

Hon Michael Ferguson MP
Minister for Health
PO Box 537
Launceston 7250

Regarding: Response to White Paper Exposure Draft – March 2015

Dear Mr Ferguson,

Thank you for the opportunity to make a submission to the White Paper Exposure Draft.

I am providing this submission from discussion and input from Midwifery staff employed at Mersey Community Hospital. We as a group understand that decisions need to be made to improve the services that are provided to the women of the North West Region of Tasmania. At the same time we wish to put forward our thoughts based on statistics and evidence that the birthing unit should be located at Mersey Community Hospital, not at North West Private Hospital.

Mersey Community Hospital has a long history of providing excellent maternity care to the women of the Devonport and Latrobe area. Our unit is staffed by extremely dedicated midwives whose prime focus is on providing evidence based; women centred care, in collaboration with the obstetric team.

Our unit currently has 4 birthing suites – this number of birthing suites would be capable of birthing up to 1200 women per year if required.

We currently have 12 postnatal /antenatal beds; however each of the rooms has the capacity to have additional beds returned to the rooms which would give us the capacity for 20 postnatal/antenatal beds. We also have a 3 bed assessment ward, used very frequently for women who present with issues in the antenatal period.

We also have a very well equipped Level 2 (previous classification) Nursery, including three incubators, facilities for low flow and high flow nasal oxygen, phototherapy, intravenous fluid/medication and gavage feeding etc. Staff are trained and receive regular education to manage neonates 34+ weeks and/or short term conditions not requiring transfer to higher level care. In this case, equipment for stabilisation prior to transfer to a tertiary facility is available including CPAP (non-invasive ventilation). Of course, to return our nursery to its full function, 24 hour on-call cover by a paediatric registrar able to attend the Unit within the recommended time-frame for the facility would be required.

On page 35 of the White paper exposure draft it is stated that numerous reviews of maternity services in the North West have identified a need to change the way that the services are delivered. These recommendations are based on;

- “ poor safety of the existing model”
- “ongoing recruitment difficulties that have necessitated long-term use of locum obstetric staff at the Mersey, and”
- “suboptimal clinical outcomes”

We as a group find it somewhat offensive that the service that we provide could be stated as having ‘poor safety’ and “suboptimal clinical outcomes”

Recent benchmarking documents provided by Women's Healthcare Australasia (WHA) lend more weight to the fact that we are a unit that has good outcomes. The data that is provided to WHA is provided directly to them from the hospital. The data is then used to compare our performance with services with a similar profile.

The profile of the women who attend Mersey community is that approximately 37.2% of our women are primigravida (first time mothers), they are usually less than 35, and are having one baby. Our rate of epidurals was 15% significantly lower than the average of 27%. Caesarean section rate was 23% in the benchmarked period – greater than the WHO recommendation of 17% but lower than the current national average of approximately 32%. The MCH rate of 3rd or 4th degree tears following birth is also well below the average in comparison to our peer group.

For neonates an indicator of wellbeing that is used at birth is the APGAR score – a score of 6 or less at 5 minutes of age indicates that the baby is still requiring significant support for normal functioning – eg has a low heart rate and is requiring assistance to breathe. The benchmarking report shows that babies at MCH have an apgar score of 6 or less at 5 minutes of age of only 1% - which is a very clear indicator that initial resuscitation efforts on babies has been successful when required and that the majority of babies born at MCH require less resuscitation effort than others in our peer group.

ANTENATAL CARE

A large contributor to the outcomes for mothers and babies is the provision of evidence based antenatal care. Our unit has 5 antenatal consultation rooms and dedicated staff that provide care in conjunction with the obstetric team to ensure that all women are appropriately risk assessed so that we are able to make decisions about the type of care provided (eg Midwifery led, Obstetrician/midwife based, or Complex care). This decision is made using appropriate guidelines and is done as a collaborative team with our obstetricians. The majority of the care provided to women in the antenatal period is Midwifery led care. When increased input is required from other specialists such as Diabetes, Endocrinologists we can also provide that service.

Our midwives also provide an antenatal clinic at East Devonport where antenatal education classes are also held in an area that is easier to access for many of our women. As a team of midwives we have also discussed the possibility of holding clinics for women in Ulverstone and Port Sorrell, bringing the service closer to the homes of many of our women.

Within our antenatal service we currently also provide consultation to women by Lactation consultants and it is intended to expand this service to include Breast feeding classes so that women can come in to the hospital prepared for the days immediately after birth in which breast feeding is so important.

MCH provide outreach services to West Coast, Smithton and King Island. This service is provided by midwives and obstetricians who fly or drive to the areas to visit patients and provide ongoing support to the staff in the area. We also provide education to the staff on a regular basis to ensure they maintain their skills. This service is managed from MCH. All referrals from GP's for women birthing in the North West Region are sent to the Outreach coordinator for initial triage prior to appointments being made for antenatal care and a decision in regard to which unit to birth at is made. All of this is done based on a risk profile for each individual.

POSTNATAL CARE

It has already been highlighted that birthing is a small part of the journey from conception to parenthood and at Mersey we pride ourselves on the excellent care provided to women in the postnatal period, our care is delivered with a focus on the family unit, inclusive of partners and siblings. The time spent in hospital is used for education to ensure that the woman and her new baby and family go home able to grow and thrive as a family group. MCH provide an extended midwifery service to the women of the North West region. This service is provided 7 days a week. In 2014 from 1/5/14 – 30/4/15 there were 2,037 occasions of service – or home visits, 732 of those were purely for lactation issues. Our midwives covered 21,920km. The standard of this service is extremely high, it is vital in ensuring that the new mother and baby receive ongoing support on discharge from the hospital, and will on more occasions than not ensure that a woman continues to breast feed rather than put the baby on to formula, because she has the support of a Lactation consultant to guide her through any issues that she may encounter. Consideration needs to be given to providing more funding for this service so that more women can be assisted to breast feed for longer periods of time and to cover the entire region.

Regardless of where a birthing occurs in the North West consideration needs to be given to the following points for women being discharged in the region

- One centralised extended midwifery care service to provide care for women from Deloraine-Smithton-Queenstown, no matter where they birth.
- Located and managed from Ulverstone- managed as separate from the birthing service but working collaboratively.
- Staff would need to be at least interested in IBCLC / demonstrate exceptional breastfeeding knowledge and skills, interested in teaching parenting.
- Division of workload geographically, therefore staff need to be equally skilled.
- Utilise staff in outlying areas such as west coast and provide phone support to those staff Provide one IBCLC with ability and time to travel to outlying areas to provide assistance in a timely manner – as per previous position run from parenting centre
- Continued comprehensive follow up and service-**NOT early discharge**.
- CHaPs services need to be increased to support women in the community after ECM discharge....their staffing has been significantly reduced. New parent groups have been almost wiped out, they are not able to provide timely or comprehensive follow up.

It would appear that a large amount of emphasis has been placed on the requirement for HDU facilities for women who birth as a key decision for where the births should be located. All statements and discussions that have currently been held at forums and information sessions have emphasised that the current function of the MCH HDU will not be changed from its current format. Women who birth do occasionally require additional support from a HDU/ICU unit – if the current MCH HDU stays as it is then this should not be considered a barrier to birthing. A woman who needs this support should be stabilised and transferred to a facility that is capable of providing ICU – this stabilisation can take place in our current HDU facility.

The consideration of MCH becoming a day surgery unit also would indicate that there would be on-call theatre staff for the occasions in which a patient undergoing day surgery may need to return to theatre. This theatre staff would also then be able to cater for emergency caesarean sections if required.

The one glaring gap in the equation of birthing services remaining at MCH is the provision of paediatric services. Currently there is a consultant paediatrician, a paediatric registrar and a

paediatric RMO at MCH Monday – Friday from 8 – 4.30. An on call roster is in place for afterhours coverage with paediatricians based at Burnie needing to come to Latrobe if required after hours. This service has been eroded over the years and due to the reluctance of the paediatricians to travel to Latrobe from Burnie, more babies have been required to be transferred by ambulance to Burnie, despite the fact that we have the equipment, the trained staff and the willingness to keep those babies here. With due respect Minister, the whole premise of your white paper is that people will be provided care where it is needed and that less people should have to travel. Surely it makes more sense that a paediatric registrar stays at Latrobe to provide overnight services for babies that may need additional support.

The current staffing of MCH maternity unit is very stable. We have a group of midwives who are passionate about the care that they provide. The education provided to the staff is exceptional.

As you are aware the North West Private Hospital is currently operated by a private company with public funding for birthing. It is imperative that any service provided in the North West region works within the current clinical governance structure of the DHHS. Without this governance structure the current service is not bound to work under the same policy/procedure or guidelines as the rest of the DHHS. This has the potential to create differences in a system that can create added risk for the women and their babies.

The right of women to choose birthing services provided in their local community must underpin the development of appropriate models of care.

The midwifery staff at MCH are currently working under a cloud of uncertainty. Their major concern is for the women of the North West region and that a safe service is provided. We as people though also have concerns in regard to our own job security and the security of our entitlements as DHHS employees. We are hopeful that a decision can be made soon, but want to ensure that all possibilities are considered.

Current rivalries between Burnie and Devonport do exist as you are aware, we would also like to suggest that if the decision is made that all births will occur in Burnie, a new maternity facility should be built at North West Regional Hospital so that a purpose built unit, with none of the history attached can be developed.

We as a group implore you to not ignore the possibility that birthing is centralised at MCH not at NWPH. We have the facilities, the knowledge and the desire to provide an excellent, safe, evidence based service.

Yours Sincerely,

The Midwives of Mersey Community Hospital
Latrobe