4. Stakeholder consultation - rural and remote forums

“The birthing journey is a major milestone in life. It’s not just clinical, its cultural, spiritual and family. It’s more than just ‘delivering’ a baby. It’s so much more.”
(clinician – site visit)
4.1. **Summary**

The Taskforce engaged with key stakeholders in rural and remote Queensland regarding access to, and provision of, safe and sustainable woman-centred maternity care. Forums were convened between February and April of 2019 in Ingham, Mount Isa, Roma, Theodore and Chinchilla.

**Consumer perspectives**

“To make it safe for women – what we do for and to a woman can make or break that woman and family, and for generations” (clinician - site visit)

Consumers reported they want to be provided with information about their maternity options (antenatal, birth and postnatal) both locally and elsewhere, and want to be supported to access their preferred maternity options. Many women desired access to maternity services as close to home as possible.

Women identified advantages and disadvantages to receiving maternity care in a rural community. Continuity of care, where the woman is cared for by the same providers continuously throughout her antenatal, birth and postnatal period, and access to planned birthing within their local community influenced their satisfaction with the maternity services they receive. Care delivered within the local community was described as more personalised and having less impact on the daily life of the woman and her family.

Consumers recognised not all birthing options can be made available within rural communities. Leaving the community to access care was problematic for some women. This experience was influenced by the length of time and costs associated with being away from home, the distance being travelled and the availability of suitable accommodation and transport for the woman and her family. Women who need to travel to access care identified opportunities for improvements in subsidy and reimbursement schemes, transport and accommodation to lessen some of the impacts of travel on them and their families.

Aboriginal and Torres Strait Islander women and communities described a range of culturally specific maternity care needs. For some Aboriginal and Torres Strait Islander women, the experience of maternity care was influenced by their ability to birth on country. Aboriginal women in some communities told the Taskforce they want more welcoming environments within which to give birth and to see more Indigenous women in maternity workforce roles.

Consumers desire greater participation in maternity service design and review. They want to be engaged from the beginning of the maternity services planning process and on an ongoing basis throughout design and review. Aboriginal and Torres Strait Islander consumers would like to be consulted separately from other consumers, as well as participating in the broader consumer engagement process.

From a community perspective, maternity planning processes need to balance safety and risk when considering what maternity services they provide and where they provide them. Community members wanted HHSs to consider needs and preferences of local women, their willingness to accept limitations of receiving care in less resourced settings, and risks associated with having no planned birthing available locally when making maternity service decisions.

**Clinician perspectives**

Clinicians described a range of locally adapted maternity service models in place in rural communities. Models developed over time based on the workforce availability and capability to provide maternity services and local community needs and preferences.

The Taskforce heard about workforce shortages across all professional disciplines, both temporary (when staff members are on leave) and long-term (recruiting and retaining local maternity staff). In some cases, inability to retain a suitable workforce led to reduced or ceased delivery of some aspects of maternity care.
Providers described a range of difficulties in developing and maintaining their clinical skills in maternity care when working in a rural setting with limited numbers of pregnancies and births. Providers work alongside a range of other health professionals who also have to maintain their maternity skills in the setting of limited numbers of pregnancies and births. In some cases, providers need to travel to larger maternity centres periodically to develop and maintain their skills.

Training and skills development needs vary according to the scope of maternity services provided within the local facility and the maternity provider’s clinical discipline, skills, experience and confidence. Training needs were described in maternity, neonatal, anaesthetic, emergency and cultural aspects of maternity care. Providers with specialised maternity skills (midwives, rural obstetricians and rural generalists with advanced obstetrics skills) and generalist providers (nurses, doctors, paramedics) described maternity training needs.

Providers expressed a preference for training to be provided locally wherever possible. Some training is more specialised and requires the provider to travel to another centre to access. Where required, providers report funding to support attendance and/or backfill of their positions is helpful.

Rural maternity services were described as configured as a network of services, from least to most specialised. Providers described the importance of developing and maintaining professional relationships across the network. A range of strategies were identified to strengthen these relationships. Linkages between general practice and other maternity services in the network were identified as important to maintaining collaborative maternity care in rural communities.

Providers reported that prompt access to patient transfer for women and babies with time-critical care needs is essential to the delivery of safe, sustainable rural and remote maternity services. These systems were described as largely accessible and timely for maternity providers working in rural and remote maternity service settings.

The Taskforce heard that the psychological safety of maternity service providers needs to be supported. Opportunities to improve access by providers across disciplines to regular structured and facilitated reflective practice were identified.

Providers reported that rural maternity models of care should be reviewed regularly and proactively by hospital and health service managers. Small changes in the availability of local rural maternity providers and changes in the socio-demographic characteristics of their local communities can have significant impacts on the sustainability of local rural maternity service delivery. Providers would like greater involvement in maternity service planning processes.

**Hospital and Health Service perspectives**

“Safety is not binary – there is a consequence for every decision you make”

_(clinician - site visit)_

HHS stakeholders report they review their maternity services on a regular basis and when there are changes to service availability in the wider community, e.g. opening or closing of maternity services within their referral network. The methods of service review, review scope and frequency of review that stakeholders described varied across HHSs.

Although HHSs recognise the importance of women and communities participating in maternity service review and design, the degree to which this occurs in practice varies across regions. Consumer feedback mechanisms were in place in all HHSs, including consumer representation on committees and advisory groups. On reflection HHS stakeholders identified opportunities to engage consumers earlier and more actively in maternity services review and design processes and to improve methods for identifying the cultural needs of maternity service users.
In reviewing maternity services, HHSs assess the scope of maternity services that can be safely and sustainably provided by local facilities within the HHS network, including considering which facilities can support planned birthing. HHS processes for conducting this assessment were not always structured or well documented.

Availability of planned birthing in local rural communities is a key consideration for HHS maternity service planners. Factors reported by stakeholders that limit the ability of local facilities to provide planned births include the size of the local population, the numbers of pregnant women in the local community, numbers of women wishing to or able to have a planned birth in the local community, and the availability of a suitably skilled, experienced workforce.

HHS stakeholders reported that all HHS facilities are required to be able to care for women with imminent (or unplanned) births.

**Next steps**

Findings from the stakeholder consultation, together with the findings from the public submission process and analysis of Queensland perinatal and maternity data, will inform the development of the RRMS Planning Framework to assist HHSs with planning, developing and delivering rural and remote maternity services.

4.2. **Overview of forums structure and process**

Forums were convened in February and April of 2019 in Ingham, Mount Isa, Roma, Theodore and Chinchilla. Forums were also held in referral sites of Townsville, Rockhampton and Toowoomba.

Invitees to the forums included:

- mothers who had had babies in the past two years
- community members
- HHS clinicians, managers, executives, and Board members,
- general practices
- Queensland Ambulance Services
- Royal Flying Doctors Services
- any rural organisation that could assist the Taskforce to find effective strategies to improve rural maternity services.

**Independent facilitation**

All forums were facilitated by an external facilitator from KP Health, an organisation separate from and independent of Queensland Health and HHSs in Queensland.

The views of forum attendees were sought regarding current maternity experiences and opportunities for improved maternity care.

After each forum, the facilitator and members of the Taskforce met with the executive leadership of the respective HHS to discuss their rural maternity service systems. This included system structure, service quality and sustainability, and approaches to planning and reviewing of rural maternity services.

The discussions of the forum were content-transcribed by the KP Health forum facilitator. Narrative was analysed thematically according to the topics that emerged. All views were captured in the content-transcription process.
Themes organised by stakeholder group

This section provides a narrative account of the themes identified in the forums. To comply with strict Queensland Health privacy laws, the results of all forum discussions are described in a way that ensures the anonymity of forum participants.

There are three sections, one for each stakeholder group. Namely:

1. Consumers (mothers, family of mothers, and community members)
2. Clinicians (internal and external to HHSs)
3. Health service managers/executive leaders.
4.3. Consumer perspectives

“Can I just find what works for me and go with it?” (consumer – site visit)

Consumers who participated in maternity taskforce consultations described that, ideally, they wanted access to maternity services where they:

- know their maternity options (antenatal, birthing and postnatal), both locally and elsewhere
- are informed about how to access their preferred maternity options, including:
  - service locations
  - risks and benefits
  - costs
  - transport and accommodation
  - cultural aspects of care
- are supported to access their preferred options.

Maternity care in a rural community

Consumers living in rural and remote areas expressed a desire for access to a broad range of preconception, antenatal, birth and postnatal health services. Many consumers desired access to these services as close to home as possible.

Community members recognised the challenge of providing rural areas with the full range of services that are available to women in urban areas. It was acknowledged that local maternity service options are impacted by such limitations as:

- the large geographical spread of women’s residences
- small numbers of women birthing in some communities
- the challenges of attracting and retaining skilled workforce in rural and remote areas.

4.3.1. Experiences of receiving rural maternity care

“It’s a more relaxed feeling. Partners can stay or visit late at night after work” (consumer – site visit)

Women described advantages and disadvantages to receiving maternity care in a rural community.

Advantages identified included:

- an experience of care that is more personalised
- more likely to receive care from the same provider over the course of their pregnancy, birth and postnatal period
- less impact on their daily life and their families’ lives
- care received close to home means no need to travel long distances.

Disadvantages identified included:

- not all birthing options are available in rural communities
- if there are complications, obstetricians, anaesthetists or paediatricians are generally not available at the rural facility
- women with extra care needs (high-risk pregnancies) have to travel from their local area to be managed optimally
in some rural communities, women need to travel to receive particular care components (e.g. tests, procedures)

communication between different hospitals involved in their care is sometimes very poor which leads to delays in receiving adequate safe care

subsidy and reimbursement schemes only partially cover the costs associated with travelling for maternity care and there are delays between when the funds are required to pay for transport and accommodation and when reimbursement is received

when accommodation is provided there are sometimes limited or no cooking facilities

receiving care in the local community affords less privacy for some women (especially those who work in the local health service).

“Need better explanation on what can go wrong. Got most of my information from Google”

(consumer – site visit)

Women who participated in Taskforce consultations reported a tendency for their local health providers to describe only those maternity options that were available locally. They were not made aware of all their maternity options and how to access them. There were concerns raised that the local health providers, who should be the gateway for women to access their preferred options, are instead gatekeepers, who only suggest the options that align with their practices. This was a source of frustration for some women who were willing to travel to access their preferred maternity options.

4.3.2. Factors that affect the maternity experience

“You shouldn’t have to retell stories” (consumer – site visit).

Whilst the maternity experience was described as largely positive by some women, it was quite negative for a number of other women. The factors cited as contributing to a negative maternity experience were:

- discontinuity of care, where women ‘didn’t see the same person twice’ for their maternity care
- a lack of available planned birthing locally
- fear associated with the anticipation of, and actual risks of, travelling alone on rural roads while in labour.

Better continuity of care to benefit women in rural communities

“There’s a connection to family and area” (consumer – site visit)

Continuity of care was described by women as seeing the same person (maternity provider) periodically throughout their pregnancy. Seeing multiple providers was acceptable to women if there was at least one provider with whom a therapeutic relationship was maintained throughout the pregnancy and postnatal period.

The benefits of continuity of care were described as:

- having someone to go to who could answer questions and provide support throughout the antenatal, birth and postnatal period
- receiving consistent advice (as opposed to the experience of women with no continuity of care, who described receiving advice from multiple different providers that is often conflicting)
- having someone who could advocate with other providers for the woman’s maternity needs and wishes to be prioritised.
Communication and information sharing between providers was also described as improved where continuity of care was provided.

Local planned birthing is preferred by most women

“You expect doctors to tell you what needs to happen. You don’t expect their values to get in the way. You don’t question it. You think they have your best interests at heart. It’s tricky to tell new mums to be well-informed” (consumer – site visit)

Local planned birthing was the preferred model of maternity care for most women who participated in the consultations. Other women preferred to travel because of:

- a desire to access higher level services with greater levels of obstetric, anaesthetic and/or paediatric services due to these models being perceived as safer
- a wish to access service models not available locally, such as birthing centres, private obstetricians or private midwives
- a desire for greater anonymity or amenity afforded by accessing care outside their local community.

For women who wished to access care locally, some described being unable to access planned birthing in their local community. For these women, having to travel was associated with:

- concerns about their baby being born before arrival at hospital
- increased financial burden on the family due to having to leave the family some time before the baby was due
- increased stress, feelings of isolation and loneliness
- decreased participation of the whole family in bonding with the new baby.

Leaving the community for birthing

“[The women] get lost in the machine in a large hospital” (GP – site visit)

The experience of leaving the local community to access maternity care was dislocating for some women. This experience was influenced by:

- the quality of accommodation and its suitability for extended family
- the availability of support for the woman’s partner, family and other support people to travel to the centre where maternity care was being delivered
- the length of time the woman is away from home
- the costs associated with being away from home.

Some women reported they are reimbursed to go to their nearest facility, not to their preferred facility. If they must travel, women want to be supported to go to their preferred place to receive care—which for many is where their extended family and friends reside, not to where the nearest maternity facilities are.

In some cases, women who do not have access to planned birthing from their local health service described intentionally attending their local facility when in labour even though this facility does not perform planned births. This so-called “planned unplanned imminent birthing” was described as the only way they could receive clinician support to birth in their local community.
Postnatal care experiences

Some women were dissatisfied with the quality of their postnatal care. The Taskforce also met with women who received no postnatal care at all. For these women, numerous difficulties in the postnatal period were described, including difficulties with breastfeeding, relationships, infant settling and mental health.

Women described the factors that contributed to a lack of acceptable provision of postnatal care. These included:

- no continuity of midwifery care
- birthing care provided at a larger centre with no local postnatal follow-up arranged
- provision of private obstetric care at a larger centre with limited access by the mother to this centre for ongoing follow-up.

4.3.3. Maternity experiences

“It’s exhausting explaining cross-cultural considerations all the time”

(community representative – site visit)

Aboriginal and Torres Strait Islander women who were consulted described a need for greater choice in available maternity options to better meet their needs. Some Aboriginal women described needing to travel well before the birth of their baby. For some of these women, their mothers, aunties or grandmothers were unable to travel or were not allowed to come into the birthing room due to the facility not wanting too many people in the room. In other cases, the person travelling with the expectant mother was not a good support for the mother—they travelled because they were available, not because they were well-suited to the role.

Aboriginal women told the Taskforce they want to see ‘black faces on maternity’, more welcoming environments within which to give birth, and more Aboriginal women in health roles that can support women who are receiving maternity care—particularly when giving birth.

Birthing on country

“My mob has had their cultural identity taken away. There’s been psychological damage. [Referral hospital] is not our country” (community representative – site visit)

For Aboriginal and Torres Strait Islander women, the experience of maternity care was influenced by their ability to birth on country.

Birthing on country was described in various ways by the women who were consulted. Although practices varied across regions, the Taskforce was told birthing on country is a cultural tradition for women and newborns to connect with their ancestors’ land.

Women reported that some traditions, such as welcoming a baby to country through smoking ceremonies, women with cultural authority being present at birth, naming practices, and related cultural practices were unable to be performed in hospitals away from country.

Women said being unable to birth on country was associated with impacts on the community, the young mother, the baby and their family. In some cases, people described a lasting sense of shame at being unable to birth on country.
4.3.4. Community participation in maternity service design and review

“We want safety discussions to include spiritual, cultural, physical, emotional, transport, and family”
(Aboriginal woman, community representative – site visit)

Local maternity service delivery impacts the community as a whole

The community’s perspective is that local planned birthing services are important to local communities for attracting and retaining young families in the local community. Community stakeholders reported that people make decisions about whether they will live in a local community based on the availability of local services, including local maternity services.

Community stakeholders also described the sustainability of local hospital services overall as linked to the ongoing availability of planned birthing services. They described a need for community to advocate for the ongoing availability of planned birthing services, otherwise they might lose their local hospital altogether.

The Taskforce encountered a strong community focus on the availability of planned birthing within local communities. Communities also valued local access to antenatal and postnatal care, however these topics were not raised as often as planned birthing.

Communities want to participate in maternity planning

“We’re at the table waiting for that [engagement] to happen”
(community representative – site visit)

Community members reported they want to participate with their health services in processes for developing and reviewing maternity services. They described currently either not being involved at all or being consulted later in the maternity review process, after health services managers had decided what services would be made available.

Some mothers who recently gave birth felt less able to participate due to the multiple competing demands on their time. However, other mothers reported they could contribute to health services processes for developing, reviewing and planning new services or changing existing services, particularly if planners ‘come to where the mothers are’. Local play groups, mothers’ groups and social networks were suggested as settings where planners could engage with mothers.

Other community members also described having limited mechanisms for meaningful participation in maternity planning decisions. In some cases, communities were unaware of who to engage with to discuss how to participate. In other cases, community members were aware of advisory groups or committees that included consumers, but were unsure of whether this form of participation was enough to have their concerns heard and addressed.

Participation of Aboriginal and Torres Strait Islander community members

“It’s not been a process where Aboriginal mothers have been heard”
(community representative – site visit)

Aboriginal people on boards and advisory groups reported to the Taskforce that they need more time to yarn about their community’s maternity needs and how these are best addressed. Formal meetings with an Aboriginal or Torres Strait Islander representative, such as Boards or consumer reference groups, were described as often time-pressured, and not enabling meaningful conversations to occur about culturally tailored care.

Some Aboriginal and Torres Strait Islander people indicated they would like to be consulted separately from other consumer groups as well as together with other consumers. Separate consultation affords Aboriginal and Torres Strait Islander consumers to more openly discuss cultural care needs.
4.3.5. Safety and risk considerations in maternity planning

From a community perspective, maternity planning processes need to balance safety and risk when considering what maternity services will be provided and where to provide them.

Some community stakeholders reported they believe safety decisions are made by HHSs based on the size of the community, the number of births by local women, the distance of the community from a larger hospital and the availability of doctors at the facility to provide emergency obstetric care.

These community members felt this concept of safety was too narrow and did not account for the risks associated with having no onsite planned birthing services at all. For most communities, the risk most frequently cited was the baby being ‘born by the side of the road’.

From the community perspective, HHS decision-makers should also consider:

- the needs and preferences of local women and their willingness to accept risks for themselves and their babies, associated with receiving care in a local, less resourced setting
- the cultural impacts of any planned decisions
- risks of decisions to the sustainability of the local community as a whole
- the availability and willingness of local health service providers to continue to provide maternity services in a local, less resourced setting.

Some communities described experiences of HHS staff members informing them that local services would cease to be provided as they were “not safe”. In some cases, these community members felt HHSs did not adequately balance the factors, both positive and negative, associated with these decisions to cease to provide local services.

4.3.6. What consumers want from Hospital and Health Services

Community members reported they want to participate with their health services in processes for developing and reviewing the maternity services.

Community members reported wanting greater transparency in how decisions about local maternity services are made by HHSs.

Some communities reported feeling as though HHSs made decisions about which maternity services would be provided in each local community in the absence of meaningful community consultation, and only involved the community once a decision had been made. Community members expressed a desire for greater involvement in discussions about their community’s maternity needs before service decisions were made, and wanted greater input into the decision-making process.
4.4. Clinician perspectives

The Taskforce met with rural clinicians who deliver maternity care across a range of different service models and clinicians from regional hospitals who receive women from rural settings. Providers who participated in the consultations work:

- in continuity midwifery, core midwifery and private practice midwifery models
- as general practice shared care, visiting medical officer and senior medical officer roles
- as senior medical officers (some but not all of whom were also general practitioners) delivering maternity services and anaesthetics services in rural hospitals
- as obstetricians and/or in Flying Obstetrician models.

The Taskforce also met with hospital and community staff working in rural Director of Nursing/Midwifery and Director of Medical Services roles, registered nurses in ward and community roles, nurse educators, child and family nurses, theatre staff, paramedics, mental health professionals, Indigenous Health Workers, social workers and Aboriginal Liaison Officers.

Locally-adapted service models in place

“rural [birthing] is about risk reduction and looks different for each scenario” (clinician – site visit)

Each HHS described differences in the range of maternity services being delivered locally. Models in place in many rural communities were forms of the 11 maternity models described by the Australian Institute of Health and Welfare (AIHW) or hybrid models which combined different elements of the 11 AIHW models.

Reasons for adaptation of AIHW models were explored with stakeholders, who reported their maternity services had evolved over time in response to local workforce availability, skills and expertise.

Workforce shortages are an ongoing concern

“People move away when services close” (GP – site visit)

The Taskforce heard about workforce shortages in medical, midwifery and nursing roles across many different rural health settings. Both temporary workforce shortages (difficulty back-filling roles when staff members are on leave) and long-term workforce shortages (recruiting and retaining maternity staff) were described.

Health professionals view service discontinuity as undermining the confidence of local communities in the ability of local services to meet their care needs.

According to stakeholders, addressing both temporary and long-term workforce shortages was an ongoing concern for health service managers and influenced the continuity of some maternity services they could offer. In some cases, inability to retain a suitable workforce had led to cessation of delivery of maternity services in local communities, particularly planned birthing in some rural communities.

4.4.1. Experiences of delivering rural maternity services

“Some rural birth experiences are the best a woman can get” (clinician – site visit)

In each community visited by the Taskforce, doctors and midwives described working together closely to deliver maternity care. Providers reported they are generally well-known to one another because of the small size of the clinical community in rural towns.

Many providers who were consulted had been living in rural communities for some years. They report being attracted to the local community by the professional opportunities rural practice afforded (including
to provide continuity of care, to work to their maximum scope of practice) and due to personal circumstances (including attachments to the community through their personal relationships and/or family connections).

Providers also reported feeling that their role in the community was unsupported and undervalued by the larger birthing units. They suggested this was demonstrated by disrespectful and less than timely communication from clinical staff at the larger hospital they had to communicate with regarding the care of local women who were pregnant and birthing.

Providers reported a willingness to continue to provide maternity services in their local community because of their desire to continue to meet local needs. Many described feeling professionally valued by their local communities, which attracted them to continuing to provide clinical services rurally.

4.4.2. Maintaining professional skills in a rural practice setting

Providers described a range of difficulties in developing and maintaining their clinical skills in maternity care when working in a rural setting. Many of these challenges centre around the limited number of pregnancies and births in some rural communities.

Small communities have fewer pregnant women who need to be cared for. In some communities, providers report there are not enough pregnant women for all maternity providers in the community (doctors, midwives, nurses) to maintain their skills in their respective disciplines.

Fewer pregnant women means fewer births occurring among local women. Smaller communities are unable to provide planned birthing for women with high-risk pregnancies. The remaining low-risk births occur in communities with planned birthing by the doctors and/or midwives who practice maternity care. The number of planned births may be insufficient for all maternity providers to feel that they are maintaining their clinical skills.

This problem was reported to be further compounded by the need to roster clinicians so that they do not experience burnout. Providers described a tension between providing enough maternity workforce to manage on-call arrangements and mitigate risk of fatigue versus having enough women requiring maternity care for everyone to develop and maintain their professional skills and interest. According to some stakeholders, the more clinicians on the roster, the fewer births each clinician individually attends. Conversely clinicians, especially midwives with additional nursing qualifications, expressed that they are often rostered to the hospital to cover the general hospital needs, usually providing care for non-maternity inpatients. This meant the midwife was not available for maternity clients when needed due to having to fill the roster at the hospital.

In some cases, local communities do not provide planned birthing at all. For clinicians, this may limit their maternity scope of practice to pre-pregnancy, antenatal and postnatal care (and managing women who present with imminent birth). This scope of maternity practice can be professionally unrewarding for some skilled health professionals who have trained to use their full scope of practice, including attending planned births.

Professional skills need to be developed before they can be maintained. For early career professionals, the number of births in small communities may not afford them the volume of work they feel they require to continue to develop their skills.

Maternity workforce training and skills development

Maternity providers described considerable variability in the workforce training and skills development needs of their different clinical disciplines. Training needs also varied according to the level of experience of the health professional, their community’s availability of back-up emergency support for women and babies with time-critical care needs, and the CSCF level of the facility where staff work.
Broadly the training areas described by clinicians were in the topics of:

- Maternity – evidence-based management of the woman through the pre-pregnancy antenatal, birth and postnatal periods
- Neonatal – care of the unwell newborn
- Anaesthetics – anaesthetic care to support delivery of birthing services
- Emergency – advanced resuscitation skills for mother and baby
- Cultural – the delivery of care that meets the cultural care needs of mothers and their families and communities.

Providers expressed a strong preference for training to be provided locally wherever possible, but recognised some training was highly specialised and that they would need to travel periodically to access training. Where this was required, providers reported they could benefit from funding to support attendance at training and backfill of their positions where possible. However, some providers advised they were unable to travel for professional development due to family commitments.

Some maternity professionals report they travel periodically to larger higher-volume maternity centres so they can continue to develop and maintain their maternity skills.

- Obstetric and anaesthetics medical professionals reported needing to travel for skills development or maintenance (senior medical officers, general practitioners).
- Some midwives reported having travelled to maintain skills.

Where providers have other clinical responsibilities in the local community, their need to travel meant women either receive care from another provider (where the position is back-filled or covered by another health professional) or the community is without its full complement of doctors, nurses or midwives during the time the health professional is away. This places a strain on the local community’s workforce and contributes to discontinuity of care for the provider’s regular patients/clients.

Health professionals in the health service that are not directly involved in the ongoing delivery of maternity care also have training needs. For example, ward nursing staff in some rural communities are required to manage the immediate post-birth care needs of women and their babies. These staff need ongoing skills development and maintenance to enable them to be confident in this role. Similarly, all rural facilities are required to be prepared to manage imminent/unplanned births should a woman present in labour. Not all facilities have midwifery trained staff available 24 hours a day to respond to these care needs. Facilities therefore need to provide education and training to staff to enable them to manage these presentations.

**Workforce networks and partnerships**

*“Where’s the culture of learning together?” (clinician – site visit)*

Rural medical practitioners described the importance of professional relationships with their peers in their main referral centre. These relationships were viewed as necessary to enable them to feel supported in their rural maternity role, particularly for less experienced rural medical professionals.

Some rural medical practitioners told the Taskforce these relationships need to be strengthened. At present, providers do not routinely work together across organisational boundaries and between facilities to deliver seamless maternity care. As a result, clinicians in larger centres do not necessarily know what local providers can do, what equipment and resources they have, and about their skills and expertise. This affects the ease with which clinicians work together to manage complex care needs and address time-critical events for a mother and/or baby in an emergency.
Clinicians identified a range of strategies to strengthen relationships across organisations, mostly underpinned by strengthened peer networks through:

- conducting regular case conferences (including reciprocal peer review of transfers as the receiver and referrer of care)
- discussing case scenarios
- participating in shared training and skills development.

Larger centres may be inflexible in applying CSCF rules rather than supporting local services to enable women to birth as close to home as possible.

**Linkages between general practice and maternity services**

General practitioners (GPs) are involved in various ways in the delivery of maternity care in all rural communities the Taskforce visited. The scope of this role varies between general practitioners. Most general practitioners primarily deliver services in the pre-pregnancy, antenatal and postnatal periods. A smaller group of general practitioners provide planned birthing services, in obstetric or anaesthetic roles, or hospital emergency services which may include a requirement to deliver care to a woman with an imminent, unplanned birth.

Some general practitioners reported dissatisfaction with their changing role in delivering maternity care. The role of the general practitioner is to deliver continuity of care to their patients. Their experience of referring some of their patients to maternity services is that they do not see the mother again until after the pregnancy and birth. They reported that receiving discharge summaries from higher level services when a woman returned to the community was an area for improvement. Many GPs who were consulted expressed a preference to continue to be involved in the delivery of the woman's maternity care needs throughout the pregnancy, regardless of which maternity model the mother chooses.

**4.4.3. The psychological safety of maternity providers**

The Taskforce heard that the psychological safety of maternity providers needs to be supported. The Taskforce met with providers who have experienced psychological distress as a result of attending to the maternity care needs of women with adverse pregnancy outcomes.

Some providers told the Taskforce they had participated in de-briefing sessions after an adverse event had occurred. Some were offered access to employee assistance programs for counselling. Providers generally do not regularly participate in structured or facilitated reflective practice where they continue to be supported in their role on an ongoing basis, and where psychological distress can continue to be monitored for and worked on.

Providers described experiencing or observing a range of unintended consequences from births where adverse outcomes had occurred, and where reflective practices were not in place:

- Some providers had ceased to practice in the maternity field as a direct consequence of an adverse outcome. This contributed in some cases to a reduction in available maternity services, including loss of some planned birthing in rural facilities.
- Providers described hypervigilance as a response to adverse outcomes, whereby the provider adjusted their maternity practice by ordering more investigations; reviewed women more frequently throughout pregnancy, birth and postnatal periods than clinically indicated; and/or refused to provide maternity care for some women with more complex care needs who they had previously been willing to care for.
• Providers reported breakdowns in relationships between providers within and across healthcare organisations, and a ‘blame culture’ was perceived to have developed within some facilities leading to detrimental impacts on staff morale and workforce retention.

Maternity providers also reported that communities were not necessarily communicated with about the adverse events. In their opinion this had impacted consumer confidence in local services in some cases and led to women choosing to access services elsewhere. As a result, maternity services that had previously been viable were viewed as having become less sustainable.

4.4.4. Rural maternity service models need frequent review

The Taskforce heard that rural maternity models of care should be reviewed frequently and proactively by hospital and health service managers. Some clinicians believed this was not occurring or were unaware if this is occurring.

Some clinicians reported the socio-demographic characteristics of their local communities have changed in response to changes in industry and local employment.

In some cases, industry has declined in rural communities and the size of the local population has changed quickly. As a result, fewer pregnant women were receiving care within the local community, affecting the appropriateness of local service models.

In other cases, clinicians reported significant or impending challenges to the delivery of local maternity services due to the retirement of local, experienced maternity providers or loss of local maternity workforce from the community.

For a small rural community, these factors can have significant impacts on the delivery of local rural maternity services and should trigger planned review of local maternity services.

Supporting local workforce through changes in the scope of maternity services

The Taskforce heard local maternity providers describe the impacts of service system changes on local maternity service providers.

Where the CSCF of local services has been reduced, providers reported a de-motivating impact on the local maternity workforce. It can be difficult for some staff who continue to live in their local community to maintain their professional identity and, in some cases, professional status within the community. Clinicians reported that staff need to be supported in these transitions.

Managing patient transfers

“The further away from home you are – care is less personalised” (consumer – site visit)

Health professionals described prompt access to patient transfer for women and babies with time-critical care needs as essential to the delivery of safe, sustainable rural maternity services.

The Taskforce heard that patient retrieval services were largely accessible and timely for maternity providers working in rural settings. From time to time the capacity of retrieval services to quickly transfer mothers and babies can be exceeded. For this reason, all maternity stakeholders consulted reported that local rural staff must maintain their emergency management skills through frequent and ongoing training and professional development.

Stakeholders reported that retrievals were often for babies with time-critical care needs. In this circumstance, providers were strongly supportive of the need for mothers and family members to be supported to also travel to the site where the baby receives ongoing care. At present, family members are not necessarily supported to travel, which causes distress and family dislocation.
4.4.5. What clinicians want from Hospital and Health Services

Maternity service providers were asked what they need from HHSs to support improved rural maternity services decision-making.

"Planned holistic care that is a wrap-around from antenatal care to early childhood"
(clinician – site visit)

Improved planning processes

The Taskforce heard clinicians want improved planning processes, where they can be involved in decisions regarding:

- the scope of rural maternity services that are offered
- the maternity CSCF of local facilities.

Clinicians want HHSs to continue to work with local maternity providers to identify the local workforce education and training needs and establish how these can best be addressed. Many clinicians view strengthening of professional networks between different facilities in the HHS maternity network as important to improving the function of maternity services regionally.

Improved systems to support psychological safety of staff

"It’s evolution, not revolution" (clinician – site visit)

Providers felt HHSs are accountable for the psychological safety of staff, and that systems and processes for supporting all maternity providers could be improved. Structured/facilitated reflective practices and support should be ongoing and embedded within usual practice, rather than time-limited and only in response to serious adverse outcomes.

Review of some policies and guidelines

"Policies are designed for bigger hospitals and don’t work in smaller facilities" (clinician – site visit)

Clinicians recognised a need for policies and guidelines that inform local decision-making regarding the care of women. Some felt policies and guidelines were too rigid and need to be reviewed. In particular:

- Some rural providers felt they could safely care for women whose body mass index was marginally higher than the cut-off for local services to support a planned birth and that these cases could be considered on a case-by-case basis with higher level services in the maternity network.
- Providers felt the requirement for some women to travel four weeks or more before birth to a centre that performs planned births was overly disruptive to women, their families and communities.
4.5. Hospital and Health Service perspectives

HHS Board members, Executive and managers were consulted. They report they regularly review their maternity services. In developing and reviewing these services, stakeholders report they consider a range of factors, including:

- the maternity care needs of the local community across the continuum of antenatal, birthing (planned and imminent/unplanned) and postnatal care
- the availability of local workforce, resources and infrastructure to meet women’s maternity care needs
- the feasibility for the HHS to provide the required workforce, resources and infrastructure to better meet needs, if gaps are identified.

Stakeholders did not report they consider all 11 of the AIHW maternity models per se in their planning processes or how these can be offered in individual communities.

4.5.1. Planning births in local communities

“You can’t decide this in an office. You need a proper process over time”

(community representative – site visit)

In general, planning processes for HHSs are oriented toward providing planned births as close to home as possible.

Planning across HHSs was not informed by set numbers of births or pregnancies that determined whether a local service could be provided or not. For example, no Hospital and Health Service manager consulted reported they use a set number of births to determine whether or not a local service can be provided.

In some cases, planned births are not able to be supported by managers of the HHS. The Taskforce heard that factors that influence the ability of facilities within the HHS to provide planned births include but are not limited to:

- the size of the local population
- numbers of pregnant women in the local community
- numbers of women wishing or able to have a planned birth in the local community
- availability of a suitably skilled, experienced maternity workforce.

Planning challenges facing health service managers

“[Community groups] are both the vehicle and the fuel [to get local support]”

(community representative – site visit)

The distance of the local community from other services that are better resourced to provide maternity care was a consideration for managers in their planning processes. The Taskforce heard numerous examples of responses to these planning challenges, including:

- In small rural communities where the nearest planned birthing service is a long distance away (e.g. eight hours or more by road) managers put into place policies where the woman travelled to the birthing centre several weeks before the estimated birth date.
- Communities with larger populations or with close proximity to a well-resourced maternity service could generally support more maternity service models, providing a suitably skilled and experienced workforce could be recruited and retained to support each model.
The Taskforce found that some HHSs only provide planned births if there is an onsite capability for an emergency caesarean section (i.e. medical officers credentialed in anaesthetics and obstetrics). Other HHSs do not have this requirement and may provide primary midwifery services for low-risk births.

The Taskforce observed that the risk appetite of the HHS executive or senior obstetrics staff were factors that influenced this local aspect of maternity service decision-making.

4.5.2. Degree of consumer engagement

Although HHS stakeholders recognised the importance of women and communities participating in the maternity service review and development process, the degree to which this occurred in practice varied across regions.

In all cases, consumer feedback was sought from maternity service users. This feedback informs planning decisions by managers. Some HHSs reported they have maternity-specific committees or advisory groups. Others incorporate maternity service considerations into the roles and functions of generic consumer advisory committees and groups.

On reflection, most managers consulted felt they could strengthen their mechanisms for maternity consumer engagement and involve consumers earlier in the planning process.

Addressing cultural care needs of service users

"Family are the biggest advocates, especially if the woman is sick and has trouble understanding medical stuff." (community representative – site visit)

Stakeholders reported various ways in which the cultural needs of maternity service users were identified in planning processes. Some HHSs have Aboriginal and Torres Strait Islander representatives who inform about cultural care needs, including for maternity care. The cultural care needs of other groups were generally more difficult for managers to identify and respond to through committee representation.

The culturally-specific maternity care needs of Muslim women were identified by some managers as an area where improved staff education and training could be provided.

Birthing environments

"Safety in childbirth is more than just a healthy mum and baby" (clinician – site visit)

Consumers identified a need for HHS planners to explicitly consider the environments within which women receive maternity care, including the birthing environment.

On reflection, stakeholders agreed with consumer feedback that maternity environments need to be welcoming, comfortable, private, afford the woman and her family with amenity and be culturally appropriate. However, these factors were often omitted from consideration when reviewing and developing maternity services. Further, consumer engagement and often clinician engagement to improve maternity environments was not currently prioritised as part of maternity service review activities in most HHSs.
4.5.3. System architecture and governance

“Return of birthing has changed the psyche of the hospital [for the better]” (GP – site visit)

Rural maternity services are configured in a network model, with ‘hubs’ (higher CSCF level services) and ‘spokes’ (lower CSCF level services) delivering care across the network. A major planning consideration is determining which services are hubs and which are spokes, and what workforce, infrastructure and resources are required to enable each facility to fulfil its role in the maternity service network.

Some managers identified opportunities for the roles of higher-level maternity services and their accountabilities to lower-level services to be strengthened through maternity planning processes. This included:

- provision of workforce education and training
- establishing and maintaining workforce networks and relationships
- supporting delivery of systems for reflective practice oriented toward the psychological safety of staff.