Australian College of Midwives

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Rural Maternity Taskforce Submissions

The Australian College of Midwives Queensland Branch wish to represent the broad range of midwives and women who live in rural and remote areas of Queensland. As part of our submission the branch wishes to not only provide the taskforce with concerns but with some options for consideration to support rural maternity service enhancement.

Utilising the Australian College of Midwives Consultation and Referral Guidelines low risk women should be able to have the option of birthing in a low risk midwifery led model of care. This continuity of care model will provide women with a know care provider close to their home if not at the local rural hospital. However many health services have looked at midwifery led models of care for even low risk women that they require rural medical officers with anaesthetic and obstetrics skills and qualifications to be available and on call.

Currently there are maternity services provided in some rural parts of Queensland however services have struggled to remain open and or open with birthing facilities. Facilities including Theodore is closed and Charters Towers opened a midwifery group practice nearly 10 years ago and still does not have planned low risk birthing options available. Rural facilities even with birthing options also do go on bypass due to a lack of medical officers and or peri operative nursing staff to be on call.

Not all rural and remote Indigenous communities are able to offer culturally appropriate maternity service models. There are regional, rural and remote communities that are now integrating midwives with the Aboriginal and or Torres Strait Islander health workers and or liaison officers to support Indigenous women and assist with closing the gap through yarning circles, mums and bubs groups. Example includes Ingham, Mackay and Rockhampton. For Palm Island the midwifery service comes on a fly in fly out arrangement and the midwife will work with the local Aboriginal health worker or liaison officer. Thursday Island is offering midwifery care that id culturally responsive to the needs of Indigenous women.

Midwifery models of care where they are rural and all risk models where the midwives take on not only a continuity of carer role but also the role of social worker and the midwife navigator role these additional roles utilise midwives hours that urban based midwifery models of care do not face and or have to deal with. There is a need for non rural maternity service leaders to understand the complexities of the role and the travel requirements in

order to provide this continuum of care. Rural and remote midwifery models of care are all unique.

Rural and remote women are socially and financially disadvantaged by having to travel to access maternity care including birthing services when low risk. This relocation from family and friends comes at a financial cost and if they do not relocate for birthing between 36 and 38 weeks depending upon location and level of risk, the women may birth at home with no qualified maternity care provider, in an ambulance enroute to a birthing hospital or roadside. All examples are not a satisfactory solution for rural and remote women. Longreach maternity services support women informed choice for example the provision of collaborative maternity care with support from regional and tertiary partners to allow women's choice to be supported including the birth of twins at 38 weeks gestation at Longreach Hospital.

It is true that the rural workforce is challenging to supply, with fewer staff residing in the areas or wanting to relocate to rural settings. However, there is an influx of newly qualified midwives who are struggling to gain positions in metro areas with limited vacancies. These graduate midwives are the workforce of the future. With appropriate clinical support, these midwives have capacity to fulfill gaps in the rural workforce and expand services to women and their families. Additionally, many rural positions request dual registration (nursing and midwifery) to fill vacancies. This prevents many midwives from applying for these positions. Rural midwifery positions should be open to ALL midwives, not just those who hold dual registration and current practicing certificates as a registered nurse and midwife. With many midwives now having completed a three year degree specific to midwifery and maternity care, they have up to date knowledge and skills with which to provide evidence based care. They are professionals in their own right and are equipped with the skills to independently address learning needs to safely extend their clinical capabilities. In the rural setting, midwives are often exposed to far greater learning opportunities 'on the job' than in metro facilities (where often obstetricians will plan and decide on care pathways and perform clinical tasks). This exposure wills quickly up skill midwives and increases their capacity to provide extensive and holistic maternity services.

Rural women do not have all the available options of care providers in rural communities this includes home birth services and or private practicing midwives. Shared care models available within rural communities may not fit the standard shared care model found in regional and metropolitan communities of shared care between a GP and a hospital, but instead in a rural community it maybe between a primary maternity care provider, a secondary care provider and then the tertiary care provider. The primary care provider being the rural midwife and the secondary care provider being the rural GP or medical officer at the rural hospital and the tertiary care provider being where women from the community go to birth even if low risk. Models need to be flexible and allow maternity services to be provided with the appropriate governance, education, skill maintenance and up to date clinical equipment based on the clinical services capability framework (CSCF) level. Some rural maternity services do have midwives being able to transfer to the birthing facility with the women when in labour. This does not come with challenges and or risks if travelling from the Atherton Tablelands to Cairns Hospital. Another factor is the great distance that some women have to travel for care. It would not be unusual for a woman to have to travel 1-2 hours to her nearest hospital, let alone one with adequate facilities and appropriately qualified staff. Women can birth in far less time than this, as is occurring with babies being

born en route to the hospital, often in private cars. This is particularly concerning as this cannot be considered safe, even with a low risk pregnancy. Add complexities such as a preterm birth or a postpartum hemorrhage and the consequences could be dire.

Rural women when faced with going to a regional and or metropolitan hospital to birth they may be excluded depending upon the health service from accessing the birth centre because of where they live even if low risk. This limits the choice of women.

Rural maternity facilities where midwifery led services are provided have improved outcomes for mothers and babies when compared with GP and/ or obstetric models of care. Rural GPs are overwhelmed with patients as it is and in many cases, their knowledge of quality maternity care is limited. In many instances, women are missing out on basic clinical investigations, are provided incorrect advice about medications and complexities are overlooked. Midwives specialise in maternity care and are well able to provide clinical care for women with low risk pregnancies, not to mention the essential primary health education (such as breastfeeding and parentcraft) which is rarely addressed by any other profession. When pregnancies are complicated by obstetric or medical issues, midwives are ideally placed to work in conjunction with the appropriate clinician(s) and assist women to navigate the health care system. This is essential to ensure ALL aspects of maternity care are collated and consistent, improving both safety and quality.

There is a need to establish a continuity of care model of care with shared care with the general practitioners in the community in partnership with a midwife in the birthing facility who can meet the woman when she comes for scans or consultant appointments (if required) The partner midwife in the birthing facility can provide labour and birthing care and if possible the rural midwife could travel to provide labour care as well if possible. The woman can return home and receive shared care with GP and rural midwife. Birthing facilities to organise care for rural women with complex care using Tele health with midwife in attendance to decrease the travel for women while using the knowledge and skills of the local midwives to do assessment or provide additional information.

There is a very successful midwifery group practice model in the Top End of Darwin where remote indigenous women have antennal and postnatal care in their community by a midwife and or a visiting outreach midwife. When these women have to travel to Darwin the Darwin based practice will provide all maternity care for these women and have an Indigenous “Aunty” that works with them to support the practice and Aboriginal student midwives are encourage and supported through this practice. Even though in this model the women still leave home for birthing they are supported and cared for in a unique way to support closing the gap strategies. The Australian College of Midwives at a national level are progressing the work of birthing on country and culturally appropriate maternity care.

Rural midwives have difficulty maintaining recency of practice hours depending upon the model of care they work in but also the number of women, what the scope of the model is. Registered nurses face having to maintain both recency of practice for nursing and midwifery. Rural midwives will have often limited exposure to emergency situations and so access to up skilling and pocket simulation emergency care scenarios is important. In some rural communities it is the general practitioner that provides most or all of the antenatal care

to pregnant women in the community limiting opportunities for the midwives to be involved in their care and therefore maintain recency of practice hours.

If these midwives want to participate in a clinical placement at a nearby birthing facility in order to get enough recency of practice hours, they are expected to do this as professional development or by taking annual or long service leave as it is not able to be funded. If rural and remote midwives cannot demonstrate recency of practice hours, midwives may considering or actually relinquishing their registration, causing further concern for rural maternity services. There is a need to review exchange programs to look at a new model that supports rural and remote midwives to identify their learning and clinical skills needs and that the program will be funded to support this. Rural and remote up skilling programs need to be relevant and responsive to the individual needs of each midwife. Rural medical officers have significant more hours to meet professional development requirements than rural midwives. It is also extremely hard for these midwives to be a long way away from their homes and families for lengthy periods of time (weeks to month at a time) as they have young families and often extra responsibilities on family properties that puts significant strain on their families. The duration of these programs needs to be considered. Suggested solutions include

- Making short term placements at closest maternity service so that they can travel home on weekends
- Having these placements being funded by the Chief Nursing and Midwifery Office Nurses and not individuals or work units, so that it is equitable to all.
- If exchange programs continue allow the program to cover salary and not only travel and accommodation, as they often have family or friends they can stay with and therefore do not require funded accommodation.

There are rural and remote communities in Queensland where they once was a midwife with a current practicing certificate. They have however relinquished their midwifery registration but they will still be called upon to assist when there is no midwife available even when utilising tele health services for example retrieval services Queensland (RSQ) and or tele emergency medicine support unit (TEMSU) are called when a pregnant women presents at a rural facility because they have midwifery knowledge and skill even though not registered.

It is a sad situation when rural women do not have access to professional midwifery care when and where she needs it, because these midwives are not supported to maintain their registration. Home birth is not an option for most rural women with a midwife. Professionally we owe rural women access to safe competent care by midwives whenever possible. We also owe these midwives the support they need to provide the care to the rural women who are greatest risk of poor outcomes.

Rural maternity services require investment and expansion of midwifery led models of care, specifically caseload midwifery. These services need to be adequately funded, staffed and supported. Funding midwifery models will ultimately SAVE money as these models of care are cheaper to run and achieve better health outcomes, reducing health expenditure.

Rural and remote midwives can provide midwifery care for women and their families through the continuum of care. They can be the primary known care provider even when the women

is not considered low risk. They are able to act to address other health concerns such as the early detection of diabetes, obesity and mental health conditions. Whilst they may not have the expertise to manage these health concerns, midwives are able to refer women to the appropriate service and enabling early intervention. In rural localities where services are limited, these conditions may otherwise go undetected.

The Australian College of Midwives (QLD Branch) hopes this has confirmed other submissions or identified additional issues to submit to the Taskforce. I am happy to be contacted further if you have any questions regarding this submission.

Regards

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