Australian College of Midwives
ACM: For midwives. With women. For the future.

QLD Health - Rural Maternity Taskforce Submissions

Please find below a submission by the Australian College of Midwives (ACM) to the Clinical Excellence Queensland, Queensland Health - Rural Maternity Taskforce, in regards to the two areas open for consideration:

- issues concerning the safety or quality of current rural and remote maternity services in Queensland
- actions/suggested approaches that could be taken to address identified issues.

This submission is in addition to and in support of the submission made by the ACM Queensland Branch.

The Australian College of Midwives (ACM) is the peak professional body for midwives in Australia who are registered with, and regulated by, the Nursing and Midwifery Board of Australia (NMBA). The ACM's position is that women be attended during pregnancy, birth and postnatally by a midwife who is registered with the NMBA. We speak with a National voice on issues pertaining to Midwifery. We are the only peak professional body to solely represent Midwives.

Issues regarding the safety, quality and acceptability of current rural and remote maternity services in QLD	**Actions/suggested approaches that could be taken to address identified issues**
All women should have access to midwifery led, continuity of care models	Increase/mandate utilisation of the Australian College of Midwives National Midwifery Guidelines for Consultation and Referral to standardise referral processes. The Guidelines have been endorsed by RANZCOG. Midwifery led models of care for low risk women to be implemented state-wide. Identify risk status for all women and clearly define 'low risk'. Access for all eligible women to midwifery-led continuity of care models. Strengthen links between midwives and general practitioners in shared care models. Low risk women have access to community-based antenatal and postnatal care by midwife and/or GP according to their preference. Birthing in local facilities with midwife and/or GP obstetrician in designated birthing centres. Expansion of and active support for eligible midwives. Telehealth utilised for complex care requirements.
Universal access to maternity services for birthing, antenatal and postpartum care close to their home. Rural and remote women are required to travel more than their urban counterparts to access their	Implement and support midwifery-led continuity of care models available to all women. Support the development of free-standing and resourced birth centres. Greater use of Telehealth services to connect women to the care/service they require including allied health, specialist care, mental health etc as required and appropriate. Reducing travel costs, time and inconvenience.

maternity care/services leading to social and financial disadvantaged. As they near the time of birth this disadvantage may be increased if they are required to relocate from their home to the closest maternity service/hospital.	Streamline and expand funding options to support women and their families if travel for appointments or birth is required. Tailor care to expressed preferences and needs of individual women and families. Supporting women's informed choice. Improve linkages with rural/remote emergency services such as the RFDS. Increase funding for supporting services providing community- based breastfeeding and parentcraft. Expansion of midwives' scope of practice allowing greater community-based roles such as sexual health, child and family health, diabetes care, immunisation, continence care, social work and perinatal mental health. Will require modified position descriptions and entry requirements for some postgraduate courses to allow for midwives without RN status to apply. Working examples include Longreach maternity services. Providing collaborative maternity care with support from and collaboration with regional and tertiary partners
All women should have access to the birthing place and model of care that they choose e.g. Homebirth, birth centers, midwifery continuity of care Women should have access to a known care provider of their choice	Increase funding and support of midwifery-led continuity of care models. Increase funding for and support of publicly funded/accessible homebirth services. Look at implementing and supporting free-standing birth centers. Support private midwives in establishing admitting rights and collaborative agreements with health services that allow them to transfer with women and continue care. Flexibility in planning and developing models of care/facilities specific to the needs and circumstances of unique communities. 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.
Unacceptable rates of stillbirth in rural and remote areas (AIHW 2018)	Implementation of midwifery continuity of care models have been shown to decrease rates of stillbirth and perinatal death Medley et al (2018)
Access to rural generalist medical officers with anaesthetists and obstetric skills and qualifications	Continued support for rural generalist training for medical personnel to provide additional care for women in complex as well as normal birthing or pregnancy situations.
Expansion of maternity services. Ensure no existing services are at risk of closure (e.g. Theodore and Chinchilla)	Support the continuance and expansion of maternity services in local communities. Consider planning, structure and implementation of maternity models of care to better utilise the maternity workforce and increase service accessibility for women. Grow your own midwives from within rural communities. Support systems/grants in place for local midwifery students and placements.

	Expansion of midwives' scope of practice to ensure full utilisation of staff potential, job satisfaction and career pathways for rural midwives. Have a sustainable back up plan to ensure services do not go onto bypass when additional medical services are required.
Closing the Gap – prioritise culturally appropriate services for our Indigenous communities	Implement a Birthing on Country Model (see ACM Birthing on Country implementation at Waminda) Continue (and increase) the rollout of the integration of midwives with Aboriginal and or Torres Strait Islander health workers and or liaison officers to support Indigenous women. Support (and increase) women's access to Indigenous-led yarning circles and mums and bubs groups. Examples include Ingham, Mackay and Rockhampton as well as Palm Island (with their FIFO services) and Thursday Island. Ask women and communities what they want and seek their feedback about the services available and the care they receive. Use their feedback to improve services.
Support graduate midwives to gain employment and be supported in rural positions	Support Midwifery graduates to relocate to rural & remote areas Expand the Rural Locum Relief Program to include midwives Remove the requirement for midwives to have a nursing degree to work in rural and remote services (this may require a review of how the workforce is structured/models of care as well as position descriptions and entry requirements being redefined) Recognise the Bachelor of Midwifery graduates as practice ready as any graduate.
GP's lacking comprehensive, contemporary perinatal knowledge	Midwife-led multi-disciplinary training Increase midwifery-led services to reduce load on rural GP's Rural maternity facilities can successfully be converted to midwifery led continuity of care services with improved outcomes (Durst et al 2016).
Lack of ongoing maternity services investment, reducing services and access options for women	Rural maternity services require investment for expansion and continuation of midwifery led models of care, specifically caseload midwifery Midwifery led models of care are cheaper to run and achieve better health outcomes, reducing health expenditure.
Professional Development duration and location flexibility to suit midwifery workforce requirements (e.g. kids, school, accommodation)	Make short term placements at closest maternity service so that midwives can travel home on weekends Have placements funded by the Chief Nursing and Midwifery Office and not individuals or small maternity units, so that it is equitable to all. If exchange programs continue, ensure the program covers salary as well as travel and accommodation (as required). Midwives may have family or friends they can stay with and therefore do not require funded accommodation.
Rural Midwives have less allocated Professional Development support than Rural GP's	Increase rural midwives PD supported hours to be similar to rural medical officers.
PD is not always midwifery or maternity specific. Can be very	Rural and remote up skilling programs need to be relevant and responsive to the individual needs of each midwife.

generalised and not meet midwives needs.	
Address reducing numbers of midwives with practising certificates in rural areas	Increase support and funding of midwifery models of care Support midwives to access admitting rights and collaborative agreements with health facilities (support the recommendation in the MBS Taskforce review for the removal of collaborative agreements for Midwives)
Rural midwifery mentors	Identify ways to tap into and utilise existing midwifery knowledge bank in rural and remote areas, especially where the individuals are no longer registered as midwives e.g. in educator or training roles, retrieval services Queensland (RSQ) and or tele emergency medicine support unit (TEMSU)

Submitted by: Ruth King, Acting CEO/Midwifery Advisor, Australian College of Midwives

Ruth.king@midwives.org.au | 0408 618 227

References:

AIHW 2018. Perinatal deaths in Australia: 2013-2014. Cat. no. PER 94. Canberra: AIHW

Medley N; Vogel JP; Care A; Alfirevic Z, 2018. Interventions during pregnancy to prevent preterm birth: an overview of Cochrane systematic reviews. Cochrane Database of Systematic Reviews, Issue 11, Art. No.: CD012505. Viewed March 2019, https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012505.pub2/full

Sandall, J; Soltani, H; Gates, S; Shennan, A; Devane, D. 2016. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews, Issue 4. Art. No.: CD004667. Viewed March 2019, https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004667.pub5/full (2016) & The Lancet Series – Midwifery, 2014. Viewed March 2019, https://www.thelancet.com/series/midwifery

Durst, M., Rolfe, M., Longman, J., Robin, S., Dhnaram, B., Mullany, K., ... Barclay, L. (2016). Local birthing services for rural women: Adaptation of a rural New South Wales maternity service. *The Australian journal of rural health*, *24*(6), 385–391. doi:10.1111/ajr.12310 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5215449/