



LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING AND COMMUNITY SERVICES
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Submission Cover Sheet

Inquiry into Maternity Services in the ACT

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Inquiry into the Maternity Services in the ACT

The ACT Branch of the Australian College of Midwives (ACM) thanks the committee leading this inquiry on the operation of maternity services across the ACT. We also appreciate the opportunity to provide comment. Many members of the ACT Branch for ACM are employed by the maternity services in the ACT or in nearby New South Wales (NSW). As an organisation the ACM is the peak professional body representing midwives in Australia.

- a) Models of care for all maternity services offered at the Centenary Hospital for Women and Children (CHWC) and Calvary Public Hospital (CPH), including, but not limited to, the Birth Centre, the Canberra Midwifery Program, and the Home Birth Trial and whether there are any gaps in care:

“Midwife-led Birth Centres and Midwifery Continuity of Care improve outcomes for women and their babies”

The Birth Centres at Centenary Hospital for Women & Children (CHWC) and Calvary Public Hospital (CPH) have been established on the success of the Birth Centre established in 1992 at the old Canberra Hospital maternity service. The old Birth Centre was funded by the Commonwealth Government through the Alternative Birthing Services Funds. Similar Birth Centres were established in metropolitan hospitals throughout Australia at this time. The Alternative Birthing Service funding model was in response to consumer led action in the 1980’s when women were confronted with medicalised models of maternity care not focused on consumer needs and choices. Like what consumers are saying today about maternity services in the ACT, these Australian women in the 1980’s felt no one listened and they were expected to just do as they are told.

Like the evidence with continuity of midwifery care midwife-led birth places such as Birth Centres provide improved outcomes for women and their babies and have high levels of satisfaction for women. Birth Centres are midwife-led units where woman-centred care and active birth are promoted. They are decorated in soft furnishings and home-like furniture to soften the medicalised hospital feel. They are places of birth designed to create reassurance and relaxation. They are highly valued by women, especially in the ACT with the ‘friends of the birth centre’ an active consumer led group focused on protecting this space.

The Birth Units at CHWC and CPH, although deemed to have slightly difference service capability, have become medicalised birth places where obstetric decision making is more valued than midwife decision making. CPH has been successful over the past 5-10 years to improve the collaboration between doctors and midwives (clinical and executive levels), but still midwives report not having the option or ability to be involved in decisions like their medical peers are. This decision-making bias to a medicalised model starts at the bed side and goes through to executive decisions and policy making. Examples of this are that women cannot access water birth at CPH even though evidence shows it is safe when women are well, their babies are reacting well to labour and midwives are trained. In addition, inclusion or exclusion criteria to the Birth Centre at CHWC is controlled by medical officer decisions rather than

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evidence-based guidelines such as the National Consultation and Referral guidelines for midwives.

The outcomes of this medicalised focus on maternity care has led to higher levels of intervention and to poor levels of recruitment and retention of midwives at CHWC. Statistics for the past 15 years show low caesarean section rates at the Birth Centre and with Canberra Midwifery Program (CMP) at CHWC compared to the growing caesarean section rate for the birth unit for women with similar risk factors. Also, the CPH Birth Centre is showing improved outcomes for women and their babies compared to women who choose to birth in the Birth Unit. At CPH the Birth Centre and midwifery continuity of care models are functioning much better and recruitment and retention are not such a problem. Regardless of this success at CPH midwives still feel that they struggle to have a voice in making clinical decisions or executive level decisions.

Repeatedly the culture surveys at CHWC show that midwives in Birth Centre and the midwifery continuity of care models (CMP and Continuity at the Canberra Hospital (CaTCH)) do not feel valued by management. Over the past seven years midwives from those working in executive positions to those working in clinical positions who have attempted to challenge the medicalised model of maternity care have felt targeted and bullied out of their job or role. It is felt by our membership that management don't value midwives being autonomous decision makers, the midwifery continuity of care programs, the Birth Centres and don't understand the significant benefit of midwife-led care.

The Publicly Funded Homebirth Service at CHWC also reflects the medicalised model of maternity care governing. This service still in a trial period is highly restrictive for women wishing to access a homebirth and for midwives wishing to work in it. Student midwives, for example, are not able to attend a homebirth, which is a fabulous learning experience for them. Women also are pressured if they choose to birth at home with this program, for example they have to sign to not have a water birth and to not decline medical or midwife advice. The restrictive consenting process for women to access a homebirth through the Publicly funded homebirth trial challenges an individual's right to make choice.

b) Provision of private maternity services including centre and non-centre services;

In the ACT women currently have access to private obstetric services and are encouraged if they have private health insurance to use this. However, private midwifery services are not valued in the same way and women are actively discouraged to access a private midwife. A good example is that both hospitals do not refer to private midwives or take referrals from private midwives. Individual staff members at both hospitals at times will collaborate with private midwives but they are strongly encouraged to not do this as a norm. Private midwives have access to the same credentialing process and Visiting Medical Officers at CHWC, but this process is difficult to access and to achieve completion. To this day only two midwives have been credentialed at CHWC.

c) Management of patient flow, including, but not limited to, wait lists, booking services, and capacity constraints;

“Staffing levels are based on management needs not the needs of the women or their choices”

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Decisions in ACT maternity hospitals are similar to other hospitals around the world where they are based on bed status and patient flow. The nature of childbirth and therefore maternity care is that it is unpredictable meaning that many maternity units/wards experience ebbs and flows of workload with staff on some shifts being 'run off their feet' and not able to provide women the care they need to shifts where no women are admitted. Also, since the cost of staffing Australian hospitals increased in the late 1980's many hospital have chosen to not staff there wards and units to a 100% capacity. This has intensified the staffing issues in maternity when it is busy and there is a 100% capacity.

Although regulations for public hospitals has required a minimum nurse to patient staffing ratio this has been difficult to apply to maternity services. This is because maternity care is so different to acute healthcare services. The Labour and birth component, for example, is often not a planned healthcare activity and as a result staffing a ward is difficult. Another example is that on the postnatal ward a midwife's workload is only based on the needs of the woman, as her baby is not seen as an admitted patient. This may be regardless that the baby may need care such as Intravenous (IV) antibiotics or frequent taking of vital signs. This results in midwives being busy but management not recognising the intricacies of their workload. Further reports from our membership is that at CHWC, due to the hospital's busy workload, women are having planned treatments and interventions at night when staffing is at its lowest. For example, a woman may have an Induction of Labour commenced overnight as it was too busy during the day and now that there are a few empty beds on the Birth Unit it is deemed safe for and Induction of Labour to be commenced. These two management decisions about staffing show that they are not based on what is best for the woman but based on bed availability. Compared to other jurisdiction ACT Health is also not regulated for women to have one-to-one care from a midwife in labour.

The active birth space of the birth centres needs to be protected and valued and for that to be done they need to midwife-led. Midwives, particularly at CHWC are voicing that they are exhausted from attempting to protect the needs of individual women, the good status of midwifery care and the sanctity of the birth centre. For example, the Birth Centre at CHWC, which has outstandingly low intervention rates and outcomes that parallel world best practice, has been directed to take the overflow of women from other units. This has resulted in some women not being able to access the Birth Centre that they were booked to use. Hospital management is overriding the management of the Birth Centre, which is another example of midwife decisions or autonomy not being valued.

- d) Management of patient birthing preferences, including, but not limited to, professional advice offered to patients, and the practices associated with birthing emergencies;

“Advice is not evidence based, inconsistent, women feel bullied and not listened to”

It necessary that staff, both doctors and midwives, be able to make decisions based on up to date evidence and knowledge and quality clinical skills. Although ACT Health provides education for the basics of mandatory requirements, for example obstetric emergencies, manual handling and resuscitation, the programs available for staff to keep abreast of latest evidence and appreciation of physiology and pathophysiology are lacking. This leads to decisions about an individual's woman's care being based on standardised processes or procedures because staff do not know the evidence or understand physiology and then be able to apply this to an individual woman's situation. There needs to be more energy put into providing staff education

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that enables them to keep up to date with the latest evidence. They will then be able to use this knowledge to support a woman and her family to make decisions that take into consideration a woman's individual preferences.

Included with this act of decision making staff need a reliable guide. The ACM guidelines for consultation and referral is one such product. These guidelines are evidence based and endorsed by RANZCOG. However, midwives and doctors are actively discouraged from using them. There is much debate of why this happens, but it appears that because it is a product produced by a midwifery organisation it is deemed as inadequate.

Also, the ACT Health website for maternity services needs improving, as it currently provides minimal useful information and is difficult to access. For example, unlike other jurisdiction health services ACT Health has no easily accessible evidence-based information available to pregnant women such as fact sheets/websites.

e) Interaction between the CHWC and CPH with other service areas, including, but not limited to, emergency departments, and operating theatres;

“There is concern that the single point entry process for maternity care in ACT will not focus on individual women's needs or choices when they choose where to birth”

ACT Health is currently working on a new access program for women seeking maternity care with the Public Health facilities. This program is attempting to create a single point of entry for women. It will be important that women are offered adequate information about the differences in the hospitals when they are making a choice of where to give birth. Rather than it being simply based on geography and obstetric risk factors. For example. women who book at CPH do not have access to water birth or home birth compared to women at CHWC. Use of water in labour or having an option to birth at home are seen as important options of care for some women. As are issues about management of complex medical situations such as raised BMI or gestational diabetes.

Also, it will be important that women can choose a place of birth based on the safest place for them. For some women who have experienced high levels of trauma at one hospital they will need to have access at the other hospital to protect them from ongoing trauma.

“There seems to be a blame culture in ACT Health”

In certain situations, and particularly with maternity emergencies or unexpected outcomes midwives in the ACT are fearful that they will be reported to Nursing and Midwifery Board of Australia as a first line of management. Midwives anticipate not being supported and concerned that they will be singled out or scape-goated. Midwives describe that in management of certain unexpected outcomes there has been no processes of natural justice or risk assessment/root cause analysis undertaken. This has resulted in them being blamed for situation instead of supported.

f) The efficiency and efficacy of maternity services;

“Women and staff become distressed when they are treated as a number and not an individual's”

Quality maternity care often is at odds with service efficiencies as the service is programmed to focus on staff-patient ratios, outcomes and statistics. In the context of midwives this often relates to skill mix being a problem on a shift. Members of the ACM and others comment that

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often the Birth Units or other wards are not staffed adequately leaving inexperienced midwives or doctors in charge. Hospital management has to look at the culture and the management of a facility and wonder why more experienced staff often leave or choose to work night shift.

There must be an emphasis on recruitment and retention strategies that encourages skilled and competent midwives to apply. When midwives are competent and skilled, they provide an organisation with another level of 'checks and balances'. With their skills and experience they will know that what seems a standard intervention for one woman may not be the best choice for another. Such candour from a midwife in a system that seems to prioritise a medical opinion over that of a midwife's can be confronting but at times is necessary. Valuing a midwife's role in maternity care enhances safety and enables a woman to have her needs/choices met.

g) The impact on maternity services on regional participants;

At Queanbeyan hospital the agreement between ACT Health and NSW Southern NSW LHD has led to an over medicalised service now operating. Their intervention rates have sky rocketed. Along with this, the women who reside in NSW now do not have access to a midwife-led birth centre. Although this has been a decision was made to counter the overburden on CHWC it has resulted in a new generation of 'low risk' women now becoming 'high risk' because they will now need a repeat caesarean section operation or want a Vaginal Birth after Caesarean.

h) Patient satisfaction with the services;

“Women struggle with certain aspects of the maternity services at both hospitals”

The accepted gestation of a woman booking into a Maternity Unit in Australia is 12-14 weeks gestation and in ACT women are often not able to get access before 16-18 weeks. Consequently, some women are falling through the gaps, especially if they have complexities with their pregnancies.

Women also comment that it is difficult for them to telephone the OPDs of either hospital and be able to speak to a midwife or doctor. In the Fetal Maternal Unit at CHWC, for example, women comment that their calls are nearly always diverted to answer machine or just ring out. For the staff they have no capacity to answer the telephone. This often relates to workload or that there is no process whereby a woman can call and speak directly to a midwife or doctor.

Sadly, women comment about staff, both doctors and midwives, not listening to women when they are talking about their choices. They experience staff being too busy undertaking tasks and often are not focused on the woman, her pregnancy/her baby or her needs. This has resulted in some women not receiving appropriate care or interventions resulting in adverse outcomes or they have received sub-standard care.

Women, who live locally who have a baby admitted to NICU/SCN are not able to stay with their baby during this time and as a result feel dislocated from their newborn. For example, a woman who gave birth at 32 weeks, was discharged home whereas her child was admitted for another month – six weeks. She had no option of staying and being with her child. Whereas in the paediatric unit parents are expected to stay with their admitted child.

The current method of consumer involvement is difficult to engage maternity consumers. Childbirth is one aspect of a family's healthcare and often once the woman and her partner have completed their family, they disengage from the issues pertinent to a maternity system. On the other hand, a consumer who may have knowledge of the acute care health system may not have

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any experience of childbirth. This results in the current consumer involvement process not representing the needs of the people accessing maternity care. It would be of great benefit if a maternity consumer organisation could provide a consumer directly to ACT Health.

- i) The impact on staff including, but not limited to, rostering policies and practices, staff-to-patient ratios, optimum staffing levels, and skills mix;

Recruitment and retention of staff at CHWC has been an issue for some years now. This had been raised in previous sections of this response. Retention of staff is linked to a healthy functioning culture. When midwives are confident, educated, up-to-date, woman centred and respected to advocate for women and midwife-led care they take pride in their work and want to stay. This influences them to interact proactively with the women and families in their care and makes for a safer healthcare service because they take on the responsibility for their decisions and the care being provided.

- j) The impact of technological advances and innovations;

Although many advances in technology, radiology and pathology have enhanced maternity care there are still concerns with the level of intervention and reliance on technology in labour and birth. The advent of technology in labour and birth care has led to an over reliance on fetal monitoring, Inductions of Labour, for example. Evidence repeatedly shows that continuous fetal monitoring is restrictive for many women being upright and mobile in labour and leading to increased intervention. Once again other jurisdictions promote one-to-one midwifery care in birth units and this enable less reliance on technology and better oversight and care of the woman and her unborn baby.

Other areas of maternity care struggle with not enough technology. Midwives who work in women's homes, for example, do not have access to laptops and instant connection with radiology, pathology and online data management.

- k) Relevant experiences and learnings from other jurisdictions;

No added comments

- l) Any related matters.

In conclusion. The maternity services in the ACT would benefit from greater engagement of the midwives. There is an overreliance on a medicalised way of working reducing the benefit of sound midwifery input into how the services are managed and care that is provided.

When the philosophy of the organisation is medicalised as it is currently at CHWC and does not respect a midwifery philosophy of care the outcomes for that organisation are about medical events not women giving birth and starting a family. Care becomes task focused, itemised and not woman-centred. Women then become seen as a burden rather than the main reason for the service in the first place.