI accreditation.
- All services support the formalisation and strengthening of referral and transfer processes.

8. **Opportunities for clinical redesign / alternative models of care to better ensure the sustainability of services**

   1. Obstetric services at MCH would benefit from redesign – options as follows:

   a) **Level 1** (Recommended by medical staff) - this would necessitate improvement in Ambulance Tasmania and provision of affordable hospital provided accommodation at NWRH and LGH.

   - **Advantages are**
     - More appropriate use of Level 4 and level 5 services by the women of Devonport and the surrounding areas;
     - Quality and Safety improvements in terms of locum cover and the consolidation of medical staff at NWPH
     - Improvement in the recruitment and retention of anaesthetists, paediatricians and obstetricians due to the above consolidation
     - Improvement in the ability of the Northwest to provide clinical education and training to midwives and doctors thereby increasing recruitment and retention
     - Removal of 2 rosters, which are onerous and depend on small numbers of clinicians, from the system;
     - Allow retention of midwifery resources at MCH. Midwives based at this site could undergo periodic upskilling at either LGH or NWPH, thus serving the dual function of skill retention and unit staffing issues at both these sites.

   - **Disadvantages of changing the service model at MCH to a Level 1 would have considerable impact on LGH and NWPH in terms of delivery numbers, changing to a Level 2 would also impact significantly on LGH (although reducing the extra birthing numbers somewhat, this would be negated by the increase in acuity), as well as impacting considerably on Ambulance Tasmania.**
b) Level 2 (Recommended by midwifery staff)
- Previous models using GP anaesthetists, obstetricians and neonatologists have been explored. Currently there are no suitably qualified individuals within the North-West. We would anticipate problems recruiting the same due to existing GP recruitment difficulties in Tasmania.

c) Level 3 (Recommended by midwifery staff)
- Current difficulties of recruitment and retention would persist and there would be a need for neonatology practitioner as required by the framework and RANZCOG.

II. Expansion of the role of GP’s and primary care by considering:

- National Maternity Services Plan
- Benchmarking nationally – Women’s Healthcare Australasia
- Occupancy and Length of Stay trends
- Research and best practice (NICE guidelines)
- Tasmanian demographics including (information sourced from Australian Institute of Health and Welfare - Perinatal Data5 for women who birthed in 2011):
  - over 30% of population lives in outer regional, remote or very remote areas
  - second highest percentage of women who smoke during pregnancy in Australia
  - second highest percentage of teenage pregnancies in Australia
  - 24% of the women had a Body Mass Index (BMI) over 30
  - The highest percentage (33%) of women who were induced prior to labour commencing in Australia.

9. Use of Technology to ensure access to services

- This is essential.
- There are currently video linkage facilities for the Perinatal Management Group discussions and educational meetings.
- This could be extended to GPs and units in more remote communities.
- The Northwest has video linked virtual clinics to its outreach services to support these units clinically and educationally. These services should be expanded.

10. Alternative patient pathways to improve access to services

- Normal risk birthing to be supported as a principle component of all Obstetric and Midwifery services.
- Improved access more locally for women with normal risk pregnancies closer to home, freeing up resources in hospital for women with more complex problems in pregnancies.
- Massive expansion of midwifery post natal support delivered in the patients’ home.

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• Provide education and training to midwives in both acute and rural and remote areas in maternity ultrasound. This would support the priority areas identified within the National Maternity Services Plan of workforce development and improve safety for women when medical officers or services are unavailable.