Dear Dr Dr Gardiner

Re: Inquiry into perinatal services: call for submissions

I am responding to your invitation to Professor Wendy Cross (on behalf of) as Chair of the Council of Deans of Nursing and Midwifery (ANZ) to provide a submission to this inquiry.

Council sincerely thanks the Committee for the opportunity to comment on the Victorian Parliamentary Inquiry into perinatal services and congratulates the Committee on work undertaken previously.

Council distributed the document to all members. Members from the University of Tasmania Faculty of Health, School of Health Sciences have made a major contribution and although we recognize this is a Victorian Parliamentary Inquiry we acknowledge the contribution from our colleagues in Tasmania in particular Dr Jennifer Ayton, Lecturer, Midwifery Course Coordinator; Ms Kerrie Walkem, Child and Family Health Nursing Course Coordinator; and Ms Rochelle Einboden, Lecturer.

We hope the feedback is useful and if we can assist further then please do not hesitate to contact me.

Thank you once again for the opportunity to participate in this important Project.

Sincerely,

Jennifer Rabach RN
Policy Officer
Council of Deans of Nursing and Midwifery (ANZ)
1. The availability, quality and safety of health services delivering services to women and their babies during the perinatal period;

Retrieval and emergency care - In geographically isolated settings such as Victoria and Tasmania a rapid, highly skilled and responsive service to perinatal emergencies is required.

Adequate funding is required to ensure sustainable retrieval capabilities for NeoNatal Emergency Transport Services/Paediatric Emergency Transport Services/Perinatal Emergency Transfer and Retrieval Services.

Education and professional development pathways are required in order to maintain and support professional clinical excellence.

A plan for attracting and supporting adequate and appropriate staffing for services particularly in remote and rural locations is recommended.

Adequate support for effective communication pathways including access to telehealth and digital health is required.

Continuity of care and Interdisciplinary workforce-An interdisciplinary continuity of care model is central to the provision of safe, effective and appropriate perinatal services.

Interdisciplinary community based programs that integrate skilled midwives, health workers, skilled attendants, general practitioners -including rural generalists, allied health, mental health professionals and counsellors has been consistently demonstrated to improve pregnancy, maternal and neonatal outcomes and are more cost effective(Lassi & Bhutta, 2015; Renfrew et al., 2014). This should involve an interdisciplinary approach through a primary health care model that responds to the women’s, infants and family’s needs(Renfrew et al., 2014).

Family centred perinatal services - A family centred approach and model to the delivery of services is required(Lassi & Bhutta, 2015). There is a need to include fathers and same sex partners when reviewing the appropriateness and accessibility of all facets of perinatal care and services.
Evidence and research - There is a gap in research and investment in midwifery, maternal and child health and perinatal research funding models at state and national levels.

A State government level commitment to dedicated research funding models is required including the establishment of maternal, child and family, and perinatal education and research centres that promote an interdisciplinary approach to research and innovation. Evidence is required to meet the increasing and changing workforce and educational needs as well as consensus on research priorities including areas where there are gaps such as perinatal mental health outcomes.

Monitoring perinatal morbidity and mortality - It is imperative that perinatal morbidity and mortality outcomes are monitored using the World Health Organizations ICD 10 definitions and classifications to support the building of pooled evidence, and identify high-risk cohorts and populations.

Benchmarking of the following is suggested.

- Folic acid supplementation. Purpose; to monitor and improve maternal and neonatal health outcomes (De-Regil, Fernández-Gaxiola, Dowswell, & Peña-Rosas, 2010);
- Remote and rural area birth transfers into territory referral centres. Purpose; Benchmark practice and policy;
- Exclusive breastfeeding; Baby Friendly Hospital/ facility accreditation (Bhutta et al., 2013). Purpose; to benchmark practice and public health policy;
- Induction of labour for selected women giving birth for the first time including data on method and the timing of the induction i.e. number of gestational weeks. Purpose: to benchmark practice.
- Unified perinatal depression outcomes (Rondon & Stewart, 2017) for mothers and fathers and infants;
- Collecting and establishing key outcome measures for father/male carer perinatal health.

2. The impact that the loss of Commonwealth funding (in particular, the National Perinatal Depression Initiative) will have on Victorian hospitals and medical facilities as well as on the health and wellbeing of Victorian families;

In light of the loss of funding it is perhaps timely to consider what has been learnt from the National Perinatal Depression Initiative (NPDI). The implementation of the NPDI has been found to be uneven across divergent contexts and settings. There is also inconsistent use of the definitions and terms used to collect data and monitor perinatal mental health and outcomes (Fisher, Chatham, Haseler, McGaw, & Thompson, 2012; Rondon & Stewart, 2017) consequently consensus around definitions and classifications is needed as well as on unified national assessment tools and referral pathways.
Contextually appropriate and community level access to mental health services is required at primary health care levels rather than tertiary referral hospitals (Lassi & Bhutta, 2015). Governance structures for perinatal mental health need to be identified.

3. The adequacy of the number, location, distribution, quality and safety of health services capable of dealing with high-risk and premature births in Victoria;

Sustainable emergency perinatal retrieval services are required (point 1).

Accredited educational and professional development pathways for health care professional are needed to maintain skills for practitioners, community nurses, midwives and GPs working and rural generalists working in acute care settings and culturally diverse, rural and remotely isolated areas.

Partnerships are required between acute services, primary health care services and key professional bodies that have established accredited training and support mechanisms for rural and remote area medical and nursing/midwifery staff such as Australian College of Rural and Remote Medicine, Council of Remote Area Nurses of Australia (CRANA plus) and the National Rural Health Alliance and aeromedical retrieval services such as RFDS.

Support and education for the use and integration of telemedicine and its funding model is needed for remote and rural primary health care services due to the distances between centres that are equipped to manage high-risk births.

Ongoing funding is needed to develop services/facilities/policies that support and allow mothers/families to remain with their infants at major referral centres when/if they require transfer out of their rural or remote communities’ due to a high-risk pregnancy or preterm birth.

4. The quality, safety and effectiveness of current methods to reduce the incidence of maternal and infant mortality and premature births;

We recommend the review consider evidence from Renfrew et al (2014) listing the interventions most effective and ineffective (Renfrew et al., 2014). In summary across multiple settings the most effective preventative measures include.

• Universal access to intrapartum skilled care; community and program based interdisciplinary models of care; and universal access to antenatal care and education;

• Initiation of and sustained exclusive breastfeeding. (Bhutta et al., 2013; Kuruvilla et al., 2014; Lassi & Bhutta, 2015; Renfrew et al., 2014).
5. **Access to and provision of an appropriately qualified workforce, including midwives, paediatricians, obstetricians, general practitioners, anaesthetists, maternal and child health nurses, mental health practitioners and lactation consultants across Victoria;**

Partnerships with key rural and remote medical and nursing/midwifery bodies such as the Australian College of Rural and Remote Medicine (ACRRM) and the Council of Remote Area Nurses of Australia (CRANA plus) should be established and strengthened.

Access to skilled midwives reduces maternal and infant morbidity and mortality (Renfrew et al., 2014). An increasing workforce problem is the ageing midwifery and nurse workforce and the declining numbers of practicing midwives across the practice setting, including rural and remote areas (Australian Institute of Health and Welfare, 2015). Staff shortages may lead to nurses who are not midwives, or inadequately supervised, trained and supported being deployed to provide care to mothers and infants during the perinatal period.

Increased Government supported places at universities are needed to attract and support students to study midwifery and become accredited midwives.

Maternal and child health (M&CH) services - To provide safe and effective care to mothers, infants and their families M&CH services and nurses/midwives require dedicated educational and professional development pathways; adequate supervision and support for physical and emotional safety; and collaborative interdisciplinary approach to perinatal health care.

Stronger interdisciplinary partnerships and improved referral pathways between acute and community care are needed for MCHN services including:

- allied health care, mental health services, social services, the families’ general practitioner, obstetricians, paediatricians, neonatal/special care nursing services, midwives and lactation consultants;
- within the government sector and between government, non-government sector and the private sectors;
- access to electronic health records (e.g. mMHealth Record)

6. **Disparity in outcomes between rural and regional and metropolitan locations**

Victoria has a highly distributed population including remote and rural areas and Tasmania in particular has island populations, which can often be isolated from the three primary maternity hospitals due to adverse weather and geographical location consequently;

- Skilled perinatal aeromedical and emergency services are required (point 1.1)
- Access to universal antenatal care within a community and primary health care model is required.
- Continuity of care is encouraged through the use of interdisciplinary midwifery and rural generalist models of care (Kerber et al., 2007; Renfrew et al., 2014).
7. Identification of best practice
Evidence based research indicates there is no one factor or intervention found to reduce perinatal morbidity or mortality. Instead a collective approach that embraces an interdisciplinary community based continuity of care model is recommended (Lassi & Bhutta, 2015; Renfrew et al., 2014). The following key points outline best practice approaches and are understood to improve maternal infant outcomes during the perinatal period.

- Skilled midwifery and sustainable educational models to support ongoing workforce needs (Renfrew et al., 2014; ten Hoope-Bender et al., 2014)
- Access to appropriately skilled medical practitioners including rural generalist in rural and remote communities with advanced skills in obstetrics, neonatology, or medicine, for serious complications (Hoang, Le, & Terry, 2014; Kuruvilla et al., 2014).
- Access to antenatal care and education (Hoang et al., 2014; Renfrew et al., 2014)
- Effective skilled intrapartum-care (Campbell & Graham, 2006)
- Reduction in caesarean section rates (Kuruvilla et al., 2014; Renfrew et al., 2014)
- Reduced induction of uncomplicated normal labour before 37 completed weeks of gestation (Kuruvilla et al., 2014; Renfrew et al., 2014).
- Reducing prevalence of smoking
- Continuity of care and program based interdisciplinary care (Kerber et al., 2007; Lassi & Bhutta, 2015; Renfrew et al., 2014).
References


