5. Public submissions

“My concern is that maternity services have been removed from my extended family’s area in remote/rural Queensland. In the short term, this has taken away the rights of pregnant women in the area to safely have their pregnancy and birth monitored close to their support group (partners, children, friends), the rights of partners, children and friends to be there in support of pregnant and birthing women and the jobs of local residents. In the long term, the future growth of these remote and rural towns and surrounds will suffer, as families and communities will be forced to choose to reside in areas where maternity services are available, whether to use themselves, for family members or as a possible job” (consumer – public submission)
5.1. Summary

The submission process commenced on 3 December 2018 with the opening of the online submission portal and call for submissions by email to a wide range of stakeholders through the Statewide Maternal and Neonatal Clinical Network distribution list and the Clinical Excellence Queensland distribution list, which have over 10,000 recipients combined, and consumer groups such as Health Consumers Queensland, Maternity Consumer Network, and Maternity Choices Australia. The submission process officially closed on 18 February 2019 at midnight. A small number of submissions was received after that date and were accepted.

A total of 309 submissions was received from individual members of the public, professional bodies and interested groups. Of the 309 submissions, 295 were submitted online, and 15 by email. There were 1,624 views of the online portal. Table 3 shows the types of roles that respondents had, with the majority being women who had used maternity services in the past five to 10 years and midwives.

Table 4 and Figure 2 show the rurality category of the respondent as chosen by themselves, compared with the official rurality index of the postcode they provided (as classified by the Australian Statistical Geography Standard (ASGS) Remoteness Structure)\(^1\). The majority of respondents were noted to be from rural areas, as identified by postcode or though self-identification.

Table 3. Respondents’ roles and recency of experience with a maternity service.

<table>
<thead>
<tr>
<th>Role</th>
<th>In the last 5 years No.</th>
<th>In the last 5 years %</th>
<th>More than 5 years ago No.</th>
<th>More than 5 years ago %</th>
<th>Total No.</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator</td>
<td>11</td>
<td>3.7%</td>
<td>0.0%</td>
<td>11</td>
<td>3.7%</td>
<td></td>
</tr>
<tr>
<td>Consumer</td>
<td>3</td>
<td>1.0%</td>
<td>2.0%</td>
<td>5</td>
<td>1.7%</td>
<td></td>
</tr>
<tr>
<td>General Practitioner</td>
<td>5</td>
<td>1.7%</td>
<td>0.0%</td>
<td>5</td>
<td>1.7%</td>
<td></td>
</tr>
<tr>
<td>GP obstetrician</td>
<td>23</td>
<td>7.8%</td>
<td>0.0%</td>
<td>23</td>
<td>7.8%</td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>78</td>
<td>26.5%</td>
<td>2.0%</td>
<td>85</td>
<td>28.8%</td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>16</td>
<td>5.4%</td>
<td>1.0%</td>
<td>19</td>
<td>6.4%</td>
<td></td>
</tr>
<tr>
<td>Obstetrician</td>
<td>5</td>
<td>1.7%</td>
<td>0.0%</td>
<td>5</td>
<td>1.7%</td>
<td></td>
</tr>
<tr>
<td>Partner / support person / relative</td>
<td>17</td>
<td>5.8%</td>
<td>0.7%</td>
<td>19</td>
<td>6.4%</td>
<td></td>
</tr>
<tr>
<td>Woman who has used maternity services in Qld</td>
<td>76</td>
<td>25.9%</td>
<td>8.2%</td>
<td>100</td>
<td>33.9%</td>
<td></td>
</tr>
<tr>
<td>Other(^1)</td>
<td>22</td>
<td>7.5%</td>
<td>0.3%</td>
<td>23</td>
<td>7.8%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>256</strong></td>
<td><strong>87.1%</strong></td>
<td><strong>12.9%</strong></td>
<td><strong>295</strong></td>
<td><strong>100.0%</strong></td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) includes allied health practitioners, health service administrators and managers, GP anaesthetists, neonatologists, paediatricians, Indigenous health workers, dual qualified nurse midwives, academics and researchers, and women planning to use Queensland Health maternity services

Table 4. Rurality of respondents (self-chosen) compared with ASGS remoteness classification\(^1\)

<table>
<thead>
<tr>
<th>Major Cities</th>
<th>Inner Regional</th>
<th>Outer Regional</th>
<th>Remote</th>
<th>Very Remote</th>
<th>#N/A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Qld</td>
<td>16</td>
<td>55</td>
<td>19</td>
<td>4</td>
<td>-</td>
<td>96</td>
</tr>
<tr>
<td>Rural Qld</td>
<td>6</td>
<td>47</td>
<td>81</td>
<td>8</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Remote Qld</td>
<td>-</td>
<td>3</td>
<td>6</td>
<td>8</td>
<td>15</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>9</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
<td><strong>114</strong></td>
<td><strong>111</strong></td>
<td><strong>21</strong></td>
<td><strong>18</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>

\(^1\) Australian Statistical Geography Standard (ASGS) Remoteness structure
The range of issues, concerns, suggestions and positive feedback spanned the key areas of service delivery, staffing, patient experience, safety, and funding, in addition to general aspects of maternity services.

5.2. Service delivery

“Decentralise health services. Restructure health services to wrap around the woman, her community and the midwife. Prioritise midwifery continuity of care models that are accessible to all women regardless of where they live.” (clinician – public submission)

Location and access to services were key issues identified in the submissions. The specific aspects included; lack of available services (inability to access services close to home), the closure of some smaller services, lack of private options available in rural areas across Queensland, availability of special care nursery beds and lack of support services such as lactation consultations, and antenatal parenting classes.

Continuity of care was also raised in relation to community care and follow-up as well as the lack of culturally appropriate services.

Respondents identified limited options available in rural and remote areas (e.g. waterbirth, homebirth, telehealth) and the more traditional models of care that are available are not meeting current needs. Respondents noted differing opinions between midwife-led models and medical models of care. The provision of maternity services within generalist areas and by generalist staff was also highlighted, including postnatal care in general wards by nursing staff without specific midwifery training as well as early pregnancy assessments carried out in emergency departments. The models of care in some rural areas also lack the option to provide antenatal and postnatal care locally, with the transfer to a larger service for birth.

Issues were also raised in relation to a range of protocols and guidelines, specifically related to neonatal retrievals (declining to activate before the baby is born), difficulties in referring to tertiary centres, variation in pain relief options across services, inconsistency in guidelines, policies and models of care offered, e.g. fetal surveillance and review and sign-off of cardiotocography (CTGs). Early discharge back to a local hospital was noted as problematic where local hospital staff do not possess the appropriate skills and support services, and resources are not in place.
A number of suggestions related to increasing or re-opening more services that are close to home (accessible, appropriate, safe, effective and affordable) and expanding models of care were provided in the submissions to alleviate or reduce the issues identified. Additionally, access to appropriate medical and midwifery staff, funding for midwifery group practices and midwifery navigators in non-metropolitan areas, the use of telehealth and collaborative models of care, and credentialing of GPs, GP obstetricians, and private obstetricians with the health service to provide care at the hospital were suggested. Homebirths, waterbirths and culturally appropriate models of care (e.g. birthing on country) were also suggestions offered for consideration.

5.3. **Staffing**

“My suggestion, increase the digital support to rural and regional areas - experts at the end of the phone using today’s technology. Increase telemedicine. Establish trusted relationships between clinicians in rural/remote and tertiary referral centres so face to face visits for patients are reduced. Even take the staff from rural and remote to the high-risk teams and ensure the competency assessments match, so they trust both ways the assessment via telemedicine. Review positive outcomes in opposition to the variances of bad outcomes to help develop the decision tree/algorithm for when to transfer.” (partner/support person – public submission)

Issues in relation to staffing of rural maternity services were raised. This included a perceived lack of qualified or experienced staff in local areas (including medical, nursing and lactation support), and a perceived lack of appropriate training and education for staff, both locally and at higher level facilities, and the ability for staff to maintain professional skills where case numbers are low. Respondents indicated they felt there are also difficulties associated with retaining staff and commented on the lack of incentives to work in non-metropolitan areas, as well as differing incentives for medical officers, and nursing and allied health staff. Cultural awareness of staff and reports of workplace conflict between and within disciplines, staff morale, reliance on agency staff, and the impact of all of these on productive teamwork and staff burnout were also raised as issues.

Associated with the issues identified, there were a number of suggestions to increase staff numbers, provide incentives to retain staff, and for provisions of options for clinicians to increase and maintain skills. Suggestions also included; establishing a permanent pool of staff to backfill in rural areas, allocation of non-clinical tasks to administration staff where possible, support for staff following on from adverse events, and identification of consequences that result from a lack of teamwork.

5.4. **Consumer experience**

“Our hospital started delivering babies again a few years ago. Before that I had to travel to deliver. I was terrified of something happening on the highway. We stayed at friends on the lounges. And went back and forwards. Thank God it is local again.” (consumer – public submission)

The consumer experience and the impacts this has on both women and their families is importantly a key issue identified in the submissions. A range of impacts on women and their families was identified for situations when they are required to travel away from home to receive antenatal care, postnatal care or for the birth of their baby. This includes financial strain; emotional impacts of being separated from family and support networks, as well as their safety with the risks of travelling long distance on Queensland outback roads. Practical issues associated with caring for older children whilst away or having young children traveling with them for appointments was also identified. The understanding and support from staff in relation to all of these factors, or lack thereof, was also raised as a key issue impacting on the consumer journey and overall experience of care.

Additionally, retrieval services can have implications for the mother’s experience as their child may be taken to a larger tertiary service, rather than a service closer to them.
In relation to woman’s choice and rights, respondents identified a lack of options or choices close to where they live, and variation in advice provided to enable the mother to make an informed choice. Respondents also highlighted that a range of different clinicians offering advice, opinions and management of care can result in confusion for the mother and family. It was stated that women and families have a right to give birth in the community where they live.

It was also mentioned that the overall experience and outcomes could lead to postnatal mental health concerns for women, which may also not be identified without the necessary support services available.

A range of suggestions was made in relation to communicating appropriately with consumers and providing more information on why it may be necessary to birth away from home. Provision of information to help understand the risks associated with the range of options and decisions would be useful. Provision of easily accessible information about the Patient Transport Subsidy Scheme eligibility was requested (an example was given where a mother was deemed ineligible for the subsidy as her baby was not born at the closest hospital, despite the hospital being flooded). Further suggestions included; provision of a list of local family friendly accommodation options, and services available for day care or babysitting when required to be away from home. Suggestions also included the provision of education about optimum pre-pregnancy health.

Additional suggestions for improving the consumer experience articulated in the submissions included having a range of consumers involved in the planning and development of services and models of care, increasing the involvement of women in decision making and providing all options for care, providing respect when choices are made by women and their families, and making available more options for treatment as a private patient (including in a public hospital).

Suggestions also included enhanced advocacy for women, including options for patient advocacy and having a support person available for women when they arrive in a larger town/city for birth.

5.5. Safety

“I had great maternity care for both my pregnancies at a rural hospital, but due to an emergency Caesar first time around, had to travel to an unknown hospital a fair distance away to give birth the second time. The care from the rural hospital was so much better than the city one. Would rather have given birth there even with the risks” (consumer – public submission)

A number of issues were identified in relation to safety, ranging from those at a broad system level to more specific hospital level and were related to the safety of the mother, baby and staff. Many of the safety issues identified were closely aligned and overlap with some of the other issues identified in relation to service delivery, models of care, women’s experience and staffing. In relation to staffing, the issues were focused on limited specialist and qualified staff and variations in skill mix and levels, potentially impacting on safety and quality. The lack of support available for clinicians in the case of an adverse event was also raised.

Aligned to women’s experience and service delivery, unplanned presentations for birthing was identified as a key safety risk. Whilst the birth may be planned at a different facility, the mother may present to their local emergency department, in a hospital that has no or minimal maternity services.

The provision of incorrect information to women, not obtaining patient consent, non-compliance with recommended guidelines and juggling culturally appropriate care while meeting clinical and safety requirements were all identified as issues to be addressed.

Concerns were raised by respondents from clinical areas regarding the professional and legal safety for clinicians when a woman declines recommended maternity care. It was noted by one respondent that Queensland Health is developing and trialling a guideline for clinicians partnering with women who
decline recommended care\(^\text{12}\) but they felt there needed to be greater clarity regarding legal protection and indemnity for clinicians\(^\text{13}\).

In alignment with the women’s experience, the respondents commented that the mother and family being required to travel sometimes very long distances for birthing and appointments can be high risk. Some respondents indicated that women may feel they have little choice but to refuse to leave their community to birth and subsequently put themselves and their baby at risk of not receiving appropriate medical and support services. Additionally, due to distances required to be travelled, there is also the risk of birthing out of hospital without clinical support while in labour, and also the risk associated with driving long distances and during the evenings.

Effective communication was also identified as a key issue, with discharge summaries not being received by local hospital services, and a lack of, or poor, communication between different services and hospitals, including between patients and clinicians and between clinicians within and across services. It was suggested a clear governance structure is required for clinical care, audit and review, ongoing education and maintenance of skills. Good governance in maternity services may include multidisciplinary clinical case conferences, and there should be clear processes for information sharing amongst all care providers and the women.

5.6. Funding

“There needs to be a whole of government push to accept the slightly higher cost of running a CSCF level 3 maternity service. The government needs to acknowledge that this provides a certain level of stability and capability to a rural hospital (beyond a maternity service) that cannot be underestimated.”

(GP – public submission)

A range of issues in relation to funding were identified in the submissions such as: additional funding for resources, staffing, training and incentives; the inclusion of Medicare item numbers for midwives; access to bulk-billed ultrasound scans; insurance options for private midwives to cover all areas of pregnancy care; and adequate and affordable indemnity solutions for all clinicians to enable them to practice women-centred care.

Funding for additional supports for women required to travel and leave their communities, such as transport options (Patient Travel Subsidy Scheme is not enough), child care options, and the provision of suitable long-term accommodation options, was a key suggestion in the submission.

It was also identified that an increase in funding is required in some rural areas for additional, or upgrades to, infrastructure and equipment.

5.7. Other/general issues

“These rural hospitals take a personal touch and they need to stay”

(partner/support person – public submission)

Other important issues that were raised include too much paperwork for clinicians, the inability or refusal of some clinicians to provide statistics to women to help in decision making, a lack of respect by both staff and patients and the effect this has on service delivery and women’s experience, and the increased incidence of obesity and Gestational Diabetes Mellitus. Major haemorrhage protocols were mentioned in


\(^{13}\) As noted in the Guideline: Partnering with the woman who declines recommended maternity care - Support for clinicians is in place under usual indemnity policies. HHSs should ensure clinicians have immediate and ongoing access to guidance, advice and support, executive team, and legal as required. Consultation and referral considerations should include assessing risk, escalating and implementing appropriate risk mitigation strategies as per local HHS Risk Management Framework and requirements with HHS executive support as required.
relation to some local services having limited blood product resources and not being equipped to follow best practice. In relation to postnatal care, some respondents suggested breastfeeding rates are not measured, and often the six weeks follow-up of baby and mother are not being conducted to the expected standard. An increased focus on general health and wellbeing during pregnancy to improve mum and newborn health post-birth, and improving health literacy, particularly in rural and remote areas were also identified as strategies that needed to be addressed.

Whist a number of key issues were highlighted within the submissions, it needs to be recognised that there was also some very positive feedback, specifically that excellent high-quality care is being provided in rural and remote areas across Queensland, by compassionate staff who are providing helpful and informative support for women and their families.

“Allow for communities and Aboriginal community-controlled health organisations [to] lead the conversations for their own trajectories. Too often this responsibility is taken forcibly without consultation. Our successes are ours to own and so are our wins!” (consumer – public submission)