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NB: In the text of the report reference is made to the general concept of a Statewide Obstetric Service, the Minister has indicated his support for the implementation of this recommendation by establishing a unit to be called the Statewide Obstetric Support Unit.

WESTERN AUSTRALIAN STATEWIDE OBSTETRICS SERVICES REVIEW

REPORT OF THE PROJECT WORKING GROUP

'an integrated maternity service,a new way forward'

DISCUSSION PAPER APRIL 2003

PROPERTY OF THE DEPUTY DIRECTOR GENERAL OF HEALTHCARE: DEPARTMENT OF HEALTH WESTERN AUSTRALIA

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WESTERN AUSTRALIAN STATEWIDE OBSTETRICS SERVICES REVIEW

REPORT OF THE PROJECT WORKING GROUP OCTOBER 2002

EXECUTIVE SUMMARY

Against a backdrop of intense and often critical media coverage, describing issues such as the Douglas Inquiry, rural Obstetricians withdrawing services, shortages of Midwives and units being forced to close down as staff could not be found, I was asked to convene a service review from a clinician's perspective. The immediate goal was to provide a vision of *a new way forward* that reaffirmed the important role of obstetrics in the community. A way forward that considers the rights, diversity and cultural dignity of the consumer to be paramount.

A culturally diverse community, increasing 'suburban sprawl' in Perth, financial constraints and changing consumer expectations also indicate a need to rethink how services are delivered to best benefit the community. In this thinking we need to be very aware of the international competition for our skilled workforce and the fact that this will increasingly challenge what can be achieved and what can be sustained into the future.

To assist the reader it is important to view the issues and recommendations in context. In 2001 there were 24,932 registered births, in Western Australia; 19,371 births in Perth, in a mix of 19 public and private hospitals. Public hospitals accounted for 10,394 births and private hospitals accounted for 8,977 births. There were 146 homebirths of which 112 were in Perth. In 2001, there were 5,415 private and public registered births, delivered in 30 country hospitals.

In December 2001 the Statewide Obstetric Services Working Group was established by the State Health Management Team to review Obstetric (Childbirth) services provided in public facilities in Western Australia. The Working Group was convened with representatives from the disciplines of Obstetrics, Midwifery, Neonatal Paediatrics, Anaesthesia, Allied Health, and General Practice. University, College, Rural and Metropolitan Consumer representatives were also included in the Working Group to provide balanced advice and input. (Appendix 1.)

The Terms of Reference of the review were; *to address issues relating to provision of public hospital birth services; to ensure optimum safety and efficiencies of services, review current and five year predictions for human resources requirements; review birth practices and procedures and identify and recommend areas for improvement with specific regard to adoption of standard protocols; indications for secondary and tertiary referral and training of staff and to review and recommend a system of clinical governance committees for birth.*

A literature review was conducted to help formulate a balanced set of principles that would support quality and safety principles, whilst acknowledging the unique circumstance of Western Australia. The first approach to make sense of this broad brief was to commence a series of site visits to make personal contact with the people who provide this care on a daily basis across the state. It also gave me the opportunity to reassure them that

their issues were going to be heard and that I would undertake to promote their concerns to the reader in this report. As the Chair of the Working Group I wish to thank all the people who assisted me with their time, contributions and support.

It was evident from the start that the practical reality in rural and particularly remote Western Australia was always going to be unique. The ability to adapt to the local conditions, maintain access to skilled staff and modern facilities and the huge challenges presented by a vast and diverse state, where a regional hospital may be many hundreds of kilometres from home, will always require innovative solutions. The site visits served to reinforce to the Working Group the need to maximise support for rural Western Australians, in isolated and remote communities. In the remoter areas where Aboriginal communities access the mainstream services of the State, the relationship between Aboriginal customary practices and the medical model, illustrates one of the real challenges of practice in Western Australia.

The myriad of issues relating to staffing levels, recruitment and retention strategies, indemnity, accountability and responsibility demands, capacity of work conditions to match service requirements and the need to effectively and efficiently integrate services on a state wide basis, were raised by the health care professionals.

To promote a system that seeks to attain excellence, the establishment of a linked network is needed to integrate training, education and research. The creation of Academic positions will further enhance the professional development of practitioners. Then, there is an urgent need to address key issues for practitioners such as financial support, recruitment and retention strategies, service funding, enhanced roles and better recognition of the results being achieved. Furthermore there is a need to invest in obstetric services and facilities to achieve the necessary changes, enhance job satisfaction and form a linked network of Obstetric Governance committees, to undertake a consistent approach to quality and safety.

The literature review suggests that clinical safety, quality, efficiency and effectiveness guidelines require determination of clear indicators of minimum births numbers where capacity to service exists and determination of travel time when a practitioner is recalled for urgent duty. These definitions can then be used as a basis for planning and the capacity of hospitals to provide safe services, optimal numbers of deliveries; resultant equipment needs, teaching capacity, professional development and staff coverage.

The Integrated Obstetric Services Model describes and defines the key roles and responsibilities for a Country Local Hospital, Country District Hospital, Secondary Hospital / Regional Hospital and Tertiary Hospital. The capacity of each centre to deliver services needs to be clearly defined to prevent inappropriate intervention, where facilities and expertise is not readily available.

The model outlined for the Perth metropolitan area when applied to sustain a safe, quality, efficient and effective service, shows that to achieve economies of scale and critical mass, it is advised that fewer Secondary Obstetric units will be required. Fewer units would better utilise the available Obstetricians, Anaesthetists, Paediatricians, Midwives and Allied Health staff. In addition this would also make better use of Level 2 nurseries, on-site Imaging, Pathology and specialised equipment. Fully staffed units can absorb greater numbers of patients with minimal adjustments to staffing ratios. Busy units that operate to

full capacity, provide greater professional development through caseload and diversity. It is recommended that the model is endorsed by the State Health Management Team and then applied to all public facilities and beds offering public obstetric services.

It is essential that a coordinating body to implement recommendations is established. The core role would be to identify the linkages between sites, act as a central reference point and help to overcome barriers to better assist the management of a state wide approach to obstetric service provision. A service is required that will ensure that support for those special individuals who practice obstetrics, especially those who choose to practice outside metropolitan Perth, is there to assist with linkages and issues resolution. This new body yet to be established has a high level of clinician support.

The implications of a failure to change could be that in the future we may see another Inquiry into Obstetric service delivery. The costs in both human and financial terms would be better met by pro-active investment now.

In summary, if the principles and recommendations contained in this report are adopted, it will create in Western Australia, a service of excellence that will attract and retain quality staff. It is also hoped that this report, which is to be considered as a starting point, will stimulate discussion and change as we examine and debate the best way forward for the future. The future requires an integrated service that supports its health professionals, linked by a centre of Statewide focus, which incorporates education and research in a culturally sensitive and multi-disciplinary approach. This change needs to be sensitive, staged and incremental. Then as a result, the community will benefit and be proud of its excellence in childbirth services.

Dr Harry Cohen, AM
MB, BS, FRCOG, FRANZCOG.
Chair
Statewide Obstetric Service Review.

LIST OF RECOMMENDATIONS

RECOMMENDATION 1: ENDORSEMENT OF SERVICE MODELS

That the proposed Integrated Obstetric Services Model and the Metropolitan Obstetric Services Model, that are both based upon minimum safety and quality requirements, are established and implemented.

RECOMMENDATION 2: CHIEF MEDICAL OFFICER CLASSIFICATION

That the Chief Medical Officer endorses the models and directs that the recommendations are applied to all facilities and beds offering public Obstetrics Services which are then classified accordingly and that services not meeting minimum standards or numbers of births may be withdrawn.

RECOMMENDATION 3: CLINICAL GOVERNANCE

That each obstetric unit must be involved in and linked to, a functioning clinical governance committee, that meets standards set by the Chief Medical Officer.

RECOMMENDATION 4: STATEWIDE OBSTETRIC SERVICE

That a Statewide Obstetric Service is established, supported and funded as a matter of priority.

RECOMMENDATION 5: CONSUMER EDUCATION

That education regarding the choices and associated risks in obstetric service provision to childbearing women, is promoted in a culturally sensitive way, in the community by publication, Internet and information handouts.

RECOMMENDATION 6: CONSUMER LINKAGE

That an information service is explored and linked to a telephone service and an Internet Web page, is established to enable the woman and her family to 'check the facts' and information they may have heard, or been given regarding pregnancy, labour, birth and the postnatal period.

RECOMMENDATION 7: WORKFORCE ISSUES WORKING GROUP

That the Health Department and Statewide Obstetric Service analyse workforce issues and recommend options for solutions to the State Health Management Team.

RECOMMENDATION 8: ENHANCED ROLE OF THE MIDWIFE

That the '*Enhanced Role of the Midwife'* is implemented as a priority.

RECOMMENDATION 9: MIDWIFERY

There is an urgent need for the Statewide Obstetric Service to conduct a review of training, support and develop methods of attracting and retaining Midwives in the speciality of Midwifery, in conjunction with the relevant colleges.

RECOMMENDATION 10: OBSTETRICIANS

There is an urgent need for the Statewide Obstetric Service to conduct a review of training, support and methods of attraction to bring and retain doctors in the speciality of Obstetrics, in conjunction with the relevant colleges.

RECOMMENDATION 11: ANAESTHETISTS AND GENERAL PRACTITIONER ANAESTHETISTS

There is an urgent need for the Statewide Obstetric Service to review incentives, availability and methods of attracting Anaesthetists and GP Anaesthetists to provide Obstetric Anaesthetic services.

RECOMMENDATION 12: ALLIED HEALTH

That the Statewide Obstetric Service undertakes an analysis to determine the quality guidelines and obstetric credentialling requirements and service demand for Allied Health staff.

RECOMMENDATION 13: MOTHER AND BABY UNIT INTEGRATED

That the mother and baby unit is transferred from Graylands Hospital to King Edward Memorial Hospital as soon as possible.

RECOMMENDATION 14: GENERAL PRACTICE OBSTETRICIANS

That the Statewide Obstetric Service formulates and implements a plan to ensure that General Practitioners are encouraged to pursue the speciality of Obstetrics and support General Practitioner Obstetricians to maintain involvement, training and credentialling.

RECOMMENDATION 15: PRACTITIONER EDUCATION & TRAINING

That a comprehensive education and training program is developed by a Working Group, to fully describe the requirements and identify the linkages across disciplines.

RECOMMENDATION 16: CLINICAL ACADEMIC TITLES

That Clinical Academic titles are appointed and located at Secondary and Regional Hospitals. This would include the establishment of a Professor of Midwifery.

RECOMMENDATION 17: ACADEMIC EDUCATION AND RESEARCH CENTRE

That a master service-plan is completed to facilitate the establishment of a new Academic and Research centre in close proximity to the Tertiary services.

RECOMMENDATION 18: BUSINESS CASE FOR FUNDING

That business cases that identify the costs in relation to a Statewide Obstetric Service, an Education and Research facility and hospital and staff accommodation upgrades are prepared for the budgetary consideration of the State Health Management Team, as soon as possible.

WESTERN AUSTRALIAN STATEWIDE OBSTETRICS SERVICES REVIEW

REPORT OF THE PROJECT WORKING GROUP OCTOBER 2002

1. INTRODUCTION

Obstetrics, for the purpose of this paper, is defined in a general context to include care provided from preconception to six weeks post pregnancy, with some disciplines such as Paediatrics, Psychological Medicine and Allied Health providing follow up care over a greater period of time. All relevant disciplines collaboratively providing the Obstetrics services are collectively referred to as practitioners. The aim of the review has been to develop an 'in principle' approach, based upon a quality and safety framework, which can be used when implementing the recommendations contained in this report.

The Obstetric Services Working Group first met in December 2001, to review public Obstetric services on a state wide basis. The Working Group, was formed by and reports to the Clinical Reform Sub-Committee and recommendations are tabled for the further consideration and action of the State Health Management Team.

The group comprised representatives from the disciplines of Obstetrics, Midwifery, Neonatal Paediatrics, Anaesthesia, Allied Health and General Practice, as well as Department of Health, Consumer, College and University representatives (Appendix 1).

A number of relevant reports such as the Report of the Ministerial Task Force to Review Obstetric, Neonatal and Gynaecological Services in Western Australia (1990) were considered. It was evident that there were recurrent themes that emerged, that remain of relevance today. This indicates a significant commitment of resource and time needs to be invested into Obstetrics Services, to allow adoption of world's best practice. Additionally, the group has had access to material sourced from interstate and overseas. A list of references is appended.

The number of births has been remarkably stable in Western Australia in recent years and no significant growth is predicted (Table1). In 2001 there were 24,932 registered births of which 5,415 were managed in 30 country hospitals across the state. There were 19,371 births in the Perth metropolitan area in a mix of 19 public and private hospitals, of which 10 provide public births. These births comprised 10,394 in public hospitals and 8,977 in private hospitals. Homebirths numbered 146, with 112 being in the Perth metropolitan area (Table 2). A list of the number of births per hospital within Western Australia in the year 2001, is found in Appendix 2. A map of the number of births per region is included in Appendix 3.

Table 1. Number of births in Western Australia from 1997 - 2001

Frequency	Metro Hospital	Country hospital	Homebirths	Total
1997	19317	5778	172	25267
1998	19801	5774	106	25681
1999	19882	5761	128	25771
2000	19497	5609	123	25229
2001	19371	5415	146	24932
Average	19573	5667	135	25376

Table 2. Breakdown of the number of births in Western Australia 2001

	Metro	Country	Total
Public hospital	10394	4911	15305
Private hospital	8977	504	9481
Homebirths	112	34	146
Total	19483	5449	24932

The last decade has seen significant changes in the way obstetric care is delivered in Western Australia. The changing needs and expectations of Western Australian women during the antenatal, labour, birth and post natal periods, has highlighted the need for an integrated approach, based on clearly defined and monitored best practice guidelines and quality improvement initiatives.

The myriad of issues relating to staffing levels, recruitment and retention strategies, indemnity, accountability and responsibility demands, capacity of work conditions to match service requirements and the need to effectively and efficiently integrate services on a state wide basis, were raised by health care professionals.

The confidence of consumers and practitioners has been challenged by the findings of the Douglas Inquiry and the subsequent media attention. This only reinforces the need to effect system wide changes by coordinated planning and appropriate resource commitment.

One aim of the review was to faithfully represent the practitioners' view of the best models of care for the Western Australian circumstance. Clinicians are weary of their concerns not being met and report a high level of burnout and cynicism about commitment to change and reform. This process of review has rekindled a sense of optimism that the government and senior health administration professionals are actively listening to what the practitioners have to say. Their optimism needs to be supported by realistic and achievable outcomes. This approach will go a long way towards reversing staff attrition trends and

making Western Australia a highly desirable work location.

It needs to be acknowledged that individuals and teams have continued to provide exemplary service and demonstrate a high level of personal and professional commitment. The Working Group wishes to formally acknowledge the high quality of care provided on a day to day basis, by the health professionals involved in obstetric service delivery. The ultimate benefactor of a renewed confidence and optimism that improvements will occur, will be the community of Western Australia.

2. THE REVIEW

2.1 BACKGROUND

The Obstetric Services Working Group (hereafter referred to as the Working Group) was commenced as part of a broad review of clinical services established in late 2001, for the Western Australian Department of Health's State Health Management Team.

2.2 VISION

The vision is of an integrated state wide public Obstetric service, established on evidence based best practice, that provides safe and responsive, culturally sensitive care, in an environment that nurtures, develops and supports the workforce and community of Western Australia

2.3 AIM AND PURPOSE

The aim of the Working Group was to develop a model that defines best practice principles of quality, clinical safety, efficiency and effectiveness and recommend future strategic initiatives. The purpose of the review group was to ascertain the current status of Obstetric services in Western Australia and to make recommendations for future strategic initiatives. This innovative approach was aimed at gaining consensus and key support from clinicians to own a model that they will support.

2.4 TERMS OF REFERENCE

i. To review the current provision of Metropolitan (and country public) hospital birth services (antenatal, delivery and postnatal) with a view to ensuring optimum safety and efficiencies of services.

ii. To review the current staffing requirements for birth services and make recommendations to address any current or future deficiencies.

iii. To review current birth practices and procedures. Identify and recommend areas for improvement with specific regard to adoption of standard protocols, indications for secondary and tertiary referral and training of staff.

iv. To review and recommend a system of clinical governance committees for births.

3 METHODOLOGY

The Chair of the Working Group accompanied by the Director of Midwifery, King Edward Memorial Hospital (Working Group member), visited most Obstetric services in the metropolitan and country areas. The aim of the site visits was to outline the Terms of Reference of the Working Group and to have face to face discussions with key people involved in the provision of Obstetric services. The approach was to meet with Health Service Managers, senior Clinicians and 'coal face' practitioners, to gain a true picture of needs and local issues. A summary of key issues and findings is included in Appendix 4.

The purpose of the visits was to ascertain as much information as possible about the various centres. A detailed survey had either been forwarded to the group or handed to them at the time of the site visit, to be subsequently filled in and returned. The survey examined a range of information about the services provided. During the visits it became obvious that there were a number of general concerns which seemed to go across the board in both metropolitan and country centres. There were also a number of issues specific to the particular hospital/district.

Other key groups with clinical involvement, not represented on the Working Group, were also consulted or utilised as a source of reference. The methodology used included:

- Regular meetings of the Working Group and its sub-groups
- Workshops to develop a state wide obstetric data matrix and to collate and examine current issues.
- Canvassing of Allied Health Practitioners for their input
- Reference material sourced, collated and reviewed
- Consultation with the Clinical Reform Sub-Committee of the Department of Health
- Analysis of WA Midwives' Notification System data

To ensure wider consultation outside of Working Group representation, the following bodies were approached:

- Perinatal and Infant Mortality Committee
- WA Centre for Remote and Rural Medicine (WACRRM)
- Rural Clinical School
- Royal Australian and New Zealand College of Obstetricians (RANZCOG)
- University Department of General Practice, University of Western Australia

3.1 CURRENT SERVICE ISSUES RAISED BY PRACTITIONERS

The current service issues gained from the direct and written practitioner survey were recorded and grouped into six key areas. The comments have been summarised and are detailed below. These concerns do not necessarily denote consensus between all practitioners. Some issues may be relevant to a specific site or discipline. This list is not exhaustive and key issues are raised as points in the Discussion and Recommendations, Section 7.

3.1.1 MODELS OF CARE AND PRACTICE ISSUES RAISED

The variety of Models of Care in practice at present emphasises the need to explore and evaluate a wider range of service models for best practice opportunities and options for consumers' choice. This will enhance satisfaction and professional interest not only for all disciplines, but also the consumer. Issues raised by practitioners are listed below.

Midwifery

- ♦ Midwives express a strong interest in Midwifery led care consistent with international models. This includes them being involved with women from preconception to the post partum period. In particular there is an interest in the greater involvement of midwives in the provision of antenatal care.

- ♦ Midwives express a strong interest in the growth and development of Birth Centres (see Section 4.1) at key locations with adequate backup and support.

Medical

- ♦ Changing role and practice delineation between Doctors and Midwives as a result of the enhanced role of the Midwife and potential overlap, is raised as an issue of significance that doctors are keen to see discussed and clarified.

- ♦ Sharing antenatal care with Midwives is raised as an issue for General Practitioner Obstetricians.

- ♦ A concern raised by Doctors is that the role delineation between Midwives and Nurses is preventing 'step down' transfer to a low care facility especially for women from smaller centres.

Allied Health

- ♦ It was raised as an issue that Sonologists need to contribute to the development of an optimal use model of Ultrasound Scanning.

- ♦ Credentialling of Allied Health practitioners with specialised skills in women's health

was raised as a practice issue.

- It was raised that there should be appropriate allocation of Allied Health staffing to correspond with levels of obstetric service demand.

- Allied Health practitioners suggested that acute obstetric care, should be funded for a 7-day per week service to ensure equity of access to optimal care.

- Allied Health Professionals expressed a need for designated senior obstetric positions to ensure optimal level of expertise and care.

General issues raised that relate to models of care and service practice.

- It was raised that the introduction of Handheld Antenatal Record will facilitate linkage of care for women. This documentation initiative has been showing positive results where trialed and practitioners express an interest in its ongoing use.

- It was raised that computerised records in doctor's offices may ultimately replace paper records and this may impact on the decision to use Handheld Antenatal Records.

- Flexible and localised access to parent education was an issue that was raised. The view being that improvement could be made, particularly in country areas.

- Midwives in Private Practice requested a review of access arrangements to hospitals.

- General Practitioner Obstetricians raised that Specialist Obstetricians may have a "comprehensive pregnancy approach" or an "on call for high risk patients or difficult deliveries only" attitude.

3.1.2 WORKFORCE ISSUES RAISED

- The need to enhance practitioner job satisfaction and flexibility in rostering was raised. Other key issues raised include: innovation in models of care, greater access to learning opportunities, supported by rostered leave and better support to reduce the risk of burnout.

- The issues of rostering, access to beds, involvement in normal births, indemnity as a disincentive and concerns about being excluded from planning and management decision making, were also raised.

- Public sector doctors raised General Practitioner Obstetrician credentialling, rosters, indemnity, governance, support, teaching commitments and role delineation of midwives as key issues of concern that require clarification.

- Generally, staff raised that the increased demand for administration and 'paperwork' competes with practitioner time spent on clinical care and should be examined to streamline process and avoid repetition. Improved and accessible Information Technology is raised as one solution to assist this process, together with clinical

pathways.

- Constantly changing consumer expectations, a higher level of patient complaint, practitioner fear of litigation, voluntary disclosure leading to legal action and increasing indemnity insurance premiums, were raised as contributors to workforce stress, attrition and act as a barrier to recruitment and retention.

- The need to fund and staff a specialised unit to provide peer support training and critical incident support and debriefing following adverse events, was also raised as a critical issue. The rising incidence of aggression in the workplace was raised and must be addressed to minimise the risk and increase the support to staff.

- Many staff expressed a need for funded *Family Friendly* policies to be adopted in Health Services (ie. provision of crèche facilities). The need for Senior Clinical Managers in all disciplines to adopt flexible rostering practices was also raised.

- It was also raised that there is a lack of positive reinforcement for both individuals and teams.

- It was raised that the Department of Health, Royal Street 'is out of touch' with what is really happening in the hospitals and that their concerns are 'not being heard' or acted upon.

- Concerns regarding the aging workforce were also raised as an impending crisis.

- It was also raised that improvements could be made in collaboration and communication between individuals, teams and disciplines in service planning.

3.1.3 WORKFORCE FINANCIAL ISSUES RAISED

- Numerous issues were raised by practitioners that related to salary and qualification increments that were industrial in nature.

- Midwives identified that after undertaking midwifery training at considerable personal cost, they gain virtually no financial recognition upon graduation.

- Many practitioners raised the issue of a lack of standardised payment of medical practitioners across Health Services as a concern. They were requesting a more open and equitable system.

- The indemnity issue, topical in the press at the time of the report, exacerbated by the collapse of United Medical (UMP) was raised. To offset indemnity costs, many doctors who provide a combination of public and private practice, raised the view that the government should extend the insurance umbrella to offset spiralling costs, as other states have done. A concern was also raised that the increasing costs will drive private practitioners and salaried General Practitioners from obstetric practice, resulting in subsequent service gaps. A brief summary of the indemnity crisis and its effect on Obstetric services detailing the key issues is attached. (See Appendix 5)

- The way the Medicare fee structure is determined at present, was also raised as an issue that constrains models of care, rather than reflecting client needs. The current mode of payment encourages General Practitioners to marginalise midwives in Antenatal Care as a competitor rather than as a mutually complementary service.

- The impact of the Federal changes creating financial penalties for people taking up private health insurance in advanced years, was raised. There is an expectation that a shift in demand for services from the Private to Public sector will occur and that it will result in additional unfunded workload demand in the public sector.

- Lack of adequate funding of outpatient services, where provided, for treatment of morbidity associated with childbirth was raised.

- The need for midwives to be acknowledged through Medicare as a viable option for funded maternity care, was raised.

3.1.4 SERVICE FUNDING ISSUES RAISED

- Issues were raised that services were funded differently across sites with the perception of some 'richer' sites and some 'poorer' sites. This mismatch of funded services is a concern to practitioners.

- The overall standard and age of facilities to afford privacy to the client and provide an optimal work environment for practitioners, was raised. It was generally felt that Obstetrics has not attracted significant funding and investment despite the nature of the speciality and its high profile in the community.

- The need for coordinated, timely and appropriate equipment funding and replacement program development, was also raised as an issue. Many units describe dependency on volunteer fund raising to for even basic improvements.

- The current issue of Commonwealth/State funding arrangements impacts on the way services are provided and may determine the approach to care. It was also raised as an issue that if Federal funding for health initiatives was recurrent following effectiveness and efficiency evaluation, then this would improve the ability to manage a coordinated program.

3.1.5 EDUCATION AND TRAINING ISSUES RAISED

- Issues that relate to access to professional and in-service education and training were raised by all disciplines. Time off rosters due to staffing demands was raised at all sites. The need to backfill staff or allow sufficient staffing levels so that staff could be released without compromising patient safety, was raised as a key issue.

- General Practitioner Obstetricians expressed a strong interest in the opportunity to access ongoing education and up-skilling opportunities that could be provided by the public hospital sector.

- The availability of a suitable central training venue that includes a lecture theatre and library for the speciality, was raised as a need by staff. The high cost of training being met by units was raised as a barrier to access by many staff.

- Practitioners raised that there is a need to involve the consumer in education. Of particular importance was the need to pro-actively target the consumers in pre-conception care and education. The need for Aboriginal Health Care workers to be involved in maternity care was also raised.

- Ongoing training and credentialling was an issue raised by all disciplines. The lack of coordinated professional development to keep up to date with changes in practices and technology was raised. Staff also raise Telehealth as one solution to assist learning.

3.1.6 INFORMATION MANAGEMENT ISSUES RAISED

- Good information transfer and management was seen as being essential to Clinical Governance. It was felt that state wide coordination and dissemination of policies on the Intranet would assist Governance.

- It was raised that 'Handheld Notes' that are currently being trialed at some sites will improve communication and patient management.

- It was raised that there are poor IT systems and replacement plans in many sites and in particular this issue was raised by the rural and remote practitioners.

4 CURRENT SITUATION

The current models of care in Western Australia reflect the diversity of approach in Obstetric practice. These models of care are described below.

4.1 CURRENT MODELS OF CARE

Practitioner discussion and feedback was utilised to review the various models of care in use at present. For example, a small group that included an Obstetrician, Midwife and General Practitioner met with the Chair of the Working Group to discuss ways of improving General Practitioners Obstetricians involvement in the various models. Another approach was to form a small reference group to discuss Rural Guidelines by 'teleconference'. It is felt that groups like this should continue to meet and feed in information, to form a whole of state view. The application of service models of care are constantly adapting and changing. Since the Working Group started meeting, the situation and therefore models of care at Osborne Park Hospital, Swan Districts Hospital and Armadale Hospital have changed.

It highlights a need however, for an audit and review of the models in use to determine their strengths, weaknesses and suitability. The findings of this audit and review can then be shared to improve learning, address deficiencies and promote new opportunities for the multi-disciplinary team approach. There are various models of care in use in public practice in metropolitan and rural Western Australia, these include:

- The traditional hospital based Specialist Obstetrician led care
- Midwife led care (e.g. Family Birth Centre; Midwifery Community Program.)
- General Practitioner units without local specialist support.
- Low risk patient antenatal clinics (e.g. General Practitioner Obstetrician/ midwife clinics.)
- Visiting medical officer (fee for service) model, where the antenatal care occurs outside the hospital, usually in the obstetrician's practice.
- Shared care involving GPs or midwives.

There are advantages, disadvantages and preferences for each model. All models of care require adequate backup and support. It is important to recognise that the introduction of alternative models of care may impact on existing services, especially in rural settings where midwives are also employed in other hospital care and General Practitioner Obstetricians may have difficulty achieving the competency requirements of the hospital's accreditation committee.

Consumer interest for women to have a choice of giving birth in an ambient homely non-clinical environment is high. The environment described as a Birth Centre is one where partners, children and families can have involvement and access. These centres are for low risk planned births and can be safely conducted by midwives, with on site access to medical and specialist emergency backup. This close call support ensures that risks of adverse events through unsupported emergency are minimised.

Similar models have proved to be successful at Woodside and King Edward's Family

Birth Centre over a number of years. The opportunity exists for a much wider application of this model and it is the view of the Working Group that similar units should be available, so that the community can access these choices closer to home. Midwives also demonstrate a strong preference to work within models that provide care for the woman with an uncomplicated pregnancy, birth and postpartum period. The 'Birth Centre' concept where adequate backup and support is available, would address this preference for the enhanced professional practice of midwives.

There is a need to fully explore a model of 'shared care' and access for General Practitioner Obstetricians. Shared care, recognises that the General Practitioners provide ongoing care, that may extend over more than one pregnancy and adopts a 'whole of life approach', that maintains support for mothers and children. The role of the General Practitioner and the Midwife in the provision of care in the home is an area that certainly requires further development and consultation. The concept of the 'seamless hospital' needs to be promoted and supported in the community.

The evaluation of customary Aboriginal birth practices and how they can be accommodated into mainstream clinical practice models, should be undertaken. This will require the development of a collaborative relationship that recognises the legitimate choices for Aboriginal women. This aim must be balanced with the achievement of safe models that minimise harm for the mother and baby and that consider the experience base of the locally accessible practitioners.

All the models of care need to be explored, piloted and evaluated on a state wide basis. This is a role that a Statewide Obstetric Service could undertake. This would assist in the dissemination of models across the state, so that information is shared and outcomes are positive.

4.2 CURRENT SERVICE ALIGNMENT

Issues relating to where services are currently provided and the impact on practitioners by stretching scarce resources across many sites, are also raised. A sustainable service requires critical mass that will ensure quality and safety practice guidelines are met. At present training and staffing of units is difficult given the shortage of Obstetric practitioners across the state. The consolidation of units would allow a greater opportunity to create stronger more stable teams, freeing financial resources for improvements.

The issue of step down facilities especially in smaller communities would need a coordinated approach between the Midwifery Manager for the region and may involve the use of local midwives if resident or the development of an outreach program using local professionals. This would of course require some credentialling process to occur.

The current location of obstetric services in the metropolitan and country areas need to be linked to planning to ensure service requirements are able to be sustained. A service with sufficient flexibility to support the creation of stronger teams, in fewer units, will allow an effective and efficient critical mass to develop.

5. EVIDENCE BASED RESEARCH

Following the consultative process, as described previously, a review of literature was commenced. It was apparent that research relevant to a large, isolated and sparsely populated State (a land mass of 2,527,633 square kilometres) is still required. Reference was made to recommendations made in numerous reports. Of particular note were the recommendations of the Royal College of Obstetrics and Gynaecology in the United Kingdom (1999), which described guidelines and minimum standards to inform decision making for service delivery. In particular the guidelines relate to Category B Obstetric units that deliver 1000 – 4000 births per annum and Category C (Tertiary Referral Centres) units that deliver more than 4000 births per annum. These descriptors closely follow the Secondary and Tertiary Obstetric services units in the West Australian context.

They further define the level of associated Consultant cover in relation to a unit's capacity to deliver births as units delivering less than 1000 births per annum and units delivering 1000 – 4000 births per annum require 'supervisory' consultant cover within 30 minutes. The Category C units require 'full' or 24 hour consultant cover. This has application for the tertiary facility in Perth. The Royal College of Obstetricians and the Royal College of Midwives have produced significant, well-researched and presented reports to identify safe practice guidelines. There is a need to apply the research and experience and determine a clear set of guidelines for Western Australia, in this matter.

The literature and worldwide experience supports defined requirements for safe and quality practice and classification of Secondary hospital's capacity to deliver obstetric services. Secondary hospitals need to include dedicated specialist staff such as an Obstetrician, Paediatrician; Anaesthetist/GP Anaesthetist supported by a dedicated after hours on call roster and 24 hour junior Medical Staff cover. The capacity of a hospital to safely provide elective and emergency Caesarean sections, is directly correlated to staffing and facilities. These hospitals should be able to effectively manage a low dependency neonatal unit for infants born who are of 34 or more weeks gestation. A recent study in Germany of over 582 000 births, over a nine year period has shown that birthweight specific mortality rates were highest in smaller delivery units and lowest in large delivery units

Another critical indicator that was researched, was the need to clearly define a guideline for recall availability of key practitioners. The Victorian Department of Human Services in their report 'Measuring Maternity Care' (2001), discusses the need for more research to determine decision to delivery times. The Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives in their report, 'Towards Safer Childbirth', (1999) clearly set 30 minutes as a benchmark for the recall of consultants to provide available and supervisory care to obstetrics units. They further state that the anaesthetic response time for epidural pain relief should also be available within 30 minutes of the decision to proceed.

The expert opinion also indicates that Tertiary (Teaching) Hospitals, that incorporate the Secondary Referral capacity from the local population catchment, should have a critical mass essential for teaching, training and clinical practice. These capacities have implications for safe rostering practice, exposure to experience, team development and information sharing. The Douglas Inquiry into King Edward Memorial Hospital (2001) examined service delivery into the State's Tertiary Obstetrics hospital and made recommendations

regarding supervision, credentialling, audit, education, training, resources to improve quality and safety. A number of the recommendations contained in the report have direct application to state wide obstetric services.

The literature also supports the enhanced role of the midwife to undertake certain procedures and have a lead role in uncomplicated 'low risk' births. The Douglas Inquiry Recommendation 9.3.6 (Volume 1, p.xxxviii), relates to the care of women at low risk of complications. This recommendation states that midwives should coordinate the care of these women. The role of the professional Midwife is supported by the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives (1999) in care of a woman during 'normal' labour, recognising complications and working as a health team 'partner'. The 'Enhanced Role of the Midwife', a Western Australian Department of Health report, highlights the need to encourage greater role responsibility for midwives in the perinatal processes.

It was evident from an examination of the literature that there was little research of direct application to the unique Western Australian circumstance. This indicated the real need to commence research and data collection and collation to provide a basis for future studies and analysis. Key performance indicators to enable monitoring of care also need to be developed and analysed.

6. PROPOSED SERVICE MODELS

Following the review of current models of care, the literature and consideration of practitioner input, based on many years of collective clinical experience, the following model was arrived at. The model takes into account safety, staffing, efficiencies and economies of scale. The capacity of a hospital to deliver services to a predetermined level was then defined. This model is conceptual and based upon quality and safety principles in the first instance.

6.1 CRITICAL ASSUMPTIONS

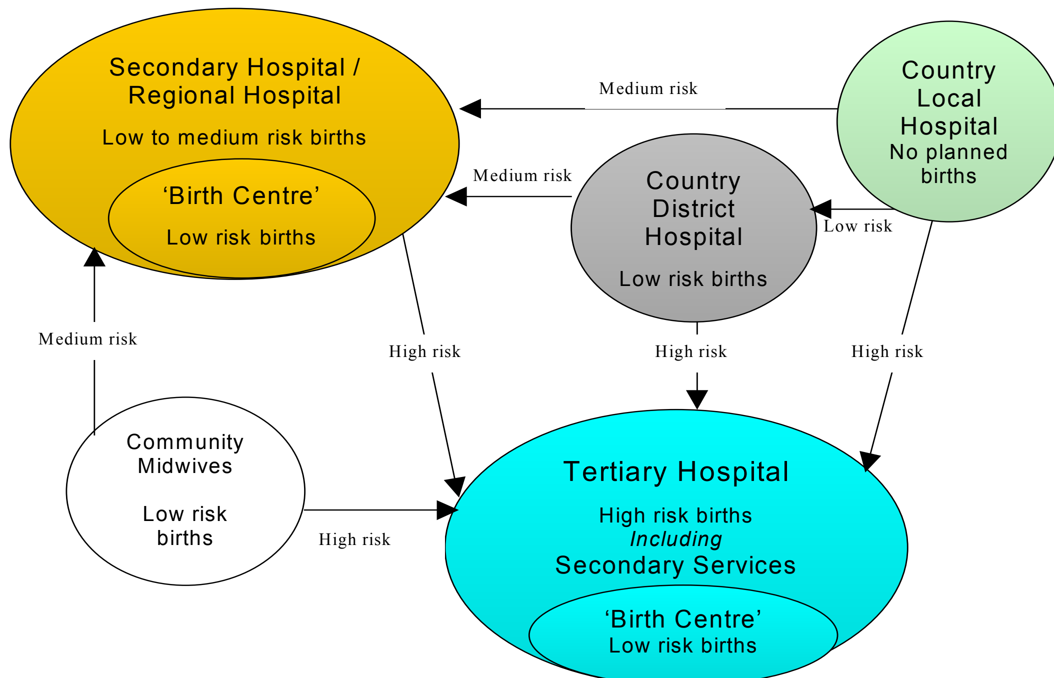
- Care should be provided as close to home as possible consistent with the risk assessment contained in the model.
- Hospitals will only deliver services consistent with a Secondary or Tertiary hospital role.
- The Tertiary Hospital also incorporates a Secondary hospital role to service the local catchment population.
- Risk is described as low (uncomplicated), medium (intervention maybe required) and high (potential for significant complication) and relates to transfer guidelines.

6.2 PROPOSED MODELS

The proposed *Integrated Obstetric Service Model* below (Diagram 1) presents the key service capacities of each level of hospital facility and provides a whole of state focus.

The *Integrated Obstetric Service Model* is then applied based upon the numbers of births, staffing levels and economies of scale to the public system in a Perth Metropolitan Model context. (In Section 6.2.2)

6.2.1 THE INTEGRATED OBSTETRIC SERVICES MODEL DIAGRAM 1



Referral sources

- Remote Area Clinics
- Population Health professionals
- General Practitioners
- Community Midwives
- Obstetricians
- Private hospitals

The obstetric service level of all hospitals is classified by the Department of Health Guidelines for Rural Obstetrics and Midwifery Services in WA. (Appendix 7)

Country Local Hospital (Level 1)

- Do not provide services for planned births
- Antenatal and postnatal care only provided by registered and appropriately credentialled Midwives and General Practitioners
- Midwife led outpatient services supported by visiting Allied Health staff
- Emergency support is available
- Appropriate care and support in the community. Recognition and collaboration with culturally significant birth practices, in particular, but not limited to, traditional Aboriginal childbirth practice.
- Defined equipment needs

Country District Hospital (Level 1A, or 1B)

- Where distance from another regional centre, size of population, or other determinants indicate the need, a hospital may provide for planned births.
- The occurrence of planned births in such centres will depend on factors such as the number of local births, local facilities, anaesthetic and surgical intervention facilities, time periods in relation to retrieval to other centres, staffing capabilities and determination from the Chief Medical Officer.
- Antenatal and postnatal care only provided by registered and appropriately credentialled

Medical Officers, Midwives, General Practitioners and Allied Health professionals.

- Midwifery led and visiting salaried specialist outpatient services
- Provides appropriate obstetric care and support in the community
- Defined equipment needs
- Birth centre model, practice approach, where appropriately supported by staff and facilities.

Country Regional Hospital (Level 2 / Includes Birth Centre)

- Daytime dedicated staff should be appropriately credentialled, supported by a dedicated after hours on call roster. All on call staff must be available at the hospital within 30 minutes of recall, as a minimum standard.
- 24 hour Medical staff cover
- GP and specialist Obstetricians outpatient clinics and rights of admission
- Appropriately designated Allied Health professionals as required
- Elective and Emergency Caesarean ability
- Low dependency neonatal unit for babies of more than 34 weeks gestation
- Appropriately credentialled services on site for Pathology and Imaging.
- Defined equipment provision
- Director of Nursing manages the Community Midwives program
- Appropriate discharge follow up
- Co-located Accommodation Units
- Regional country hospitals that deliver less than a thousand births will need to adapt the model based upon the operant constraints including retrieval times, travel time between towns and population demographics.
- Will manage the Birth Centre that include:
    - Midwifery led service for uncomplicated births
    - Home like / relaxed ambience
    - Provides for culturally sensitive practice

- Employs a variety of endorsed models of care
- Encourages and promotes General Practitioner Obstetrician's share care access
- Access to Allied Health services as required
- 24 hour midwife cover
- Return to home / assisted accommodation usually within 24 hours of birth (as practicable)
- Midwives provide community based follow up / or outreach service for women delivering at the centre
- Co-located on Country Regional Hospital campus
- Defined equipment needs

Metropolitan Secondary Hospital

- Daytime dedicated staff should include a Specialist Obstetrician, Anaesthetist, Paediatrician, Consultant or GP Anaesthetist supported by a dedicated after hours on call roster. All on call staff must be available at the hospital within 30 minutes of recall, as a minimum standard.
- 24 hour Junior Medical staff cover for teaching, training, research and service
- Director of Obstetrics on each site
- GP and specialist Obstetricians outpatient clinics and rights of admission
- Appropriately credentialled Allied Health professionals designated to obstetric services.
- Elective and Emergency Caesarean ability
- Low dependency Neonatal unit for babies born at greater than 34 weeks gestation
- Appropriately credentialled services on site for Pathology and Imaging.
- Defined equipment provision on site
- Appropriate discharge follow up
- Co-located Accommodation Units where indicated
- Minimum 1000 births per annum (including those delivered at the 'Birth Centre') for clinical safety best practice.

- Will manage the Birth Centre that include:
  - Midwifery led service for uncomplicated births.
  - Home like / relaxed ambience.
  - Employs a variety of endorsed models of care.
  - Caters for culturally sensitive practice.
  - Encourages and promotes General Practitioner Obstetrician share care access.
  - Access to Allied Health services as required.
  - 24 hour Midwife cover.
  - Return to home usually within 24 hours of birth, with Midwife community support and follow up.
  - Co-location on the Secondary Hospital campus for Emergency or complications support.
  - Defined equipment needs.

Metropolitan Tertiary Hospital

(Includes Secondary Hospital and Secondary Hospital Birth Centre functions)

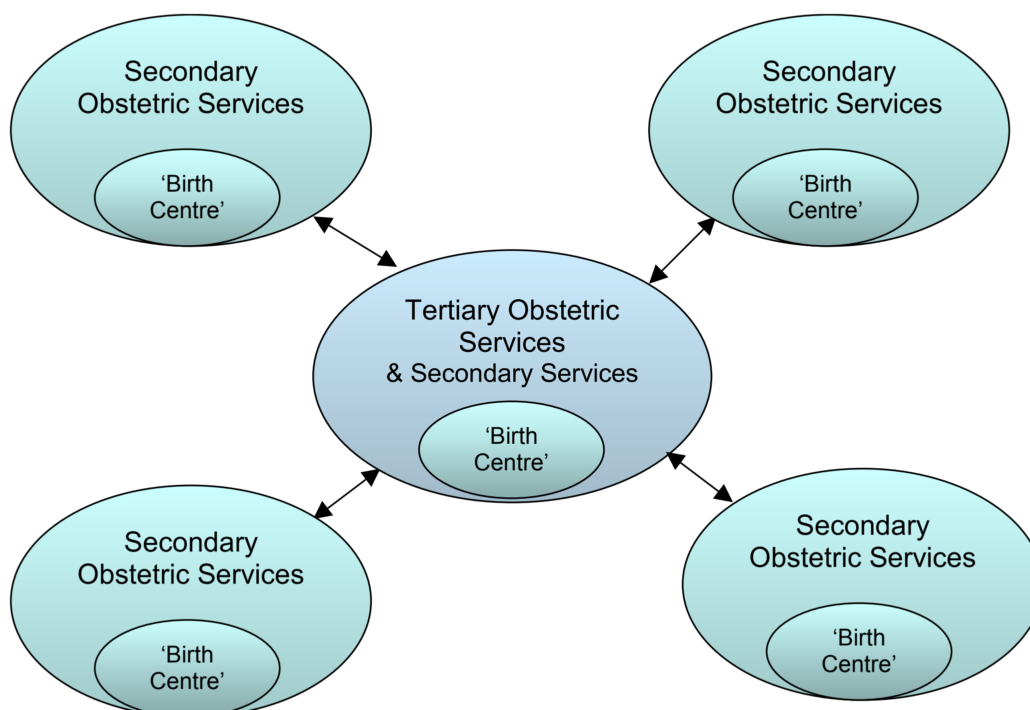
- Daytime dedicated staff should include a Specialist Obstetrician, Anaesthetist, Paediatrician, Consultant or GP Anaesthetist supported by a dedicated after hours on call roster. All on call staff must be available at the hospital within 30 minutes of recall, as a minimum standard.
- Teaching, training, research and service for all disciplines
- Full range of appropriately specialised consultants
- Full range of appropriately specialised Allied Health Professionals
- Specialist Genetic consultation, counselling and outreach service
- High dependency Neonatal unit
- State wide specialised services eg. maternal fetal medicine, perinatal loss service, chemical dependency, diabetes, adolescent, specialised outreach services
- Defined equipment needs
- Accommodation Unit for PATS family support members
- Director of Nursing manages the metropolitan Community Midwives program, which provides birth services for women choosing to birth at home.

6.2.2 METROPOLITAN OBSTETRICS SERVICES MODEL

(10,394 PUBLIC BIRTHS – 2001)

(MODEL SHOWS OPTIMAL NUMBER OF OBSTETRIC SERVICES)

DIAGRAM 2



The model above for the Perth metropolitan area applies the criteria described previously for Secondary and Tertiary Hospitals. It is apparent when applying *minimum* numbers required to sustain a safe, quality, efficient and effective service, that Perth should only sustain a maximum of five Secondary Obstetric units (more than 1,000 births) and one Tertiary hospital (more than 5,000 births). To achieve optimum safety, economies of scale and critical mass, it is advised that four Secondary units delivering 1,500 births per annum provide for better birth per practitioner ratios.

The Tertiary hospital at present provides for an average of 4999 births per annum (over the years 1997-2001) and currently has capacity to cater for 6000 births per annum. 5000 births per annum is seen as an acceptable size to;

- provide training for Doctors, Midwives and Medical Students where numbers of births are sufficient to ensure adequate experience is obtained.
- provide sole tertiary support across a land mass equal to the combined states of Queensland, New South Wales and Victoria, with various Regional and District hospitals, where birth numbers average less than 500 births per annum.
- the current operating size of the tertiary hospital has been determined by many years of

experience and determination of key staffing requirements to maintain a critical mass.

- to provide local catchment population with the necessary secondary services.

Four units would better utilise the available Obstetricians, Anaesthetists, Paediatricians, Midwives and Allied Health staff. In addition this would also make better use of Level 2 Neonatal nurseries, on-site Imaging, Pathology and specialised equipment. Fully staffed units can absorb greater numbers of patients with minimal adjustments to staffing ratios. Busy units that operate to full capacity provide greater professional development through caseload and diversity.

6.2.3 MODEL ADVANTAGES

1) Better access to a range of childbirth services by;

    a) An increased number of Birth Centres.

    b) Midwifery led care in Birth Centres.

    c) Traditional Obstetrician led care with enhanced access to consultants.

    d) 24 hour specialist services.

    e) Access to Obstetric Allied Health services as required.

2) Improved monitoring of adherence to Best Practice Guidelines resulting in increased quality of care and clinical governance.

3) Increased birth numbers at the Tertiary and Secondary hospitals will enhance collegiate team development, education and research opportunities, clinical governance, opportunities for training, professional support and development.

4) Service realignment will allow enhanced local community opportunities for other health needs such as aged care or rehabilitation.

5) Recruitment and retention ability will be enhanced with an increase in critical mass at centres. This will reduce agency nursing requirements and costs, redistribute the existing staff pools across fewer centres, whilst training and recruitment packages address the medium and long-term deficits.

6) Practitioner lifestyle improvements due to more predictable rosters will enhance recruitment and retention ability and decrease staff burnout. Larger teams also provide better opportunity for peer support.

7) The proposed model takes into account the international and national growing shortage of General Practice Obstetricians, Obstetricians, Midwives, Anaesthetists, Paediatricians and Allied Health professionals.

8) The proposed model provides increased opportunities for the development of the role of midwives as independent and interdependent professionals in the provision of

childbirth services

9) The proposed model supports the enhancement of the General Practitioner Obstetrician role by increased involvement and further development of a collegiate partnership. The opportunity to maintain and develop skills of General Practitioner Obstetricians linked to effective public system credentialling, increases with staff availability needs being met. This will result in greater opportunities for public sector professional development.

10) On site provision of essential support services at Secondary/Regional Centres such as Pathology, Diagnostic Imaging, Physiotherapy, Social Work, Dietetics and Psychological Medicine support as required, will be improved.

11) Increased efficiency in capital works, equipment, staff rosters, support services, consumables and transport/transfer of patients will reduce costs by reducing number of duplicated centres. This will facilitate redirection of funds to improve quality of services and facilities such as the birth centres.

12) Facilities and services that better reflect changing population demographics, aligned to transport links and indicators of current and future growth in Perth, would be created.

6.2.4 CHALLENGES FOR IMPLEMENTATION

1) Lobbying may result in community distress over changes to local facilities, such as perceived lack of access in local areas with prior service delivery history. These issues need to be addressed by wide consultation and community education.

2) Patch protection at some hospitals and by some clinicians may divert the attention from the real issues as described above.

3) Change management issues such as staff movements, service rationalisation and claims that service will decline, need to be managed effectively and in a timely manner.

4) Possible loss of remuneration to some current service providers may result in a public campaign to discredit the model, despite the clinical imperative provided.

5) Capital works requirements and service funding required may not be allocated in a timely manner resulting in delays and negatively affecting morale.

6) Early acceptance of the model by users and consumers is desirable. Therefore consultation with the following groups needs to be planned and undertaken and will help to resolve some of the challenges identified above. Relevant and important suggestions may arise from this process.

   a) Australian College Midwives (ACMI)

   b) Australian Nursing Federation (ANF)

   c) Australian Medical Association (AMA)

d) Royal Australian College of General Practitioners (RACGP)

e) Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)

f) Australian and New Zealand College of Anaesthetists (ANZCA)

g) Royal Australasian College of Physicians (Paediatricians) (RACP)

h) Division of General Practitioners (Div.GPs)

i) Western Australian General Practice Education and Training (WAGPET)

j) Rural Doctors Association (RDA)

k) Western Australian College of Rural and Remote Medicine (WACRRM)

l) Health Consumers Council (HCC)

m) Department of Health Western Australia (Other task forces/key stakeholders)

n) Australian Physiotherapy Association (APA)

o) Aboriginal Medical Services (AMS)

p) Royal Flying Doctors Service (RFDS)

q) Medical Defence Australia (MDA)

r) Hospital Salaried Officers Association (HSOA)

s) Miscellaneous Workers Union (MWA)

t) Other Professional, Federal, State, Local Government and community groups as indicated

7. DISCUSSION AND RECOMMENDATIONS

With the number of issues arising and the conclusions available from the literature a discussion is now made of some key issues. All recommendations are listed in the List of Recommendations at the beginning of this report.

7.1 CONCEPTUAL OBSTETRIC MODELS

The literature review suggests that clinical safety, quality, efficiency and effectiveness guidelines require determination of clear indicators of minimum birth numbers where capacity to service exists and determination of travel time when a practitioner is recalled for urgent duty. These definitions can then be used as a basis for planning the capacity of hospitals to provide safe services, optimal numbers of deliveries; resultant equipment needs, teaching capacity, professional development and staff coverage.

The Integrated Obstetric Services Model describes and defines the key roles and responsibilities for a Country Local Hospital, Country District Hospital, Secondary Hospital / Regional Hospital and Tertiary Hospital. (Referral Centres are also identified although their role is not considered within the scope of this review.) The capacity of each centre to deliver services needs to be clearly defined to prevent inappropriate services where facilities and expertise is not readily available.

On this basis and drawing upon the vast expert and experiential knowledge of practitioners, the Integrated Obstetric Services Model and the Metropolitan Obstetric Services Model is defined.

RECOMMENDATION 1

That the proposed Integrated Obstetric Services Model and the Metropolitan Obstetric Services Model, that are both based upon minimum safety and quality requirements, are established and implemented.

7.2 CHIEF MEDICAL OFFICER FORMAL ENDORSEMENT OF MODEL

The method of determining a hospital's status to deliver Obstetric services needs to be made on a case by case basis utilising the key guidelines for safety and functionality previously described. All hospitals should then, upon further advice, be gazetted or declared formally. This determination should then provide a legal basis and policy guidelines for safe practice interventions and treatments to be practiced at these facilities.

There may be a need, from time to time, for the Chief Medical Officer to review standards or the viability of a service based upon birth numbers. If the Chief Medical

Officer deems it necessary the accreditation of the hospital's status to provide obstetric services, consistent with the models, may be withdrawn.

RECOMMENDATION 2

That the Chief Medical Officer endorses the models and directs that the recommendations are applied to all facilities and beds offering public Obstetrics Services, which are then classified accordingly and that services not meeting minimum standards or number of births may be withdrawn.

7.3 GOVERNANCE

The fourth Term of Reference of the Working Group identifies a need to comment on a state wide system of clinical governance. The Working Group decided that this process is best managed by the Office of Quality and Safety linking to the sites. The Office of Quality and Safety could then brief the Statewide Obstetric Service, who would then coordinate and assist with implementation of recommendations by education, follow-up and advice.

A state wide coordinating body would also initiate or respond to appropriate audit requests. This may result in recommendations to the Chief Medical Officer when obstetric units are not meeting standards as to their status consistent with the models and any consideration of closure or temporary withdrawal of services. The need to audit standards would include evaluation of the success or validity of a new model of care being piloted. The Royal College of Obstetricians and Gynaecologists identifies key components of governance as;

"Clinical guidelines, Clinical audit, Education and training, continuing professional development, Clinical risk management, Complaints procedures, Revalidation of specialists and Service accreditation."

(pp 1-8, Clinical Governance, Setting Standards to Improve Women's' Health, 1999)

The Statewide Obstetric Service (referred to in Section 7.4) would provide a lead role in providing advice to the Deputy Director General of Health Care and the Office of Quality and Safety, in relation to credentialling, professional portfolio policy and competency standards matters.

There is a need to develop and establish, in partnership with the Office of Quality and Safety of the Department of Health, a system of linked and functioning Clinical Governance committees to monitor obstetric service practice.

RECOMMENDATION 3

That each obstetric unit must be involved in and linked to, a functioning clinical governance system, that meets standards set by the Chief Medical Officer.

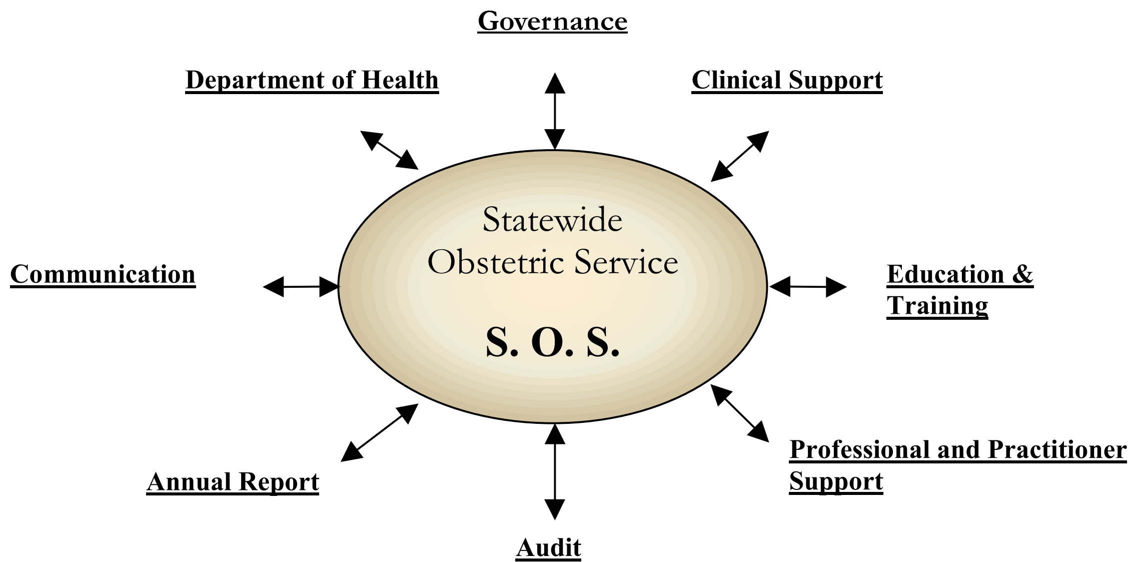
7.4 STATE COORDINATING ROLE

There is a clearly identified need for a state wide obstetric advisory and coordinating body to be formally established. It's core role would be to identify the linkages between sites, act as a central reference point and help to overcome barriers to better assist the management of a state wide approach to obstetric service provision. This role would have a high level of clinician support.

This group, now referred to as the Statewide Obstetric Service would require an effective management structure and delegated authority as needed to promote change. The Statewide Obstetric Service would report to the Chief Executive Officer of the Women and Children's Health Service. It is envisaged that staff with a state wide focus would link to this group to ensure coordination. Adequate staffing and funding to support this role would be required. The Statewide Obstetric Service would link facilities and practitioners, to achieve a unified whole of system approach and should be co-located on the tertiary campus. This approach would better:

- Co-ordinate candidate placement, recruitment and link training, education and practitioner professional support through the infrastructure of the Women's and Children's and other health services.
- Provide a key link to the General Practitioner Obstetricians, Clinical Senate, Clinical Reform Sub-Committee, Consumers, Department of Health and Deputy Director General Healthcare.
- Ensure consistency in relation to clinical quality and safety.
- Co-ordinate standards and policy issuance and monitoring.
- Assist with practice issues resolution.
- Co-ordinate recruitment and retention strategies development.
- Provide professional advisory support.
- Ensure metropolitan, rural and remote linkage.
- Provide a single point of reference to an 1800 free call number for practitioners.
- Co-ordinate collection, comparison, analysis and dissemination of data and information.
- Ensure ongoing clinician input.
- Ensure key Allied Health representative input.
- Ensure linkage with Mental Health services.
- Promote Western Australia as a world's best practice model that attracts staff and promotes a quality service in a culturally sensitive environment.

There is a clearly identified need for a single point of reference represented schematically in Diagram 3.



RECOMMENDATION 4

That a Statewide Obstetric Service is established, supported and funded as a matter of priority.

7.5 CONSUMERS

Child bearing women of Western Australia and their families are the basis for the existence and establishment of obstetric health services. Their needs should therefore be the focus in the provision of such services. All women should be offered the choice of services that promote and provide optimal, holistic health outcomes for themselves and their babies.

Consumers expect quality and safety in health service provision and require providers who have an understanding and sensitivity to their individual needs and choices. Consumers require a forum of open and honest communication of information that is factual, and where possible evidence based, from all obstetric service providers. This enables them to make appropriately informed choices and to be actively involved in their child-bearing experiences. The models proposed allow for a wide range of consumer choice, from appropriately skilled practitioners.

The role of the father in the birth process needs to be further encouraged. Inclusion in the birth process needs to be incorporated into planning. There is evidence that suggests that domestic violence is decreased and breast-feeding rates are increased by early and

continued paternal involvement. There is a strong and legitimate desire by men to be involved in all the stages of the pregnancy and birth process. In remote areas this requires us to rethink how we apply guidelines and incorporate the rural father in the birth experience when the mother is required to travel to another town to deliver.

Application of consumer input and liaison with consumer groups could be undertaken by the Statewide Obstetric Service to ensure consumer involvement in planning and have a clearly identified point of reference for contact regarding service issues. This role could be enhanced by a telephone information service and a web page accessible to consumers. The Aboriginal consumer also needs to be involved in decision making and planning to improve access to customary models, a linkage that the Statewide Obstetric Service could promote.

RECOMMENDATION: 5

That education regarding the choices and associated risks in obstetric service provision to childbearing women, is promoted in a culturally sensitive way, in the community by way of publication, Internet and information handouts.

RECOMMENDATION: 6

That an information service is explored and linked to a telephone service and an Internet Web page, is established to enable the woman and her family to 'check the facts' regarding information they may have heard, or been given regarding pregnancy, labour, birth and the postnatal period.

7.6 WORKFORCE

There is a need to address issues identified and raised by practitioners relating to remuneration, indemnity, salary inequities and constraints on practice caused by the Medicare agreement. Billing arrangements for General Practitioner Obstetricians are complex and prohibit easy integration of service arrangements.

Different methods and amounts of payment in different health services, in the same specialities, for the same work, creates ill feeling and a sense of injustice. This needs to be remedied. A system wide audit of payment arrangements needs to be undertaken to restore equity.

The workforce issues identified in this report are complex and impacted by industrial and other agreements and need to be referred to the State Health Management Team for further direction to an appropriate Project Working Group to respond to the identified clinician concerns on a point by point basis.

There is a prediction that an increased shortage of skilled practitioners is forecast to occur in the next five to ten years. With reduced attraction into the Obstetrics services

and an ageing workforce, a problem looms on the horizon. This shortage is a worldwide problem and if Western Australia is not pro-active then this could reach crisis proportions in both Obstetrics and Midwifery.

RECOMMENDATION 7

That the Health Department and the Statewide Obstetric Service analyse workforce issues and recommend options for solutions to the State Health Management Team.

7. 7 PROFESSIONAL MIDWIFERY

The many issues confronting midwifery across the state are subject to reports and recommendations. Midwives comprise a vital functioning component of the health team. Their practice is supported by the *Nurses Act 1992 (as amended)* and in particular the need for specialised knowledge is required for antenatal care and birth episodes. Douglas Inquiry recommendations support the role of midwives in Birth Centres and the importance of continuity of care wherever this can be achieved.

7.7.1 SUPPORTING THE RURAL MIDWIFERY PROGRAM

A commitment to providing appropriate education for midwives working throughout rural WA has been demonstrated through the successful delivery of professional development programs both on-site in the rural hospitals and more recently, through the Telehealth medium. Clinical midwifery updates have been provided to enable midwives to update their knowledge and skills by spending time at a tertiary hospital with preceptor support. These initiatives have been supported by the Department of Health and through a successful Rural Health Services Education and Training grant. It is planned to continue with this state wide midwifery education framework, for which new recurrent funding needs to be sought.

7.7.2 GRADUATE MIDWIFERY PROGRAM

King Edward Memorial Hospital has provided a Graduate Midwifery Program since 1998. This was developed in direct response to the feedback received from midwifery students and newly graduated midwives. The program has been altered in response to continuing feedback from the participants. The program is beginning to meet its objectives that promote personal and professional confidence and competence in their midwifery practice. Retention of midwives has been positive following completion of the program. Programs are provided by other hospitals outside the tertiary hospital, however there has never been a coordinated approach to this strategy. The diversity of programs and hospital locations could prove very positive for the continued development of graduate midwives. The Statewide Obstetric Service would play a significant role in any such proposal for Western Australia.

7.7.3 COMMUNITY MIDWIFERY PROGRAM

To support, develop and enhance the Community Midwives program, responsibility for management of outcomes needs to be clearly identified. Whilst recognising the independence of the community midwife, there remains a need to monitor standards of practice delivery of these publicly funded practitioners. To maintain appropriate standards the responsibility for supervision should be vested in the Director of Midwifery at the tertiary hospital for the metropolitan area; and to the Director of Midwifery where possible or Director of Nursing in the Regional Hospitals.

7.7.4 ENHANCED ROLE OF THE MIDWIFE

The Working Group supports the implementation of the Enhanced Role of the Midwife in Western Australia. The implementation of the recommendations from the report 'Options for Effective Care in Childbirth', (1996) and the subsequent 'Review of Services Offered by Midwives', (1998) contribute to the formulation of the Enhanced Role of the Midwife. The enhanced role of the midwife primarily relates to the initiation and administration of pharmacological substances and the ordering and interpreting of routine tests only apply during uncomplicated pregnancy, labour, birth and the postnatal period.

RECOMMENDATION 8

That the '*Enhanced Role of the Midwife*' is implemented as a priority.

RECOMMENDATION 9

There is an urgent need for the Statewide Obstetric Service to conduct a review of training, support and methods of attracting and retaining Midwives in the speciality of Midwifery, in conjunction with the relevant colleges.

7.8 OBSTETRICIANS

There are several areas of concern to Obstetricians that need early attention. The workforce is ageing and recruitment into the speciality is decreasing as doctors make lifestyle choices not to be available on call at all hours. The staffing levels and support to sole practitioners, especially in the country, is of particular importance and concern.

Inadequate recognition and payment to the speciality is a concern and may be contributing to reduced recruitment rates. There is also a particular concern that there is a low attraction rate of local graduates, as evidenced in the declining number of applications for positions offered at Resident and Registrar levels. This is symptomatic of the overall need to support Obstetricians and trainees in areas such as personal non-clinical development, communication, conflict resolution, and counselling.

A Rural Locum Service should be developed as a spin off of the Swan Districts Hospital Model of Care. Since each practitioner works for a 24 hour period on site and has no other commitments and has Crown Indemnity, it is possible to "slot in" practitioners who may have recently retired from Obstetrics or new Fellows. These people could be induced by adequate remuneration and Crown Indemnity to also fill in country posts for short and medium terms and some may eventually elect to enter rural practice.

RECOMMENDATION 10

There is an urgent need for the Statewide Obstetric Service to conduct a review of training, support and methods of attraction to bring and retain doctors in the speciality of Obstetrics, in conjunction with the relevant colleges.

7.9 ANAESTHETISTS

The availability of appropriately credentialled Anaesthetists or General Practitioner Anaesthetists is critical to safe provision of obstetric services, consistent with Australian and New Zealand College of Anaesthetists guidelines for the Professional Standards of Anaesthetists. The model must ensure those issues of availability and remuneration with respect to limited resources is addressed. The continued support of the Statewide Anaesthesia Reference Group and initiatives such as Medical Specialists Outreach Assistance Program as related to training in Anaesthesia and Pain Medicine is vital.

There is a need to resolve the major problem in finding Anaesthetists prepared to work on after hours rosters. The current number of available Anaesthetists is sufficient to maintain an on call roster arrangement. Site accreditation requiring participation in an after hours roster may resolve this issue.

RECOMMENDATION 11

There is an urgent need for the Statewide Obstetric Service to review incentives, availability and methods of attracting Anaesthetists and General Practitioner Anaesthetists to provide Obstetric Anaesthetic services.

7.10 PAEDIATRICIANS

A concurrent state wide review of Paediatric services is being undertaken that will outline the issues, concerns and recommendations related to neonatal paediatrics. The important role of neonatal paediatrics in the health team is acknowledged. In rural areas the role of the paediatrician is largely provided by General Practitioners and this role needs to be supported by opportunities for ongoing education, support and development.

7.11 ALLIED HEALTH

It is important to note that Allied Health practitioners involved in obstetric care (which collectively includes the disciplines of Physiotherapy, Social Work, Occupational Therapy, Imaging, Pharmacy, Dietetics) may have a differing level of priority from that of doctors and midwives. The demands for specialised expertise as an integral component of an

Obstetric Service therefore differ. Services are required that are flexible, meet the needs of the community in terms of standard of care and equity of access and are delivered consistent with best practice principles. It is important that the Allied Health Practitioner is vitally involved in Health Team planning.

RECOMMENDATION 12

That the Statewide Obstetric Service undertakes an analysis to determine the quality guidelines and obstetric credentialling requirements and service demand for Allied Health staff.

7.12 PSYCHOLOGICAL MEDICINE

The important role of mental health professionals in the provision of services must be incorporated into health planning as an integral component of any holistic model. This need is no more clearly demonstrated than in post partum depression and the devastating impacts this has on women and their families. Early pregnancy and perinatal loss are also issues which may have psychological sequelae and should be included in an outreach service.

Of the 24,932 births per annum in Western Australia, 14% or 3,490 women will experience a mood disorder of significance. To reach as many women as possible in rural and remote areas the use of Telehealth will be vital. This method of clinical consultation will allow specialists to support the women and their carers in their community. The use of consultation, admission and discharge planning will be invaluable. The ideal method of implementing this is a state wide clinical consultation outreach service using Telehealth. The incorporation of this function into a state wide program makes a lot of sense.

The consolidation of services would be enhanced by the establishment of a 'mother and baby unit' on site at King Edward Memorial Hospital. This would allow a close access and integrated service on one site. The stigma and community perception for the consumer, who is currently hospitalised in Graylands, would be reduced. Further discussion of this matter is attached, see Appendix 6.

RECOMMENDATION 13

That the mother and baby unit is transferred from Graylands Hospital to King Edward Memorial Hospital as soon as possible.

7.13 GENERAL PRACTITIONER OBSTETRICIANS

Service interface between the General Practitioner Obstetrician and the public system needs to be carefully determined. There is a need to expand the role of the General Practitioner Obstetrician and how they link to the public hospital system and analyse their relationship with public sector Obstetricians and Midwives. The high value placed upon the General Practitioner Obstetricians in the continuum of care needs to be reinforced.

The flexibility required by General Practitioner Obstetricians to be involved in a system

that acknowledges their other practice commitments also needs to be considered. It is evident that there is also a strong interest in access to ongoing education and other up-skilling opportunities, provided by the public hospital sector linked to a credentialling process. This may require a locum relief arrangement for country General Practitioner Obstetricians and would require a relationship to be developed by the Statewide Obstetric Service and the Western Australian General Practice Education and Training body.

Some of the options to improve General Practitioner Obstetrician's involvement in public obstetric service are as follows.

- Firstly General Practitioner involvement in antenatal care could be either as total care with the patient confined directly under the General Practitioner as a Hospital funded semi-private patient. In this case, the practitioner should have a Diploma of the Royal Australian and New Zealand College of Obstetricians and Gynaecology or equivalent. Evidence of ongoing education should be monitored by the College and the hospital.

- Secondly, the General Practitioner Obstetrician could work in a clinic at each Hospital. There should be clear guidelines of what to refer on and this model could be continued with a Midwife clinic for low risk cases. The relevant guidelines are currently being reviewed.

- Lastly, there could be shared care. The exact requirements and time for referral back to the Hospital would have to be agreed and the practitioner would need experience equal to the Certificate of Completion of Specialist Training and also evidence of continuing education.

RECOMMENDATION 14

That the Statewide Obstetric Service formulates and implements a plan to ensure that General Practitioners are encouraged to pursue the speciality of obstetrics and support General Practitioner Obstetricians to maintain involvement, training and credentialling.

7.14 ENCOURAGING AND SUPPORTING MEDICAL STUDENTS

There is a need to encourage students and junior medical staff to consider a career as a General Practice Obstetrician in both rural and metropolitan areas. Coordinated support and clinical mentoring is an important feature in this process, as is the need to speak to students during training and promote the career speciality of Obstetrics.

The Rural Clinical School and its new and innovative methods of teaching are an example of the way forward. This was illustrated by the case of a fifth year medical student in Port Hedland working under the guidance of the Rural Clinical School and the

Consultant Obstetrician.

The role of the Midwifery tutor of medical students, should be promoted and continue to be supported. This initiative was put in place some ten years ago and continues to function well. This type of approach may be also useful for broader application to other disciplines.

7.15 PRACTITIONER EDUCATION AND TRAINING

Wherever the Working Group attended, there was a consistent request for increased opportunities for education, training and up-skilling for General Practitioner Obstetricians, General Practitioner Anaesthetists and Midwives. Consultant Obstetricians generally have access to courses, professional conferences and study leave. Sole country obstetricians however, need support and locum cover to enable them to access these opportunities. The Statewide Obstetric Service could undertake a role to assist in the management of this process.

Midwifery education also needs much more financial support. The cost of courses, travel and accommodation and the difficulty of backfilling especially in small or remote centres, make it extremely difficult, if at all possible, for education to be accessed. This increases the risk of midwives not being appropriately skilled to manage women through the childbearing period.

A coordinated Telehealth program and educational outreach to deliver services on site, such as training by the Perinatal Loss Team, the Advanced Fetal Assessment Team and Ultrasound Training Program, would improve access.

Allied Health Professionals require similar support for funding for education and should be included in a coordinated Telehealth and educational outreach program.

RECOMMENDATION 15

That a comprehensive education and training program is developed by a Working Group, to fully describe the requirements and identify the linkages across disciplines.

7.16 ACADEMIC TEACHING AND RESEARCH

There is a need to link Academic teaching and research into centres other than the tertiary referral centre. Appointment of a Clinical Academic title eg Clinical Senior Lecturer located at Secondary hospitals would be very positive and reward and recognise the leaders in the field. This would be appropriate for all disciplines, especially Obstetrics and Midwifery. The linkage and development of regional posts should also be considered. This would link practice to research in key areas including remote and indigenous health. The appointment of a Professor of Midwifery will establish a strong presence within the Tertiary centre and be involved in the development of the collaborative Centre for Women and Children's Education and Research. The Professor would facilitate academic developments that promote the reputation of midwifery in Western Australia both nationally and

internationally, by ensuring that midwifery practice in Western Australia is of a world class standard supported by research. Appointment of a Clinical Academic title eg Clinical Senior Lecturer located at Secondary Hospitals would be very positive and reward and recognise the leaders in their fields.

It is proposed that Research and Education be co-located in a multipurpose redevelopment in close proximity to the Tertiary services. A central facility that combines services with a state wide focus on Obstetrics is indicated.

The proposal would include construction of a Research and Education building to house

- a lecture theatre,
- tutorial rooms with teleconferencing capabilities,
- medical library,
- the University of Western Australia School of Women's and Infants' Health (formerly the University Department of Obstetrics and Gynaecology);
- research staff of the Women's and Infant's Research Foundation,
- the Postgraduate Midwifery School (a joint initiative of the Hospital and Curtin and Edith Cowan Universities),
- the Perinatal Information Data section (currently housed within the Department of Health.)
- the Statewide Obstetric Service (as an independent entity from the Tertiary hospital but co-located to retain access and linkages.)
- the University of Western Australia School of Medicine and Pharmacology Chair of Obstetric Anaesthesia.

RECOMMENDATION 16

That Clinical Academic titles are appointed and located at Secondary and Regional Hospitals. This would include the establishment of a Professor of Midwifery.

RECOMMENDATION 17

That a master service-plan is completed to facilitate the establishment of a new Academic and Research centre in close proximity to the Tertiary services.

7.17 INFORMATION AND COMMUNICATION

The overall area of information and communication between sites is of great importance. This relates not only to information technology use and Telehealth, which has been tremendously well received as an educational tool. The opportunities in pre-admission, consultation and discharge planning and follow up are as yet not fully developed. The coordination of this role on a state wide basis will be crucial to successful implementation. Some remote areas experience difficulties with capacity to access rapid information transfer. This will require capital works expenditure in information technology.

The trial use of Handheld Antenatal Records in Western Australia comes as a result of extensively researched usage in centres both nationally and internationally. King Edward Memorial Hospital is currently managing the pilot and if broader implementation is to occur, funding allocation will be required across the state. There is a need to ensure that the endorsed Handheld Antenatal Record is appropriate to use in all circumstances and methods of dealing with loss or misplacement of records is provided for.

7.18 SERVICE FUNDING

Investment into modernisation of facilities, equipment, research centre, Information Technology and the staffing of a state wide coordinating body will require a clear commitment in terms of capital works and staffing requirements. Costs will be offset by efficiency gains such as reduced reliance on Patient Assisted Travel costs by the use of Telehealth and improved service provision.

There is an urgent need to address the current deficits in the overall configuration of buildings and services, to enable staff working on a common purpose to be collocated. This is of particular importance for the establishment of a state wide service, if approved. This appears to be a lynch pin to the whole reform process that is required.

Master service planning for the Tertiary Hospital (King Edward Memorial Hospital) site that includes the building of a state wide focused multipurpose centre and incorporates education, library, research, and assisted accommodation for remote area practitioners to use whilst training, needs to be funded and allowed to proceed. Other developments proposed for the site should include;

- Accommodation for short-term stay for women and their families attending the campus from remote and rural areas.
- A multi-level car-park (may assist in cost recovery)
- Commercial medical suites to attract private practitioners and resources to the campus
- Appropriate retail outlets for pharmacy and baby merchandise

Funding for the proposal may be provided by a mix of initiatives conducted through the Women and Infants Research Foundation, as well as support from government.

Funding for improvements in hospitals to bring them up to acceptable standards expected of modern government facilities is required. This is particularly evident in some locations where old carpet squares, aging facilities that are dark and unwelcoming, lack of consumer privacy or choice, no options for private patients, crowded staff facilities and lack of access to information technology are some obvious examples of areas needing attention.

Attraction and retention of staff in rural and especially remote areas would be greatly improved by providing accommodation to the standards that other state government departments or Homeswest residents enjoy. This could reduce the costs of agency staff and frequent turnover in the country.

RECOMMENDATION 18

That business cases that identify the costs in relation to a Statewide Obstetric Service, an Education and Research facility, and hospital and staff accommodation upgrades are prepared for the budgetary consideration of the State Health Management Team, as soon as possible.

8. CONCLUSION

The aim of the review was to develop a framework on which to create a *new way forward* in the provision of obstetric care for the community of Western Australia. It is evident that for significant change to occur, there are a number of issues that need to be addressed to enable this to happen.

The upheavals and changes in the current service environment mean that doing nothing is no longer a viable option. Carrying on in the same way will lead to a further decline in obstetric services. This is not in the best interest of the Western Australian families and ignores the needs of those members of the community who rely on the public system.

Every effort was made to involve a broad base of viewpoints and experience by including Review members, who could represent and canvass the views of their peers. A number of site visits were undertaken to gain further insights into the problems facing service providers and consumers. Although many issues of concern were raised, enormous goodwill was shown and this needs to be supported by positive action.

This report and the recommendations contained therein, provide *a new way forward* that ensures that the major issues of safety and quality are addressed whilst at the same time the rights and position of the consumer are seen as paramount.

The vision is to have a state wide integrated service, established on evidence based best practice, that provides safe and responsive, culturally sensitive, care in an environment that nurtures, develops and supports the workforce and community of Western Australia.

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10. APPENDICES

APPENDIX 1:

WA OBSTETRIC SERVICES WORKING GROUP MEMBERSHIP

Dr Harry Cohen	Chair
Dr John Bates	Eastern Districts Obstetric Group
Mr Graeme Boardley	WA College of Midwives
Dr Myra Brown	G.P. Obstetrician
Ms Robyn Collins	Director of Midwifery, KEMH
Ms Jane Cornes	Metropolitan Consumer Representative
Ms Lyn David	Allied Health Representative
Dr Louise Farrell	Chair of RANZCOG (WA)
Ms Vivien Gee	Maternal & Child Health Unit, Department of Health
Dr Ronnie Hagan	Newborn Services, PMH
Ms Maureen Hutchinson	Research Assistant/Information Technology Coordinator KEMH
Dr Panos Maouris	Obstetrician (remote and rural experience)
Professor John Newnham	School of Women's and Infant's Health
Dr Margo Norman	Northern Districts Obstetric Group
Ms Naomi Ogden	Country Consumer Representative
Assoc. Professor Michael Paech	Anaesthesia Representative
Ms Theresa Williams	Strategic Planning and Evaluation, WADOH

PROJECT DEVELOPMENT AND SUPPORT

Mr Paul Fitzpatrick	Health Reform Branch WADOH
Mr Mark Slattery	Health Reform Branch WADOH

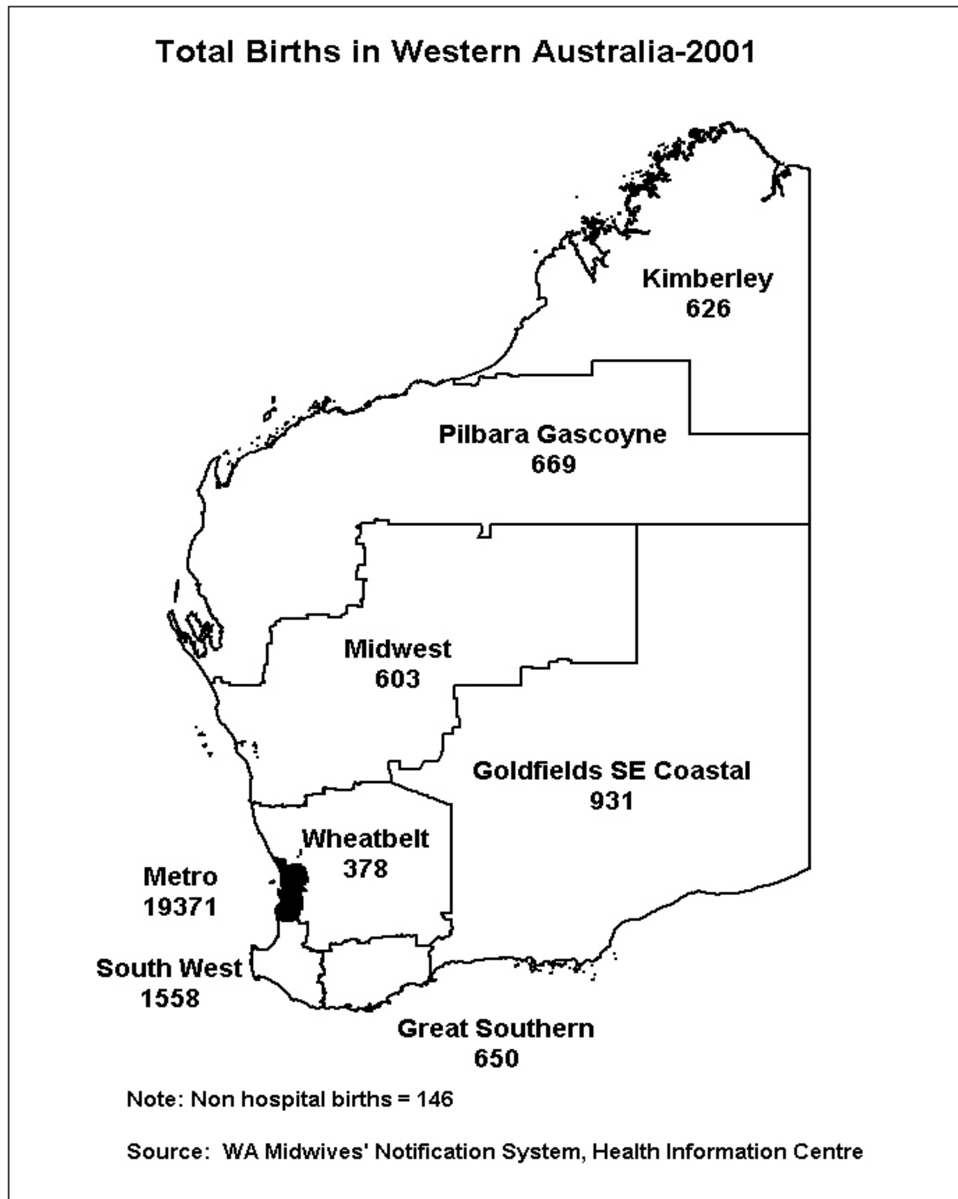
Thanks to Mrs Louise Rudeforth and Ms Carol Davies for Project Support

APPENDIX 2.

Births by Western Australian Hospital for 2001

Hospital	Number of total births		Hospital	Number of total births
Albany Regional Hospital	448		Margaret River District Hospital	71
Armadale/Kelmscott District Memorial	710		Meekatharra District Hospital	6
Attadale Hospital for Women	508		Mercy Hospital	977
Born Before Arrival	1		Merredin District Hospital	27
Bentley Hospital	765		Moora District Hospital	3
Bridgetown District Hospital	63		Murray District Hospital (Pinjarra)	9
Broome District Hospital	200		Narrogin Regional Hospital	172
Bunbury Regional Hospital	680		Newman District Hospital	14
Busselton District Hospital	175		Nickol Bay Hospital	219
Carnarvon Regional Hospital	104		North Midlands Health Service	1
Collie Health Service	112		Northam Regional Hospital	156
Dalwallinu District Hospital	2		Osborne Park Hospital	1464
Denmark District Hospital	29		Peel Health Campus	658
Derby Regional Hospital	269		Pemberton District Hospital	1
Donnybrook District Hospital	13		Planned Home Birth	145
Esperance District Hospital	200		Plantagenet District Hospital (Mt Barker)	31
Exmouth District Hospital	1		Port Hedland Regional Hospital	314
Fitzroy Crossing Hospital	1		Rockingham - Kwinana District Hospital	775
Fremantle Hospital	1		Rockingham Family Hospital	215
Galliers Private Hospital	29		Roebourne District Hospital	1
Geraldton Regional Hospital	436		South Perth Community Hospital	126
Glengarry Hospital	751		St John of God Bunbury	344
Gosnells Family Hospital (Galliers)	209		St John of God Geraldton	160
Halls Creek District Hospital	11		St John of God Murdoch	1329
Harvey District Hospital	24		St John of God Subiaco	2691
Joondalup Health Campus	1489		Swan Districts Hospital	896
Kalamunda Community District Hospital	418		Tom Price District Hospital	13
Kalgoorlie Regional Hospital	729		Wagin District Hospital	18
Katanning District Hospital	141		Warren District Hospital (Manjimup)	74
King Edward Memorial Hospital	4402		Wickham District Hospital	2
Kununurra District Hospital	138		Woodside Maternity Hospital	955
Laverton District Hospital	1		Wyndham District Hospital	4
Leonora District Hospital	1		**Total**	**24932**

APPENDIX 3.



APPENDIX 4

STATEWIDE OBSTETRICS SERVICES PROJECT WORKING GROUP COUNTRY & METROPOLITAN VISITS 2002

INTERIM SUMMARY OF FINDINGS AND ISSUES

During the review various sites have been visited to determine clinician issues, suggestions for service improvement and what works well. The sites visited include:

COUNTRY SITES VISITED

Albany	Broome	Bunbury	Busselton	Collie
Denmark	Derby	Geraldton	Kalgoorlie	Katanning
Mount Barker	Narrogin	Northam	Port Hedland	Wagin

METROPOLITAN SITES VISITED

Armadale	Bentley	Joondalup	Kalamunda	Osborne Pk
Peel	Rockingham/Kwinana		Swan Districts	Woodside

Whilst each site had particular issues relating to their circumstance the following key issue emerged from all sites. Some comments may be site specific.

ISSUES RAISED

ISSUES AFFECTING THE DEPARTMENT OF HEALTH

- Department of Health out of touch
- No staffing requirement forward planning by Department of Health

ISSUES AFFECTING KEMH

- Quarterly newsletter from KEMH
- Outreach service provision from KEMH
- Midwife rotation from KEMH was requested from other hospitals
- Improved feedback from KEMH on the treatment and progress of transferred patients
- KEMH Locum cover to allow training and leave

TRAINING AND EDUCATION

- Access to fetal assessment courses
- Midwives running CTG courses on site
- Training staff to conduct skilled training
- Professional development
- On site training
- Telehealth opportunities for training, education and practice

CLINICAL CARE

- Midwives need to be available to work on medical or surgical wards to fill staff vacancies, detracting from full care.
- Primigravidas stay in hospital for 5 days due to lack of available follow up care
- Hand held records supported
- Practice demarcation between midwives, consultants and junior medical staff
- Greater involvement of midwives in antenatal care
- Midwives wish to enhance their role and improve the current share care arrangements with General Practitioners
- Enhance role of the midwife
- Clinical governance and credentialling
- Need for greater definition and consistency in clinical governance and audit
- Epidurals used on a ‘just in case basis’ due to inability to secure at short notice
- Perineal suturing
- Variance in section rate 20 – 31% (low rate link to audit and governance)
- Concern with AMS linkages leading to fragmented care
- Need for Antenatal clinics to be established
- Aboriginal clients needs require consideration to enhance engagement with midwives. Many Aboriginal women prefer a direct approach with the hospital rather than community facilities.
- Desire for state wide updated, easy to access, common practice approach to policy and procedure available free of charge

STAFFING ISSUES

- Shortage of skilled staff available in some areas leading to increased competition for scarce resources across the State and Country
- Sites running similar services in close proximity competing for staff resources
- Ageing workforce
- Staff time to pass on skills training
- Rural staff attending metropolitan clinical updates would like a welcoming environment
- Inequity in payment modes for specialists causing concern
- Practitioner concern and prediction of exponential increase in litigation including 20 year ‘tail’ impacts
- Senior Registrar in rotation
- Need to review employment and remuneration practices
- No response to vacancy advertisements
- Indemnity concerns leading to decision to withdraw services.
- Link between models of care and ability to attract and retain staff.

MANAGEMENT AND FUNDING ISSUES

- VMP agreement needs review

- Hostel and lodge accommodation needs for rural centres need to be addressed.
- Lack of rural incentives for Paediatricians / Obstetricians / Anaesthetists and midwives
- Costs of attraction will offset costs of PATS
- Standard of much rural accommodation poor
- Equipment deficiencies such as fetal monitors
- Accommodation issues related to sharing, standard of accommodation and privacy for Midwives
- Budget restrictions leading to reduced opportunities for midwife training
- Aging facilities with insufficient capital to effect improvements
- Community funding for improved facilities has led to greater satisfaction for local clients
- Funding for payment of student midwives should be separate from normal staffing funding. Current arrangements see that in some cases normal staff complements are eroded to fund student placements.

APPENDIX 5

THE MEDICAL INDEMNITY CRISIS

AND IT'S EFFECT ON OBSTETRIC SERVICES (2002)

- Rising obstetric premiums may make **all** obstetric practice non-viable. Both private and public fee for service.
- Current MDA WA premiums are $72,000 per year. This is expected to increase by $7,000 next year.
- The United Fund of NSW has just been struck at $118,000 and another rise is to be decided shortly.
- Over the past 2 years and prior to the latest increase, 50% of obstetricians in Australia gave it up.
- Only 25% of trainees plan to begin private obstetrics on graduating FRANZCOG in 2001.
- St Paul's Medical Indemnity, $62,000 last year, has withdrawn from Medical Indemnity. But they require a fee of $2^1/_2$ years premium if an obstetrician retires within 5 years of commencing practice.
- Other funds have buy-out schemes to cover the 'tail' liability for retiring obstetricians.
- Private practice premiums may collapse private obstetric practice. The patient load will fall on the public sector as it is unlikely patients will pay the gaps required.
- Higher premiums will make fee-for-service public obstetrics non-viable and obstetricians will withdraw.
- Obstetricians will service the public sector only on a full time or sessional basis.
- Sessional obstetrics will be undertaken **only** if payment is adequate.
- Crown indemnity must provide **certain** cover without escape clauses.
- Current sessional payments are insufficient to carry the costs of private practice. Average practice costs are $20,000/session year.
  Sessional payments are $15,000/session year.
- On-call rates need to reflect the nature of obstetric practice. It is **not** an availability rate but a rate for control of a labour ward with responsibility for decisions and outcomes.
- Full-time obstetricians, sufficient to staff rosters, will only be sustainable in large units.
- In summary:
  There is an imminent threat of collapse of the private sector with transfer of patient load to the public sector. Indemnity costs will make fee-for-service public obstetrics non viable unless Crown Indemnity is provided. Alternatively all obstetrics will be full-time or sessional.

(***Personal communication from National Association of Specialist Obstetricians and Gynaecologists*: *August 2002***)

APPENDIX 6.

DISCUSSION PAPER

MOTHER BABY UNIT AND A STATEWIDE PERINATAL PSYCHIATRY SERVICE

Of the 25,000 deliveries that occur in Western Australia per annum. 14% of these women will experience a significant Mood Disorder in the postnatal period. Around 1% will experience a serious Psychiatric Illness with potentially serious consequences for the mother and/or baby. The Confidential Inquiry into Maternal Deaths in the United Kingdom states that Psychiatric Illness is now the leading cause of maternal deaths in the United Kingdom.

The recommended bed allocation for Mother/Baby Units is 8 per million of the population. There are only three Mother/Baby beds within a Mother/Baby Unit for the State – located in the Cullity Unit at Graylands Hospital. There is agreement between the Director of Medical Services at Graylands Hospital, the Consultant in Charge of the Mother/Baby Unit and the Head of the Department of Psychological Medicine at King Edward Memorial Hospital for Women that Clinical Service of, and the resources allocated to, the Cullity Unit, be transferred to the King Edward Campus. It was a Recommendation of the previous Chief Psychiatrist and the Psychiatrist in Charge of the previous Metropolitan Mental Health Service that the bed capacity be expanded to an 8 bed Service for the State.

The Mother/Baby Unit could be the hub of the State wide Perinatal Mental Health Service – in conjunction with the Statewide Obstetric Service. Roles for the Service would include:

- State wide Guidelines in relation to detection and Best Practice Management of Perinatal Mental Health issues
- Pre-conception counselling in relation to the risks of, and the optimal management of, Psychiatric Illness and psychiatric medication in pregnancy and lactation
- State wide Consultation and Management Planning for women at risk of serious Mental Health Illness in pregnancy, with delivery and the postnatal period
- State wide education and support
- 24 hour telephone access to a trained Mental Health Nurse in the Mother/Baby Unit and/or the Consultant Psychiatrist on call in the Mother/Baby Unit in relation to clinical matters that could not wait for conventional Telehealth consultation and clinical support.

Many of the above Services could be provided through Telehealth, through accessible Guidelines and Protocols, Telehealth Education and Telehealth Consultation. Clinical visits from the Mother/Baby Unit to metropolitan and rural and remote units would be of ongoing value and would be extremely important in the initial establishment of the Service.

The 1997 Proposal in relation to the Mother/Baby Unit and State wide Service furthers supports the practical implementation detail behind this discussion paper. The President of the World College of Psychiatrists, Professor J. Cox, has stated in personal communication that, apart from a state wide consultation service, the current service at King Edward Memorial Hospital provides the gold standard of perinatal mental health care. The gold standard is a measurement of excellence and achievement in providing a service that meets all the recommendations of the Confidential Inquiry into Maternal Deaths in the United Kingdom 2000. To broaden this care in provision of outreach services to the community would establish Western Australia as a world leader in the field.

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APPENDIX 7

Extract from the Guidelines for Rural Obstetric and Midwifery Services in Western Australia

LEVEL 1

Service description
No planned births, but will provide antenatal and post partum care for uncomplicated cases.

In cases where unplanned admissions are likely, each hospital must have a clinical management plan and protocol for managing such cases. Availability of midwives is highly desirable and basic equipment and neonatal resuscitation should be available for unplanned admissions in an emergency case only.

Requirements

- May have general practitioners
- Registered nurse(s)
- Availability of midwives is desirable
- Standard minimum obstetrics equipment

LEVEL 1A

Service description
Confinements are undertaken where the accredited obstetrician judges that there is not a high likelihood of caesarean section or in his/her and the hospital's opinion, the type of delivery is not beyond the capacity of the unit to provide safe care.

Requirements
- 24 hour midwife cover
- 24 hour obstetric cover by doctors holding appropriate clinical privileges in obstetrics for that hospital. Variations to this level of cover, ie. that effect the standard minimum service level, are the responsibility of the above stated doctor, made in accordance with the assessed needs of the woman and unborn child. Any variation in the level of cover requires the doctor to notify and make appropriate arrangements with the relevant health service/s, doctors and, as appropriate, patients.
- Appropriate infrastructure
- Labour delivery area
- Full adult and neonatal resuscitation facilities
- In circumstances such as remote centres where planned deliveries are being offered and transfer time or back up for surgical intervention is more than one hour, then planned deliveries will be restricted to:

Low risk patients, as assessed by the doctor, who will be fully informed by the treating doctor of the risks associated with delivery at the Health Service, through informed discussion and signed consent.

- Pregnancy is to be beyond 36 weeks (unless unavoidable).

LEVEL 1B

Service description
As for Level 1A and in addition provides for planned caesarean section.

Requirements

- 24 hour midwife cover
- 24 hour obstetric cover by doctors holding appropriate clinical privileges in obstetrics for that hospital. Variations to this level of cover, ie. that effect the standard minimum service level, are the responsibility of the above stated doctor, made in accordance with the assessed needs of the woman and unborn child. Any variation in the level of cover requires the doctor to notify and make appropriate arrangements with the relevant health service/s, doctors and, as appropriate, patients.
- Intermittent caesarean and anaesthetic capability provided by doctors holding clinical privileges in obstetrics and obstetric anaesthesia for that hospital
- Appropriate infrastructure
- Labour delivery area
- Full adult and neonatal resuscitation facilities
- Caesarean section facilities available
- Laboratory services including blood cross-match

LEVEL 2

Service description

As for Level 1A & 1B and in addition provides for those cases where there is an increased likelihood of emergency caesarean section.

Requirements

- 24 hour midwife care
- 24 hour obstetric cover by doctors holding appropriate clinical privileges in obstetrics for that hospital and caesarean capability. Variations to this level of cover, ie. that effect the standard minimum service level, are the responsibility of the above stated doctor, made in accordance with the assessed needs of the woman and unborn child. Any variation in the level of cover requires the doctor to notify and make appropriate arrangements with the relevant health service/s, doctors and, as appropriate, patients.
- 24 hour obstetric anaesthesia
- 24 hour theatre availability

GENERAL

Every hospital should implement this policy.

Practitioners:

The focus will be on providing obstetric care as near to the place of residence of the patient as is possible. It is recognised that this requires attention to local circumstances and the fine details of care at that local level. It is also recognised that this task entails a multi-disciplinary team approach involving GP obstetricians, specialists and midwives.

In circumstances such as remote centres where planned deliveries are being offered and transfer time or back up for surgical intervention is more than one hour, then planned deliveries will be restricted to:

Low risk patients, as assessed by the doctor, who will be fully informed by the treating doctor of the risks associated with delivery at the Health Service, through informed discussion and signed consent.

There should be a sharing of antenatal history between GPs, hospital staff and the woman and the maintenance of appropriate records should be linked to clinical privileges.

The **standardised** use of the **Partogram form** is required.

Appointed obstetricians and midwives need to have neonatal resuscitation expertise and be accredited by the local clinical appointment committees in neonatal resuscitation.

Clinical appointments are to be made in accordance with the Health Department of WA (HDWA) requirements

The various clinical appointments committees and obstetric units shall have free and open access to the Rural Obstetrics & Midwifery Standing Committee. This body will comprise of rural GPs, specialist obstetricians, midwives and HDWA representatives and will meet regularly to discuss matters pertaining to the effective delivery of safe obstetrics care to rural Western Australia.

Where there is a maternity unit, the unit manager must be a registered midwife. The clinical management of obstetrics in hospitals where the Director of Nursing/Health Service Manager is not a midwife, must be the responsibility of a designated registered midwife.