

**Submission from Women's Healthcare Australasia re the
National Framework for Maternity Services: Consultation draft for feedback**

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Women's Healthcare Australasia (WHA) is the peak body for hospitals providing maternity and women's health care services. WHA membership currently consists of more than 100 maternity services across Australia including the majority of tertiary hospitals, as well as many medium metropolitan, regional and rural maternity services. Collectively our members support more than 140,000 births per year, which is approximately 60% of all births occurring in public hospitals.

WHA support our members to achieve excellence in maternity and women's healthcare through benchmarking performance with one another, networking to share information and expertise, delivering education and training and through advocacy to governments and the community.

As the providers of the majority of Australia's maternity care, WHA members are key stakeholders in the National Framework for maternity services. WHA consulted its membership on the draft National Framework for Maternity Services, and provides the following collated feedback.

Does the Vision statement actively reflect a clear goal for the Framework? If not, what should be included?

"All women in Australia have access to and receive evidence based, high quality maternity care that achieves optimal health outcomes for the mother, baby and family now and into the future."

WHA broadly supports the Vision statement. However members urged that the statement include reference to the provision of care (receiving care) as well as to 'access'. As the AIHW findings from 2014 summarised in the consultation paper show, 95% of women had five or more antenatal visits and 98% of women had their babies in a hospital. While there is still room for improvement in terms of access, especially for indigenous women, a more significant challenge for Australian maternity services is to increase the consistency and reliability with which evidence based care is actually delivered to women, especially during labour and birth (see further comment on this under the value 'excellence' below).

Do the identified Values appropriately guide achievement of the Vision?

- ***Respect – A woman's choices, preferences and values are respected and supported by maternity services and providers.***

WHA supports respect being included as a value. However, the emphasis should be on ensuring women are supported to make informed, evidence based decisions about options

related to their care. Ideally there would be national, or at the very least, state-wide resources developed to assist women to make informed decisions about a range of clinical issues. Examples of best practice information resources exist (for example on the relative benefits and risks of induction of labour, or of Vaginal Birth following a primary caesarean section) but it is generally up to each maternity service to invent its own resources, and few have the time or resources to do so. Evidence based, impartial tools to assist in this process are rare in the sector.

- ***Accountability – Maternity services and providers are accountable for the provision of safe and quality outcomes that aligns with a woman's needs.***

WHA welcomes a commitment to accountability. It is disturbing, however, that as a National Framework, this document says nothing about how such accountability should be achieved. To whom should services and providers be accountable, based on which measures, and reported how frequently? Australia's efforts to measure and monitor outcomes from what is essentially the largest single use of hospital bed days – maternity care – is patchy and lacking in timeliness to inform improvement in service management and clinical practice. The draft Framework is also silent about such accountability being applied to all providers, including public and private hospitals, as well as public and private community based providers of care. While not negating variation in practice within their own organisations, our members have cited examples of variations in private practice that put women at risk from either underservicing or from over-servicing (e.g. a VMO having 68% rate of caesarean sections for generally well women, or a GP doing upwards of 24 ultrasound examinations for a well woman in pregnancy). Accountability mechanisms need to be nationally consistent, comprehensive of all services actively providing maternity care, and to provide timely information to those that need it, including providers, funders and consumers. Generalised reports such as the AIHW's Mothers & Babies Report, published 4-5 years after the time period they relate to does not influence outcomes for women & babies.

The views of women themselves – and their families – should also be fundamental to ensuring accountability for maternity services & providers. While some jurisdictions have mechanisms in place to reliably capture and learn from consumer feedback (such as Victoria), most do not, notwithstanding the clear international evidence that the safest & most reliable health services are those that partner closely with consumers in the design, delivery and evaluation of their services. Some individual maternity services endeavour to collect and assess consumer feedback regularly, but implementation of improvements intended to respond to consumer feedback is often ad hoc and or not sustained. A national commitment to accountability would be welcome. Please articulate what this would look like, how it would be implemented and how the insights gained would be translated into improving outcomes for women and newborns.

- ***Excellence – Maternity services are evidence based, innovative and informed by research and the application of best practice to achieve optimal outcomes.***

Australia's overall outcomes as measured by maternal and perinatal mortality are comparable with other developed countries, albeit as the paper notes, with room for improvement in our rate of perineatal deaths. However, there is clear evidence of unwarranted variation in clinical practice related to labour and birth care, with rates of key

interventions such as induction of labour, caesarean sections, and instrumental births using forceps varying significantly (more than 2 standard deviations) among services of similar size and capability across and within jurisdictions. This variation has been recognised by both the Australian Commission on Safety & Quality in Healthcare, and by the Independent Hospital Pricing Authority, among others. It is manifest in WHA's annual clinical benchmarking. Importantly, this variation is not delivering optimal outcomes for women and babies, as the vision aspires to achieve. Year on year trends to increase interventions in labour and birth have persisted in Australia over the past 10-15 years without associated improvements in outcomes for women or babies, with significant increased morbidity for women and their families, and at increased cost to the health system. That is why the vision must incorporate a commitment to the reliable provision of evidence based care not just access to care.

- ***Leadership – Maternity services, providers, women, their families and communities lead the delivery of the vision, values and principles at a national, state and service level.***

WHA acknowledges the critical importance of leadership in achieving safe, high quality maternity care. However this statement as currently drafted, in its effort to include everything and everyone, actually says nothing meaningful. It would be much more meaningful to commit to ensuring that consumers of maternity services are actively engaged in the planning, design, delivery and evaluation of every maternity service. There is global evidence supporting this approach as being instrumental to the reliable provision of safe care, and to continuous improvement of health services.

Are the Principles of the Framework reflective of the needs of mothers, babies and their families? If not, what should be included?

1. **Woman-centred** – Women and their families, support networks and communities are at the heart of maternity services and are empowered to make informed choices regarding their care.
2. **Culturally safe** – Maternity services reflect an understanding of the diversity between and within cultures, supporting a woman's wellbeing, and meets the needs of the woman, her partner and/or support network including her community.
3. **Safe, high quality maternity care** – Maternity services across the care continuum are safe and provide high quality care to a mother and baby, promoting a healthy lifestyle and responding to a woman's antenatal health needs.
4. **Access** – All women, including Aboriginal and/or Torres Strait Islander women, culturally and linguistically diverse women, women living in socioeconomically disadvantaged communities and rural and remote women and their families, have access to high quality, safe, evidence-based maternity care.
5. **Equity** – Recognising that many of the determinants of health lie outside the health system, health and maternity services work with other sectors and communities to address inequality in maternity outcomes.
6. **Collaboration** – Through collaboration and partnership between women, care providers and health services, all women have access to a seamless service across the maternity continuum with defined transition points when required to transfer care between care providers and health services.

7. Sustainable – Services achieve the desired maternity care outcomes with the most cost effective use of resources, while improving the capacity of the system to sustain workforce and infrastructure, to innovate and to respond to emerging needs.

WHA members support the principles outlines. However for some of our members, it was not clear why/how values and principles are differentiated. It would be preferred if the 2 lists were combined to articulate a clear commitment of discrete elements that support the vision.

Does the Framework provide direction for the planning of maternity services? If not, what should be included?

WHA members regard the draft Framework in its current form as providing little or no useful guidance for the planning & delivery of maternity services in the coming years. By articulating only a range of values and principles which no one would disagree with, WHA members believe the document is a missed opportunity to provide a truly valuable national direction for the maternity services sector & to support their ongoing efforts to improve outcomes for women and their babies & families.

In reacting to apparent criticism of the National Maternity Services Plan (from whom? - this is not disclosed), the draft Framework throws the baby out with the bathwater for want of a better expression. The crux of the issue is that outcomes for Australia's maternity services, as described in the National Core Maternity Indicators have **worsened** in the past 10 years, as the consultation paper acknowledges on page 13:

The statistics for these 15 indicators are presented in Appendix 7.3 which shows Australia has experienced an unfavourable change in nine of these indicators from 2004 to 2013. This data will be regularly reviewed and updated in the Appendix as part of the enduring NFMS.

When you review the indicator results, the only indicators on which there was improvement were:

- smoking in pregnancy prior to 20 weeks (down from 12.7% to 11.2% of women),
- use of general anaesthetic during caesarean section (down from 8.2% to 6.4% of women), and
- a drop in the number of small babies born at or after 40 weeks from 2.1 to 1.6%.

A change in the rate of vaginal birth following a primary caesarean section from 13.1 to 13.6% is also claimed as an improvement but is hardly a significant change over 10 years.

Over this 10 years many indicators have deteriorated, with more women smoking after 20 weeks, fewer women accessing antenatal care in the first trimester, more inductions of labour, fewer unassisted vaginal births, more women giving birth with use of instruments, and episiotomies, and more term babies having an Apgar score of less than 7 at 5 minutes. There has also been no reduction in harms associated with third and fourth degree tears, which has lifelong impacts on health and wellbeing for some women.

On page 14, under a heading about the “benefits of a framework approach”, it is claimed: “A (sic) development of a framework is consistent with the concepts of National Health Care

Reform with a focus on outcomes rather than inputs". To this end, the following page flags a commitment to "continue the development of clinical indicators and data bases that will inform evidence based decisions". A commitment only to "*continue to develop clinical indicators and data bases*" is essential but manifestly inadequate. A far more valuable approach would be for this National Framework for Maternity Services to commit to measurable improvement in all of the National Core Maternity Indictors within 5 years.

For example, if all state and national Health Ministers committed to increase the percentage of women having an unassisted vaginal birth from 47.1% (or whatever rate it is in 2017) back to the 2003 level of 52% or beyond, each jurisdiction could have the flexibility to consult and work with its maternity service managers and clinical leaders to deliver on that. Improvements in nearly all of the other indicators would flow from that. Similarly, if "*Early and regular antenatal care is linked to improved maternal health and fewer interventions in late pregnancy*" (page 11) then a national target should be set for increasing access to antenatal care in the first trimester from the 2013 rate of 62.5% to 70% or more, or to halving the percentage of women who do not begin antenatal care until after 20 weeks gestation (from 12 to 6%). An appropriate postnatal target could also be identified.

An additional, and related, concern WHA has with the draft Framework is the absence of a commitment to develop national evidence based clinical practice guidelines for maternity care. This issue was raised by many participants in the consultations held in December but is not reflected in the current draft Framework. Currently the only nationally (government) endorsed CPG for maternity care is the Clinical Practice Guidelines, Antenatal Care. A few other national guidelines (e.g. on stillbirth prevention or gestational diabetes screening) exist in the not-for-profit sector but in general Australia is devoid of robust, concise & evidence based clinical practice guidelines that are nationally consistent. While jurisdictions are service managers and some have state wide maternity care guidelines, others do not and it is left to individual hospitals to determine protocols for care. This results in significant differences in recommended practice both across and within jurisdictions. A recent review by WHA of guidelines on induction of labour found more than 30 different documents, of varying levels of currency in terms of contemporary research evidence. Even one state-wide guideline was more than 5 years out of date and did not reflect contemporary research evidence. The lack of a national consensus on evidence based maternity care is clearly manifest in the variation in rates of common interventions such as induction of labour, which varies from as low as 25% to 50% in WHA benchmarking data regardless of service capacity (tertiary or secondary). While jurisdictions vary, women do not. There would be significant advantages to a single process for developing and maintaining evidence based CPGs on key aspects of maternity care such as Induction of Labour, Caesarean Section, VBAC and care for women with obesity, prevention of third & fourth degree tears, and management of postpartum haemorrhage. The development of national clinical practice guidelines for maternity care need not be million dollar projects that are each ten years in the making. The NHMRC's proposed 'live online CPG portal' would provide an ideal mechanism for the development of such guidelines, and credible international documents could be reviewed and adapted to the Australian context. While guidelines are only part of the answer to unwarranted variation, they are a very important part of the story to achieving optimal outcomes for women & newborns, as the vision aspires to do.

Does the national antenatal health risk factors strategy adequately define health risk factors that affect pregnant women and their babies?

WHA members were uncertain of the need to include Section 3.7.3 *Key risk factors* within the National Antenatal Health Risk Factors Strategy in the NFMS. As the framework mentions, the antenatal considerations listed within the draft strategy are largely covered in the Clinical Practice Guidelines Antenatal Care-Module 1.

The document references further strategies, including The National Drug Strategy 2010-15, the Australian Dietary Guidelines, the National Strategic Framework for Chronic Conditions, the Australian National Diabetes Strategy 2016-20, and the National Perinatal Depression Initiative. WHA members suggest that the NMSF may be better placed to monitor compliance with the existing frameworks and guidelines, rather than potentially creating confusion and duplication of guidance for clinicians working in maternity care.

Do you have any additional comments that you would like to make in relation to the consultation draft for the National Framework for Maternity Services?

WHA is concerned about the hasty process used to consult stakeholders about the development of the draft NFMS. Many of our members received very short notice (less than a week) of the opportunity to participate in stakeholder consultations held in December 2016. This timeframe was inadequate for busy managers and clinical leaders who are key stakeholders in the design and delivery of maternity services.

We are not in agreement with the intention to establish an “enduring framework” based only on “values and principles”. As articulated above, we do not regard this as the only way to provide flexibility to jurisdictions to implement a common vision for improving maternity care. Nor do we regard it as providing meaningful direction for this important sector of healthcare.

WHA strongly urges the Maternity Care Policy Working Group to recommend to Health Ministers that the NFMS should be brief, should focus on measurable, targeted improvement in the National Core Maternity Indicators within the next 5 years and should facilitate the timely development of national maternity care clinical practice guidelines with input from all jurisdictions, professional, industry and consumer stakeholders.

Thank you for the opportunity to comment. We look forward to seeing the final framework.

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