

REPORT OF THE REVIEW

OF THE

BEGA VALLEY MATERNITY SERVICES

REVIEW TEAM MEMBERS

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Executive Summary

For some years the Bega Valley has had considerable difficulty in sustaining maternity services in both Bega and Pambula. The distance between the two towns is 33 kms, with a travelling time of between 20 and 25 minutes. Since January 2007, efforts have been made to maintain both units, initially through alternating weekends and, since November 2007, alternating weeks in which each unit is open.

A single maternity service will operate when the new Bega Valley Health Service, which will replace both Bega and Pambula Hospitals, is completed. Construction has been approved, with an anticipated completion date of 2012. There remains some dissatisfaction in the southern part of the Shire that the preferred site is close to Bega.

The current arrangements are not only a source of considerable distress to the community, but also may be contributing to a diminution in the standard of service. Mothers are unhappy with the lack of certainty of the hospital in which they will be confined. Some are electing to have early intervention to eliminate the uncertainty, and many are choosing early discharge to avoid the need for transfer to the alternate hospital in the post-natal period.

Providing a safe service for mothers and babies has been the primary consideration of the Review Team. In the interests of safety, we believe that a single service operating from Bega should be implemented as soon as possible. We make this recommendation after giving due consideration to the fact that that it may contribute to the loss of services from procedurally competent general practitioners at a time when considerable effort is being devoted to maintaining and expanding the role of such general practitioners and of maintaining maternity services in rural Australia.

We have concerns that a single service will not be viable unless additional support is available to allow the Bega general practitioner obstetricians to maintain a safe and sustainable after-hours roster. We have identified a number of options that can be explored to achieve this sustainability, but recognise that it will require considerable effort and additional resources.

We believe that there will be a need for strong midwifery leadership in the single site, to assist with upskilling of staff, ensure consistency of advice and oversee the development of choices in models of care.

We believe that a unit with over 250 births per annum will enable mothers to have greater choice in relation to model of care, will assist in the recruitment of midwives and hopefully general practitioner obstetricians, and will reduce the risks associated with the current model.

We note that there are some areas of concern that are unrelated to the location of the service, and believe that these should be addressed as far as possible within the existing facilities.

Recommendations

1. All obstetric services should operate from a single site at Bega Hospital
2. A senior specialist or general practitioner obstetrician should be engaged for a period of three months to oversee implementation of the changes
3. Additional medical practitioners should be recruited, aiming to achieve a 1:6 after-hours roster for Bega medical practitioners, but with a minimum of 1:4
4. A new position of Clinical Midwifery Consultant should be established for the Eastern Sector, with the initial responsibility directed towards implementing the above changes
5. A program of education and upskilling for midwives should be implemented
6. The maternity service should be adequately staffed, with one midwife and a second appropriately trained nurse at all times dedicated to the service
7. Pambula midwives should be consulted individually to identify and, if possible, overcome, barriers to their relocation to Bega
8. Beds should be dedicated to the obstetric service, with the three delivery suites used only for delivery, and dedicated post-natal beds
9. Antenatal and post-natal care should be provided from multiple sites across the area
10. The post-natal outreach service should be expanded to ensure access for all mothers
11. A mechanism to ensure a strong clinician and consumer voice in the planning of maternity facilities in the new hospital should be identified, either as a separate Maternity Advisory Group or a subgroup of the Bega Valley Health Advisory Council. This group should also monitor progress of and satisfaction with implementation of the recommendations of this report
12. Issues of concern such as privacy, a partner- and family-friendly service and quality of food, should be addressed
13. The Bega Valley should not attempt to recruit a permanent solo specialist obstetrician and gynaecologist, but should maintain a close relationship with obstetricians at the Canberra Hospital

1. Introduction

The Greater Southern Area Health Service has requested an independent assessment of maternity services in the Bega Valley.

Terms of reference for the review are:

1. To review current service delivery within maternity services across Pambula and Bega Hospitals, with the specific role delineation of each site
2. To highlight both areas of concern and opportunities for improvement within the service delivery process
3. To make recommendations on the most appropriate option(s) for safe and sustainable maternity service delivery in the immediate, medium and long term for the Far South Coast.

2. Bega Valley

The Bega Valley Shire covers an area stretching 106 kms from Bermagui in the north to the Victorian border. The major towns are Bega, Merimbula (with Tura Beach), Eden, Tathra, Bermagui and Pambula, with ten villages with populations of less than 1,000. Residents of Mallacoota and Cann River in Victoria also access services within the Shire.

The population of the Bega Valley in the 2006 Census was 31,062, with population projections of increases of between 5 and 6% each five years. The indigenous population was 2.6%. English was the language spoken at home for 93.7% of the population. The median family income was \$898 per week compared with the Australian average of \$1,171.

There are two public hospitals, Bega Hospital is a 67 bed district level 1 hospital and Pambula Hospital is a 30 bed community acute hospital. In 2005-06, Bega Hospital had 4,796 separations with bed occupancy of 77% and 11,271 ED attendances. Pambula had 2,207 separations with 7,913 ED attendances. The distance between the two towns is 33 kms, with a travelling time of between 20 and 25 minutes.

A recent Area Health Service re-structure has created the position of General Manager, Eastern Sector, with the proposal for an Integrated Services Manager, responsible for health services in Bega, Pambula, Moruya and Bateman's Bay.

Construction of a new hospital to replace both Bega and Pambula Hospitals has been approved at a cost of \$100 million. In November 2007, a Greenfield site in the South Bega zone was announced as the preferred site for the new 136 bed Bega Valley Health Service, with an anticipated completion date of 2012.

There are some longstanding tensions between the northern and southern parts of the Shire, and access to health services is included in these tensions. Despite the fact that the preferred site for the new hospital has been decided, there has been, and continues to be, intense lobbying for it to be located in a more central position between Bega and Pambula. At the same time, there is considerable concern that funding will be at risk if the community is seen to be divided.

3. Approach to Review

The Review Team comprised:

- Dr Andrew Child, Specialist Obstetrician
- Dr Samantha Egan, Consumer
- Ms Jane Griffith, Midwife
- Dr Sue Morey, Review Coordinator and Public Health Physician
- Dr Ross Wilson, General Practitioner Obstetrician

The Team was provided with copies of previous reviews and other documents prior to visiting Bega and Pambula on 20 and 21 May 2008, and meeting with those listed in Appendix 1.

The GSAHS issued a media release on May 13 calling for submissions to be lodged with the AHS by May 20. Following concerns that the closing date disadvantaged the southern parts of the valley, the closing date was extended until 27 May. Two submissions were received.

*BirthCentral*¹ emailed its associates on May 15 calling for comments from pregnant women and mothers who had recently used the service, and provided the Review Team with ten de-identified responses from consumers regarding their experiences.

A submission was received from the four Pambula general practitioner obstetricians.

4. Current Situation

4.1 Alternating Rosters

As a result of insufficient numbers of midwives and theatre staff, the two sites have been unable to operate independent services since January 2007. At that time, a new model was introduced, with general practitioners providing a 1:6 roster, allowing both units to operate from Monday to Thursday, with services from Friday to Sunday and on Public Holidays to alternate between Bega and Pambula.

A Review Advisory Committee, comprising management, general practitioners, midwives and consumers from both Bega and Pambula met between May and July 2007 to analyse the impact of the changes. They identified significant dissatisfaction with the model from consumers and midwives and concluded:

- No further modifications can be made to the current model of maternity service provided within the Bega Cluster;
- A single maternity service to be provided from one site in November 2007.

In September and October 2007, all maternity services operated from Pambula to allow renovation of Bega operating theatres. Following re-opening of the Bega theatres, due to reduced availability of midwife and operating theatre staffing, the service was changed to provide maternity services in Pambula one week in every two.

This arrangement has been in place since that time, with services provided as detailed below for the month of May 2008.

¹ <http://thebegavalley.org.au/birthcentral.html> A group of mothers and community members who are advocating for safe, women-centred, family oriented and accountable maternity services in the Bega Valley Shire.

For May 2008, maternity services are provided in Bega on 24 days and in Pambula on 14 days. There are 8 days on which the service is provided from both hospitals. A calendar similar to the table below is forwarded at the commencement of the month to each person booked from 36 weeks. We understand that approximately once per month Pambula has insufficient staff to fulfil the roster requirements.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
			1 Bega	2 Bega	3 Bega	4 Bega
5 Bega	6 Bega	7 Bega + Pambula	8 Bega + Pambula	9 Pambula	10 Pambula	11 Pambula
12 Bega + Pambula	13 Bega + Pambula	14 Bega	15 Bega	16 Bega	17 Bega	18 Bega
19 Bega	20 Bega	21 Bega + Pambula	22 Bega + Pambula	23 Pambula	24 Pambula	25 Pambula
26 Bega + Pambula	27 Bega + Pambula	28 Bega	29 Bega	30 Bega	31 Bega	1 Bega

4.2 Activity

July 2006 – June 2007

	Total births	Spontaneous vaginal births	Elective LSCS	Emergency LSCS	Vacuum	Forceps	Not known
Bega	149 (30 PDH booked)	97 (65.1%)	19 (12.75%)	19 (12.75%)	11 (7.4%)	0	3 (2%)
Pambula	112 (17 BDH booked)	78 (69.7%)	15 (13.4%)	8 (7.14%)	10 (8.9%)	1 (<1%)	0
Total	261	175 (67%)	34 (13%)	27 (10.3%)	21 (8%)	1 (<1%)	3 (1%)

July 2007 – April 2008

	Total births	Spontaneous vaginal births	Elective LSCS	Emergency LSCS	Vacuum	Forceps	Not known
Bega	119 (16 PDH booked)	79 (66.4%)	13 (10.9%)	14 (11.8%)	10 (8.4%)	1 (<1%)	2 (1.7%)
Pambula (to 03/08)	107 (39 BDH booked)	80 (74.8%)	5 (4.7%)	15 (14%)	6 (5.6%)	2 (1.9%)	0
Total	226	159 (70.3%)	18 (8%)	29 (12.8%)	16 (7.1%)	3 (1.3%)	2 (<1%)

Note: All births at Pambula September and October 2007 due to closure of Bega Theatres

4.3 Models of Care

General practitioners attend virtually all births in both hospitals. The midwives deliver a number of the babies, and at times the general practitioner may arrive shortly after the birth, but the intention is to have a midwife and a doctor at each birth to ensure care for both mother and baby.

Antenatal care is largely provided in the rooms of the general practitioners, although a Shared Care “Pregnancy Partnership” Model has recently been introduced in Bega, with four midwives participating. Antenatal visits are alternated between the midwife and the general practitioner. The model is said to be popular with the community, which offers an additional source of information, enables some antenatal visits to be provided at home for residents of outlying villages, and also reduces the cost of antenatal care.

Two independent midwives offer home births, but the number of homebirths is not known.

4.4 Physical Facilities

Bega Hospital has three birthing rooms, in which mothers usually remain until discharge. A 2 bed room is available if the rooms are required for birthing, and is shared with surgical patients as necessary. There are two cots in a special care nursery.

Pambula Hospital has a single birthing room and one special care nursery cot. There is a verandah common room for use by families.

4.5 Midwives

In Bega, there is one midwife per shift, with a second person (not necessarily a midwife) brought in to assist as required. Until recently, Pambula midwives have covered the general wards as well as maternity. In the past six months, three FTE midwives have worked a seven days on, seven off roster, plus additional shifts. Theatre staff are on call for the week that Pambula is open for maternity.

There is one outreach midwife responsible for early discharge post-natal visits (up to 10 days post-natally) but also for the initial assessment of people booking into hospital. She undertakes some antenatal home visits.

A midwife (0.6FTE) for the Aboriginal community works mainly from the Aboriginal Medical Service.

4.6 Medical Practitioners

Pambula Hospital

- 9 General Practitioner VMOs
 - 4 GP Obstetricians, 1 with Caesarean Section privileges
 - 2 GP Anaesthetists (+1 recently ceased anaesthetics)
 - 1 GP with advanced Neonatal skills (APLS instructor)
- 1 Visiting Gynaecologist (recently transferred operating lists to Bega) provides cover for Caesareans during her visits

Bega Hospital

- 6 General Practitioner VMOs
 - 2 GP Obstetricians, 1 with Caesarean Section privileges
 - 3 GP Anaesthetists
 - 1 GP Anaesthetic registrar
 - 1 GP registrar
- 3 General Surgeons – perform LSCS with GP assistant
- 2 Orthopaedic Surgeons
- 1 Consultant Physician
- 1 Specialist Anaesthetist
- 1 Visiting Urologist
- 2 RMOs
- 2 Registrars (medical and surgical)
- 24 hour CMO cover for Emergency Department

4.7 Other Services

Antenatal education classes of six weeks duration are held continuously, alternating between Bega and Pambula.

Pambula does not have access to after-hours pathology. Blood samples for cross matching are sent to Bega during pregnancy, with two bottles of O negative blood kept in Pambula.

Pambula has publicly funded access to ultrasound, but in Bega a private service only is available.

4.8 Quality

Professor David Ellwood from the Canberra Hospital visits quarterly for a combined clinical review meeting. Transfer links are well established and high- risk patients are referred for antenatal consultation. Pregnant women are given an updated hand held medical record at each antenatal visit to take with them when admitted to hospital. Both sites are currently using the same policies and guidelines.

5. Midwife Views

Midwives would like to see two fully functioning units but believe that this cannot be sustained. There is considerable dissatisfaction with the model in which there is a single midwife on duty for each shift, which they believe is a barrier to recruitment. While some enjoy a broad range of roles that includes midwifery, others see a distinction between the role of a midwife and that of a nurse and believe that a combined role is not satisfactory. Some find that the seven day roster, together with the option of additional shifts, leads to fatigue. Assistance from general ward staff at busy times is not a satisfactory arrangement, as the nurses brought in to assist frequently do not have midwifery training and skills and can offer only limited support. Midwives support the need for two people on the maternity roster at all times, acknowledging that the second person need not be a midwife as long as they are on a dedicated maternity roster and have received specific training in their areas of responsibility.

Midwives would like to see more midwifery led care. However, the Caseload Model, in which a single midwife on a flexible on-call roster can provide continuity of care throughout pregnancy, birth and post-partum for 30 to 40 women per year, has been considered to be not sustainable with the current workforce. Midwives enjoy the recently introduced Shared Care Model, which has now reached capacity.

6. Medical Practitioner Views

Pambula doctors support a commitment to a full service at both sites, but maintenance of week-about services if staffing levels do not permit a full service. They base their preference primarily on the medical capacity at each site and patient convenience, and have outlined the disadvantages that would follow the closure of either site.

The Pambula general practitioner credentialed for Caesarean Section formerly contributed to the Bega roster one weekend per month, but withdrew some time ago, apparently on the basis of safety concerns. Pambula doctors have indicated that they would be unable to participate in a Bega-based service. Reasons given include the impracticality of leaving a busy surgery to drive 20-25 minutes each way to a delivery, the inability to provide optimum care to a person in labour through several visits a day, the difficulty of being on call for Emergency presentations at Pambula as well as for obstetrics at Bega, the need to participate in separate after-hours rosters at each hospital, and the fact that the road can be dangerous, particularly after hours, with fog and animal hazards. The difficulties would be exacerbated for the obstetrician whose practice is in Eden. Although it was acknowledged that traffic in capital cities can lead to an equivalent travelling time, it was noted that most city hospitals have access to junior staff on site.

Bega doctors indicated that the minimum after hours roster would be 1:5, with 1:6 the ideal.

Doctors from both sites indicated that attending normal births is one of the more rewarding aspects of general practice, consistent with the “cradle to grave” continuum of general practice, and one of the attractions of rural general practice.

7. Community Views

The Review Team received negative and positive feedback from consumers both in meetings and in written submissions. The major concern related to dissatisfaction with the alternating arrangements between the two hospitals. The positive feedback related to satisfaction with the care given by general practitioners, particularly the continuity for antenatal care and the birth, and for that given by midwives and by the post-natal outreach nurse. One Eden-based mother had transferred from Bega to Pambula after the birth and found that a very satisfactory experience.

Although several submissions expressed dissatisfaction at the need to travel to Moruya or Canberra for multiple births or complications of pregnancy, the major problems identified were:

- Not knowing which hospital will be open at the time of the birth
- Premature discharges to avoid the need for post-natal transfer to the other hospital

We were provided with a copy of a *BirthCentral* sponsored petition currently circulating in the community asking the Health Service to “put an end to the ultra fragmented maternity service and transferring of women between Bega and Pambula Hospitals”.

We heard in both oral and written submissions of a number of women who had requested early intervention to avoid the uncertainty of where they would deliver, and of those who discharged themselves within 48 hours of a Caesarean Section rather than be transferred to the other hospital. However, we recognise that we heard of the experiences of only a small proportion of the women who have given birth since the shared roster was introduced.

Other more general concerns expressed by consumers related to both hospitals

- Lack of privacy and confidentiality
- Lack of facilities for partner/children to be present
- Lack of facilities for husband to stay after the birth
- Lack of baths
- Inconsistent advice from different midwives
- Poor quality and quantity of food
- Not enough post-natal home visits
- Level of staffing inadequate leading to lack of attention from midwives during labour
- Culture of staff at the unit

8. Discussion

Pambula Hospital has four general practitioners credentialed for obstetrics, although only one with Caesarean Section privileges. There are two general practitioners currently providing anaesthetics, and one with expertise in neonatal care. In contrast, Bega only has two general practitioner obstetricians, one with limited Caesarean Section privileges, but the three consultant surgeons are also credentialed to undertake Caesarean Sections, assisted by a general practitioner obstetrician. (It is noted that not all locum specialist surgeons are able to perform these procedures). Bega Hospital also has junior medical staff and career medical officers on site.

It is not possible to clearly define the numbers of midwives at each hospital as some are working between hospitals. Nevertheless, numbers remain insufficient to maintain the current roster and to support an on-call theatre roster at Pambula. The fact that only one midwife is on duty for each shift was said to be a major barrier to recruitment of permanent or agency midwives to Pambula, as well as a reason for at least one midwife to withdraw from midwifery practice. With the recent decision of the visiting gynaecologist to transfer her operating list to Bega, Pambula theatres are used for only a few minor gynaecological procedures each week, thus making it impractical to maintain a roster and difficult to maintain skills of nursing staff. We were advised that the second Bega operating theatre is under-utilised due to lack of anaesthetic staff, and that emergency Caesareans have been delayed while lengthy orthopaedic cases are in progress.

We accept that Pambula has some advantages over Bega – It is closer to the airport (Bega has a helipad), it has access to public ultrasound, under-utilised theatres, and more space for visitors. Pambula has a general practitioner credentialed for emergency gynaecology whereas Bega does not. Travel distances are shorter for women living in Eden and further south than from Bega.

We accept that the issues identified that would inhibit Pambula doctors from working in Bega are legitimate barriers, and that a decision to close Pambula maternity services is likely to cause procedurally competent general practitioners to cease procedural practice, and, in addition, to adversely affect the future recruitment of general practitioners to Pambula, Merimbula and Eden.

Nevertheless, we believe that Bega has the potential to offer a safer service, and that construction of the new Bega Valley Health Service should facilitate development of a maternity service of high quality for the women of the Bega Valley.

Sufficient numbers of midwives will be required, and we understand that some Pambula midwives would not relocate to Bega.

We note the NSW Health Information Bulletin IB2008_004 *Pregnancy: Improving Early Pregnancy Care*, which provided funding in 2007-08 for publicly funded antenatal clinics, and identified both Bega and Pambula as eligible sites for this funding.

We note also the principles of the *National Consensus Framework for Rural Maternity Services*², and have taken these principles into account in our discussions.

9. Conclusions

The Review Team believes that the delivery of maternity services in the Bega Valley for the foreseeable future will rest with midwives and general practitioner, rather than specialist, obstetricians. We acknowledge that, despite the difficulties, the general practitioners and midwives have been providing a high quality service to the Bega Valley.

We are acutely aware of the shortage of general practitioner obstetricians across rural Australia, and of the importance of maintaining and, where possible, expanding access to maternity care in rural areas. The Bega Valley is extremely fortunate to have six general practitioner obstetricians. However, safety of mothers and babies must be the prime consideration, and we have concluded that the current system of alternating rosters is not only causing dissatisfaction, but may be contributing to a diminution in the standard of service. In the interests of safety, we believe that a single service operating from Bega should be implemented as soon as possible.

A combined unit would have at least 250 births per year. A new hospital could potentially see an increase in these numbers, and may also have a positive influence on recruitment of both midwives and general practitioners. A unit of this size has the potential to increase the range of options available to women, although it is unlikely that a caseload model would be able to be supported. The challenge is to meet the requests of consumers to offer women a choice of antenatal and birthing services, while allowing both midwives and doctors sufficient numbers of pregnancies and births to maintain their skills.

² Consensus of Australian College of Rural and Remote Medicine, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Australian College of Midwives, Rural Doctors Association of Australia, Rural Health Workforce Australia, and Royal Australian College of General Practitioners, April 2008

The single unit will only be sustainable if sufficient numbers of medical practitioners credentialed for obstetrics can be recruited to enable an after-hours roster of 1:6.

Clearly, innovative ways of reaching this target will be needed, and resources will need to be directed towards implementing the new model. We do not support the recruitment of a solo specialist obstetrician in the long term. However, we see that engaging a specialist or a general practitioner obstetrician, perhaps one recently retired, for a period of three months to implement the changes would be extremely valuable.

Options for increasing the medical workforce include:

- Use of locum specialist obstetricians or general practitioner obstetricians (although we recognise the difficulties associated with multiple new practitioners unfamiliar with facilities and policies)
- Employment of an obstetrics CMO
- Incentives to encourage Pambula doctors to maintain involvement eg payment to leave their practice for a day and spend a day in Bega, perhaps assisting in the Emergency Department, or to contribute to the weekend roster
- Renewed approach to Bega doctors who have ceased obstetric practice with an offer of re-training
- Participation by GP registrars with obstetric skills

In addition to the medical practitioners, we see the need for midwifery leadership. We understand that although midwives have ready telephone access to a Consultant, opportunities for on-site contact are limited. We propose creation of a position for a Clinical Midwifery Consultant for the Eastern Sector. The initial role of this person would be restricted to the Bega Valley, to assist in the integration of the two services, to provide education and upskilling to the midwives, and to further develop the shared care model of midwifery care. While some of the current Pambula midwives could provide antenatal and postnatal services in the southern parts of the Valley, consideration of incentives to encourage others to relocate may be necessary.

There should be two persons on duty at all times in the maternity unit. If the second person is not a midwife, it should be someone with a nursing background who works only in maternity and is provided with training in those areas of maternity care for which they will have responsibility.

It is clear that there are areas of concern that are unrelated to the issues of the two sites and that provide opportunities for improvement within the service delivery process. These relate to privacy and confidentiality, a facility that is partner and family friendly, consistency of advice and quality of food. While physical space in the existing premises may be a barrier to overcoming all of these concerns, we believe that they do need to be addressed.

We believe it is vital that there is strong clinician and consumer involvement in the planning of maternity facilities in the new building. There also need to be a mechanism for monitoring the implementation of the recommendations of this report. This could be through establishment of a separate Maternity Services Advisory Group or a sub-committee of the Bega Valley Health Advisory Council, but it must have a strong voice and ready access to decision-makers.

We note the view of *BirthCentral* that the Greater Southern Area should “employ a quality and permanent obstetrician.” We support the views of the Royal Colleges and the Specialist Group of the Rural Doctors Association of Australia that solo specialist practice is not sustainable, and therefore prefer to see a service based on procedurally competent general practitioners with a close working relationship with a specialist hospital.

Recommendations

1. All obstetric services should operate from a single site at Bega Hospital
2. A senior specialist or general practitioner obstetrician should be engaged for a period of three months to oversee implementation of the changes
3. Additional medical practitioners should be recruited, aiming to achieve a 1:6 after-hours roster for Bega medical practitioners, but with a minimum of 1:4
4. A new position of Clinical Midwifery Consultant should be established for the Eastern Sector, with the initial responsibility directed towards implementing the above changes
5. A program of education and upskilling for midwives should be implemented
6. The maternity service should be adequately staffed, with one midwife and a second appropriately trained nurse at all times dedicated to the service
7. Pambula midwives should be consulted individually to identify and, if possible, overcome, barriers to their relocation to Bega
8. Beds should be dedicated to the obstetric service, with the three delivery suites used only for delivery, and dedicated post-natal beds
9. Antenatal and post-natal care should be provided from multiple sites across the area
10. The post-natal outreach service should be expanded to ensure access for all mothers
11. A mechanism to ensure a strong clinician and consumer voice in the planning of maternity facilities in the new hospital should be identified, either as a separate Maternity Advisory Group or a subgroup of the Bega Valley Health Advisory Council. This group should also monitor progress of and satisfaction with implementation of the recommendations of this report
12. Issues of concern such as privacy, a partner- and family-friendly service and quality of food, should be addressed
13. The Bega Valley should not attempt to recruit a permanent solo specialist obstetrician and gynaecologist, but should maintain a close relationship with obstetricians at the Canberra Hospital

Appendix 1

Persons Consulted

Greater Southern Area Health Service

Mr Ken Barnett, General Manager, Eastern Sector

Mr Ray Toft, A/General Manager Bega Valley Health Service

Ms Rosemary Hamilton, Nurse Unit Manager, Bega Valley Health Service

Bega Valley Shire Council

Mr Tony Allen, Mayor

Ms Leanne Barnes, General Manager

Bega Valley Health Advisory Council

Ms Jan Aveyard and members of Council

Pambula General Practitioners

Dr Rob Morton

Dr Michael Pentin

Dr Frank Simonson

Dr Janet Watterson

Pambula Nursing and Midwifery Staff

Mr Andrew Barr

Ms Wendy Grealy

Ms Roxanne Hopkins

Ms Leonie Munro

Mr Phil Munro

Ms Simone Shaw

Ms Judy Whiteside

Ms Maryanne Potts

Bega General Practitioners

Dr John Marshman

Dr Patricia Salisbury

Bega Midwives

Ms Jane Adams

Ms Julie Atkin

Ms Kathy Dack

Ms Kate Leiper

Mr Stuart Murphy

BirthCentral

Ms Tammy Glass

Ms Penny Green

Ms Cindy Turner

Ms Marianna Ypma

The Canberra Hospital

Professor David Ellwood

Appendix 2

Extract from Bega Valley Health Services Plan 2005 -2010

Maternity services are provided at level 3 role delineation at both Bega and Pambula Hospital. Both sites provide level 3 prenatal, intrapartum and postnatal care and level 2b nursery care to sick neonates and neonates returning from tertiary referral centres.

The Bega maternity unit is an independent unit consisting of 3 labour, birth and recovery rooms, a two cot level 2b special care nursery and a 2-bed ward. The Pambula unit is located in the middle of the general ward with a birthing room and one cot level 2b nursery. Approximately 290 babies are born in the Bega Valley Health Service Cluster each year. Both hospitals provide birthing facilities. In 2001/02, 183 babies were born in Bega Hospital and 116 at Pambula Hospital. In 2002/03, 168 in Bega Hospital, and 116 in Pambula Hospital. By 2003/04 the number of babies born has gradually decreased to 151 in Bega Hospital and increased to 127 in Pambula Hospital.

GSAHS is working with the Rural Obstetric Training Network to develop a Maternity Services Plan for the Area. This plan will include consideration of revised models of care, the establishment of clinical networks for obstetricians, GP obstetricians and midwives.

Projected Demand

As the populations projections do not predict an increase in younger population it is therefore assumed that the demand for obstetrics services will continue at the same or slightly increased level.

Context Factors

- *Maternity services are duplicated at Pambula Hospital and Bega Hospital.*
- *No current gynaecology service in the Bega Valley Shire. An interim monthly service will start in September 2005. The health service is advertising for Obstetrician and Gynaecologist to support the current service.*
- *The birthing room at Pambula Hospital is isolated from the prenatal/postnatal beds.*
- *APPI projections indicate that current number of beds will be sufficient to 2011.*
- *Medical and midwifery workforce is constantly at risk at both sites.*
- *GSAHS integrated perinatal program has been implemented across Bega, Pambula and Community health facilities.*

Recommendations for Maternity Services

1. *Explore options for developing one Bega Valley Health Service Cluster maternity service.*
2. *Plan the implementation of a midwifery model of care.*
3. *Develop a shared care (GP) midwifery model and enhance and extend outreach models.*
4. *Integrate medical and midwifery resources, training and skill mix requirements into workforce plan.*
5. *Continue to work toward recruiting a specialist Obstetrician and Gynaecologist.*
6. *Explore options to increase the health service capacity to reduce length of stay and increase community based support through service redesign processes.*
7. *Continue to support and further develop integrated perinatal program.*
8. *Work with GSAHS maternity services planning process to develop a safe and sustainable maternity service in the Bega Valley Shire.*

Appendix 3

Summary of Previous Reviews of Bega Valley Maternity Services

1999 **Review – Dr Vic Carroll and Dr Penny Knowlden**

Over the previous five years, Pambula had averaged 133 and Bega 260 deliveries per year. There was a specialist obstetrician at Bega supported by GP anaesthetists, and 6 GP obstetricians at Pambula.

Recommended:

- Close the obstetric unit at Pambula Hospital and create an expanded central unit at Bega Hospital, *or*
- Improve existing delivery of obstetric services at Pambula, by
 - 24/7 on-call theatre roster
 - GPs with low numbers to relinquish privileges
 - Specialist obstetrician to be Director of O&G for both hospitals
 - Commitment to CME for GP obstetricians
 - Formal on-call roster for anaesthetists
 - Guidelines for formal midwifery on-call staffing
 - Only one induction of labour scheduled per day
 - Formalised attempt to maintain and augment contemporary midwifery and operating theatre nursing skills

The review did not support downgrading Pambula to 'low risk' confinements only.

November 2005 **Review of GSAHS Surgical Services – Profs Brian McCaughan and Donald MacLellan**

Concluded "Having two separate services with urgent caesarean sections in both Bega and Pambula Hospitals is a strain on anaesthetic and other services. A review of the Obstetric Services and its rationalisation is urgently required."

November 2005 **Review – Dr Ian Stewart, Dr Penny Knowlden, Ms Sue Kruske, Ms Danette Watson**

Identified that the cluster could not safely support two maternity units, and recommended:

- Fast track the new combined hospital
- One maternity service be established with services across both sites
- Continue to offer services to clearly defined low risk women in Pambula
- Offer the choice of a midwifery service at both sites
- Improve education and support for midwives and GPs
- Establish a Regional Maternity Service Advisory Group
- Encourage consumer involvement and communication
- Develop efficient transport system
- Improve outreach services
- Improve links between AMS and health providers to improve services for Indigenous women and their families
- Implement the use of hand-held records
- Improve communication between midwives and GP obstetricians at both sites
- Promote early booking in to hospital for women accessing GP based antenatal care
- Employ short term or long term midwifery consultant to provide leadership
- Facilitate access to publicly funded ultrasound services for all women
- Long term recommendations to consider innovative, sustainable, evidence-based models of care

Appendix 4

Bega Valley

