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RACP written submission to Strategic Directions for Australian Maternity Services (consultation paper 2)

November 2018

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Thank you for the opportunity to provide feedback on the 'Strategic Directions for Australian Maternity Services' consultation paper 2.

The Royal Australasian College of Physicians (RACP) represents over 17,200 fellows and 8,265 trainees across over 30 specialties in Australia and New Zealand. Our membership includes 5,300 paediatric fellows and trainees, who routinely work with newborns, infants, young children and their families. Our Paediatric and Child Health Division works across a range of children's health policy issues. Significant current areas of focus include inequities in child health, optimal early childhood healthcare and Indigenous child health.

The RACP previously made a submission on the draft National Strategic Approach to Maternity Services (NSAMS) (consultation paper 1, June 2018). An RACP representative, Prof Callaway, attended the Brisbane workshop to provide feedback on the Strategic Directions for Australian Maternity Services (consultation paper 2) as part of the second round of consultations. The RACP learned that its initial submission was very valuable to the Department of Health and was encouraged to provide a submission to this second consultation paper.

This submission draws on the expertise of members of our Paediatrics and Child Health Division, the Australian Diabetes in Pregnancy Society (ADIPS) and the Society of Obstetric Medicine of Australia and New Zealand (SOMANZ). The RACP acknowledges the valuable expertise of members of ADIPS and SOMANZ during the development of this submission.

Overall, the RACP supports the four values used to structure consultation paper 2 – respect, access, choice and safety. These values align well with the values recommended by the RACP in our submission for consultation paper 1. Specifically, we advocated for safe, high quality care that is respectful, supportive and woman-centred.

The RACP commends the way that the values are each supported by principles for women-centred care, that are in turn followed by strategic directions with the explanatory underpinning rationale. Mechanisms for achieving the strategic directions, in the form of enablers or actions and activities are also described.

We would like to provide the following detailed feedback to further strengthen the document.

Detailed feedback on the Strategic Directions for Australian Maternity Services consultation paper 2

1. Value: Respect

The first value 'Respect' describes the need for 'respectful, wholistic care' (1.1) of women and the respectful 'collaboration between health professionals' (1.2) aiming to strengthen interdisciplinary collaboration, culture and communication between health professions.

'Collaboration between health professionals' (1.2)

The RACP recommends that the strategic direction under 1.2 should be amended to address systemic issues that influence interdisciplinary collaboration, culture and communication. The RACP recommends investing in systems which nurture and support interdisciplinary collaboration, culture and communication.

Under the enablers for 1.2 we recommend considering the introduction of MBS item numbers for specialist expertise (e.g. obstetric physicians, neonatologists, maternal fetal medicine specialists) to be provided to a local health care team via email, phone calls or other methods of communication.

Through such MBS items specialist to specialist or specialist to GP non-face to face communications could be facilitated and supported including for communications without the patient needing to be present

Another enabler under 1.2 would be ensuring that the upcoming roll out of digital patient health records effectively crosses and integrates the different health and allied health service sector involved in maternity services.

The RACP strongly recommends that the second enabler listed on page 5 includes the Royal Australasian College of Physicians (RACP) as another important stakeholder when developing and issuing a joint statement about working together for the benefits of women, babies and health professionals. A joint statement should highlight the importance of transitioning women who have had complicated pregnancies to long term specialist care and to specialist preconception care prior to another pregnancy. The inter-conception period provides an excellent opportunity to improve the health of the mother and future children after a complicated pregnancy.

2. Value: Access

Under this value, 'improving access to continuity of care (2.1), to maternity care (2.2) and mental health support' (2.3) are listed.

'Improving access to continuity of care (2.1)

The RACP supports the first enabler listed under 2.1 (page 6) that seeks to increase the range of continuity of care models available for women in their geographic location. The RACP recommends strengthening the first enabler through specialist training upskilling physicians in obstetric medicine, neonatology and maternal fetal medicine, as well as the development of telemedicine approaches of care which would allow highly specialised expertise and care to be accessed by women and their babies in their own geographic location.

The RACP acknowledges that GP obstetricians are often the local medical professional also responsible for the care of the newborn. The RACP agrees that a lot of uncomplicated neonatal medical problems can be cared for in local centres by appropriately trained non-paediatricians (with paediatric support provided by phone or telemedicine as required), however, a common factor determining the need for transfer is the availability of nurses/midwives and their respective level of training to care for the baby at the local centre.

The RACP suggests that the third enabler to 'conduct research on the cost benefit of models' under 2.1 should also include researching the 'intention to treat'. It would be beneficial to calculate the cost of needs according to where women were initially assigned to be treated, rather than where they ended up. Some obstetric physicians report that they often see women who were assigned to (or accessed) very low risk models of care, with high-risk features of their health either not being disclosed or being missed resulting in preterm birth and severe maternal complications. Those women wrongly assigned to very low risk models of care result in a very high burden of costs to the system, as well as to the preterm infant, mother and family. If these women were cared for in a high-risk care environment, adverse outcomes could be prevented or at least these women could be treated earlier for example with therapies such as aspirin, plaquenil, anti-coagulation, immunosuppressants for florid auto-immune disease.

'Improving access to maternity care (2.2)'

The RACP recommends that the strategic direction under 2.2 be reworded to 're-design services around the needs of women, their babies and communities, *ensuring these services are also safe and sustainable for the health care professionals delivering them'* (italics inserted by RACP).

The RACP recommends that the health and wellbeing needs of health care providers must also be considered when redesigning services. We are aware of the detrimental impacts of high rates of

anxiety, depression, suicidality and burnout in clinical staff and the organisational responsibility to address the mental health of staff. Anecdotal evidence from RACP members report having to support health care professionals from regional and rural areas who are stressed about having to care for a high risk pregnant woman who does not want to leave her local community to access specialist pregnancy care. When adverse outcomes occur in these highly complex and sensitive circumstances, it is important that health care workers receive appropriate support and best practice debriefing care including counselling. The RACP advocates for the redesign of health care services to meet the health and wellbeing needs of the health care workforce to deliver quality care to pregnant women and their babies in their community.

The RACP is supportive of the enablers listed under 2.2 but suggests that options for specialist expert support to local doctors via phone, email and telemedicine should be included. Consideration needs to be given to supporting women experiencing a high-risk pregnancy and their families through a time of additional financial and psychological burden. Such pregnancies are associated with extraordinary financial costs and stresses, for example in accessing high level maternity care services in tertiary centres far from home over a prolonged period.

With regards to the second strategic direction under 2.2 'to improve care in the postnatal period', the RACP recommends that a further enabler be added. A nationwide recall system/register should be developed reminding postpartum women about the need for long term chronic disease prevention after a complicated pregnancy. There is substantial evidence[1,2] that pregnancy is a metabolic stress test for the woman and that complications of pregnancy indicate a risk for that woman to develop that disease later in life. For example, gestational diabetes[3], hypertension in pregnancy, liver dysfunction in pregnancy, renal dysfunction in pregnancy, thrombocytopenia in pregnancy.[4,5]

'Improving access to mental health support' (2.3)
We recommend that this principle be amended to provide access to mental health care for the whole family including the mother, father, partners, carers and siblings.

The corresponding enablers under 2.3 should to be amended to include the need for trauma-informed care. There is increasing evidence that adverse childhood events underpin much adult chronic mental illness, and that it particularly influences maternity care[6]. Research has shown that up to 30 per cent of Australian women have experienced some form of sexual abuse in their lifetime [7] and that this can greatly impact on their maternity care. In fact, this may significantly influence women to seek "non-institutional care" such as home births for example. Hospital (institutional) care may sometimes be safer for these women if it was recognised more clearly why it is so hard for them to engage in models of care embedded in a hospital. There are national frameworks published

[1] Williams, D (2003): Pregnancy: a stress test for life. Current Opinion in Obstetrics and Gynecology. 2003 Dec;15(6):465-71. DOI: 10.1097/01.gco.0000103846.69273.ba
[2] Bilhartz TD, Bilhartz PA, Bilhartz TN, Bilhartz RD. (2011): Making use of a natural stress test: pregnancy and cardiovascular risk. J Womens Health (Larchmt). 2011 May;20(5):695-701. DOI: 10.1089/jwh.2010.2291.
[3] Catalano, PM (2010): Obesity, insulin resistance, and pregnancy outcome. Reproduction. 2010 Sep;140(3):365-71. doi: 10.1530/REP-10-0088.
[4] Craici I, Wagner S, Garovic VD.(2008): Preeclampsia and future cardiovascular risk: formal risk factor or failed stress test? Ther Adv Cardiovasc Dis. 2008 Aug;2(4):249-59. doi: 10.1177/1753944708094227.
[5] Newstead J, von Dadelszen P, Magee LA. (2007): Preeclampsia and future cardiovascular risk. Expert Rev Cardiovasc Ther. 2007 Mar;5(2):283-94. Review.
[6] Quadara, A. and Hunter, C. (2016): Principles of Trauma-informed approaches to child sexual abuse: A discussion paper, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney., page 12. Available at: https://www.childabuseroyalcommission.gov.au/sites/default/files/file-list/Research%20Report%20-%20Principles%20of%20trauma-informed%20approaches%20to%20child%20sexual%20abuse%20A%20discussion%20paper%20-%20Treatment%20and%20support%20needs.pdf (accessed 7 November 2018)
[7] Quadara, A. and Hunter, C. (2016) and Child Families Communities Australia (2013). The prevalence of child abuse and neglect. Fact Sheet

around trauma-informed care which the RACP recommends should be referred to in this document.[8,9]

As an additional enabler under 2.3, the RACP suggests that a national working party around trauma-informed care in maternity services be convened to develop safer maternity services for women and their families. We also recommend that a national strategy for universal parenting education be developed to reduce the transgenerational transmission of trauma (especially emotional trauma) and reduce the stress for parents.

3. Value: Choice

The consultation paper 2 lists under this value 'providing information about local maternity services' (3.1) and 'supporting informed choice' (3.2).

The RACP recommends that the principles under 3.1 and 3.2 include a reference to preconception care. Although preconception care is generally provided by GPs, increasingly women need to access highly specialised preconception care, which is a fundamental part of most high-quality maternity services. As the RACP has outlined in its previous submission[10] to consultation paper 1, preconception care is critical for the health of future Australians. Preconception assessment of pre-existing diabetics for example is essential to improve blood glucose control and prevent fetal malformations. Poorly controlled diabetes in the first trimester increases rates of miscarriage and serious congenital malformations. These complications can be improved by good preconception diabetes control.[11,12]

Specialist preconception care has been demonstrated to be cost effective and to prevent adverse pregnancy and neonatal outcomes, including congenital anomalies. There is indisputable evidence for this in pre-pregnancy diabetes.[13,14,15] Therefore, the RACP recommends that the enablers under 3.1 be amended to include:

- a national review of the costs/benefits of preconception care and
- the development of a national set of standards for high quality preconception care.

4. Value: Safety

This value includes 'supporting cultural safety' (4.1) for Aboriginal and Torres Strait Islander women and women from culturally and linguistically diverse background, 'supporting the maternity care workforce' (4.2) and 'supporting safety and quality in maternity care' (4.3) including reducing the stillbirth rate.

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[8] Kezelman, C and Stavropoulos, P. (2012): 'The last frontier'. Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Available at: https://www.blueknot.org.au/Portals/2/Practice%20Guidelines/Blue%20Knot%20Foundation%20Guidelines_WEB_Final.pdf (accessed 7 November 2018)

[9] Mental Health Coordinating Council (MHCC) (2013): Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction, Position Paper & Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group, Authors: Bateman, J & Henderson, C (MHCC) Kezelman, C (Adults Surviving Child Abuse, ASCA). Available at: https://www.mhcc.org.au/wpcontent/uploads/2018/05/ticp_awg_position_paper__v_44_final___07_11_13-1.pdf (accessed 7 November 2018)

[10] RACP (2018): RACP submission to the National Strategic Approach to Maternity Services Consultation Paper (June 2018), page 4

[11] Wong VW, Suwandarathne H, Russell H: Women with pre-existing diabetes under the care of diabetes specialist prior to pregnancy: are their outcomes better? The Australian & New Zealand journal of obstetrics & gynaecology 2013, 53(2):207-210. Available at: https://obgyn.onlinelibrary.wiley.com/doi/10.1111/ajo.12044 (accessed June 2018)

[12] Towner, D. et al (1995): Congenital Malformations in Pregnancies Complicated by NIDDM: Increased risk from poor maternal metabolic control but not from exposure to sulfonylurea drugs. Diabetes Care 1995 Nov; 18(11): 1446-1451. Available at: http://care.diabetesjournals.org/content/18/11/1446.short (accessed June 2018)

[13] Egan, A M et al (2016): A pre-pregnancy Care Program for Women with Diabetes: effective and cost Saving. J Clin Endocrinol Metab, April 2016, 101(4):1807–1815.

[14] Murphy HR, Roland JM, Skinner TC, Simmons D, Gurnell E, Morrish NJ, Soo SC, Kelly S, Lim B, Randall J et al: Effectiveness of a regional prepregnancy care program in women with type 1 and type 2 diabetes: benefits beyond glycemic control. Diabetes Care 2010, 33(12):2514-2520. Available at http://care.diabetesjournals.org/content/33/12/2514.short?rss=1&cited-by=yes&legid=diacare;33/12/2514&patientinform-links=yes&legid=diacare;33/12/2514 (accessed June 2018)

[15] Yamamoto, Jennifer M. et al (2018): Community-based pre-pregnancy care programme improves pregnancy preparation in women with pregestational diabetes. Diabetologia (2018) 61: 1528. https://doi.org/10.1007/s00125-018-4613-3 (accessed June 2018)

‘Supporting cultural safety’ (4.1)
The RACP has recently published a position statement on inequities in child health which suggests that cultural safety alone is not enough to address inequities. The RACP believes that achieving equitable outcomes requires services to take active steps to “*reach out and be available for families who struggle to access our current system*” and to address inequitable access to health services through direct and proportionate action. The RACP’s Indigenous Strategic Framework formalises work that has been underway to help the medical community address health inequities for Aboriginal and Torres Strait Islanders in Australia and Māori people in New Zealand.

‘Supporting the maternity care workforce (4.2)’
The RACP recommends amending the enablers listed under this principle to support training and upskilling of physicians and obstetricians including specialist college trainees in more advanced obstetric medicine and maternal-fetal medicine skills by providing curriculum changes, funding of courses, novel educational approaches and time for health service staff to attend conferences or undertake short tertiary centre placements.

The RACP welcomes the enabler raising consideration of the impact of ‘unqualified neonates’ on cost and workforce but recommends that staff/patient workload ratios in postnatal wards need to be reviewed given that most women in postnatal wards are medically and psychosocially complex care needs and that neonates need to be counted as patients.

The last enabler listed under 4.2 accords with the recommendation the RACP made in its previous submission that midwifery-led continuity of care models that have worked well in antenatal care for Aboriginal and Torres Strait Islander women should be expanded to complex and high-risk women (either for medical or psychosocial reasons).

‘Supporting Safety and Quality in maternity care’ (4.3)
While the RACP welcomes the principle under ‘supporting Safety and Quality in maternity care’ (4.3), we suggest adding an extra principle requiring maternity service providers to implement measures to maintain low rates of maternal mortality and reduce maternal morbidity (both physical and psychological) as much as possible.

The enablers listed under 4.3 should also include a call for additional resources to expand the scope of Maternal Mortality Review Committees to review key measures of maternal morbidity as markers of quality health care such as the rates of postpartum depression, fourth degree tears and post-traumatic stress disorder (PTSD) after birth.

The RACP also recommends including an enabler advocating to properly fund and support the Australasian Maternity Outcomes Surveillance Study (AMOSS)[16], which has mechanisms in place to assess maternal morbidity.

[16] https://www.amoss.com.au/index.html