# Integrated Primary Maternity System of Care

**August 2018**

## Questions and answers

**Why are primary maternity services changing in the Southern district?**

Primary birthing is safe and the best option for healthy women with low risk pregnancies. Southern DHB strongly supports the need to have an infrastructure in place that ensures that options for primary birthing are accessible for as many women as possible.

In addition, we recognise that birth is only one aspect of maternity care – it is also essential that women have access to excellent antenatal and postnatal care, and that this is effectively integrated with other health services that women and their families receive.

Further, Southern DHB is the largest district health board by geographic area in the country. This presents unique challenges for providing healthcare services and primary maternity care is an important part of this.

To achieve this, we need an infrastructure that is **flexible, sustainable, takes a whole-of-district view and is truly integrated into the overall health system**.

Previously, there have been challenges with ensuring maternity care reach across our geography, and that the infrastructure in place has been able to cope with the changing needs of the population – whether that means continuing to be financially viable as birth numbers remain static or decline, or accommodate increases in population. The configuration of maternity facilities and services had developed over time, and inequities and gaps in services had emerged.

It has also been recognised that a key element of a sustainable maternity system is supporting the LMC midwives who perform an essential and enormously valuable service. While DHBs do not contract LMC midwives directly – midwifery income is set and paid directly by the Ministry of Health – DHBs can help provide an infrastructure to better support their ability to provide services, and alleviate some of the challenges they may face in their role.

This new system of primary maternity care builds services around women, in conjunction with other community and primary healthcare services and supports, and better recognises the critical role of LMC midwives across the district.

There are many strengths to the current system of care, and we have had a great basis to build from. But there are also gaps. We have taken a whole of system, and whole of district approach, to developing a system of care that will serve women, communities and the maternity workforce for the decades to come.

**What will the new system of care look like, and how will it be different from what we have?**

The new system of care has the following key features:

- Introduction of a new layer of maternity support, named Maternal and Child Hubs. These expand the reach of services further across the district and provide greater infrastructure support for LMC midwives, including integration with primary care services
- Funding support package for LMC midwives working in remote rural locations, to recognise the additional duties they perform
- Investment in technology to support access to specialist care, reducing the need for some women to travel
- Dedicated positions and resources to provide leadership support to promote quality and safety, recruitment and retention of LMC midwives, and communication.

**Where will the primary birthing units and maternal and child hubs be located?**

Maternal and child hubs will be created in Wanaka, Te Anau, and Lumsden, and existing primary maternity supports enhanced at Tuatapere and Ranfurly. These are non-birthing units (except in urgent situations) that bring together resources to better support antenatal and postnatal care.

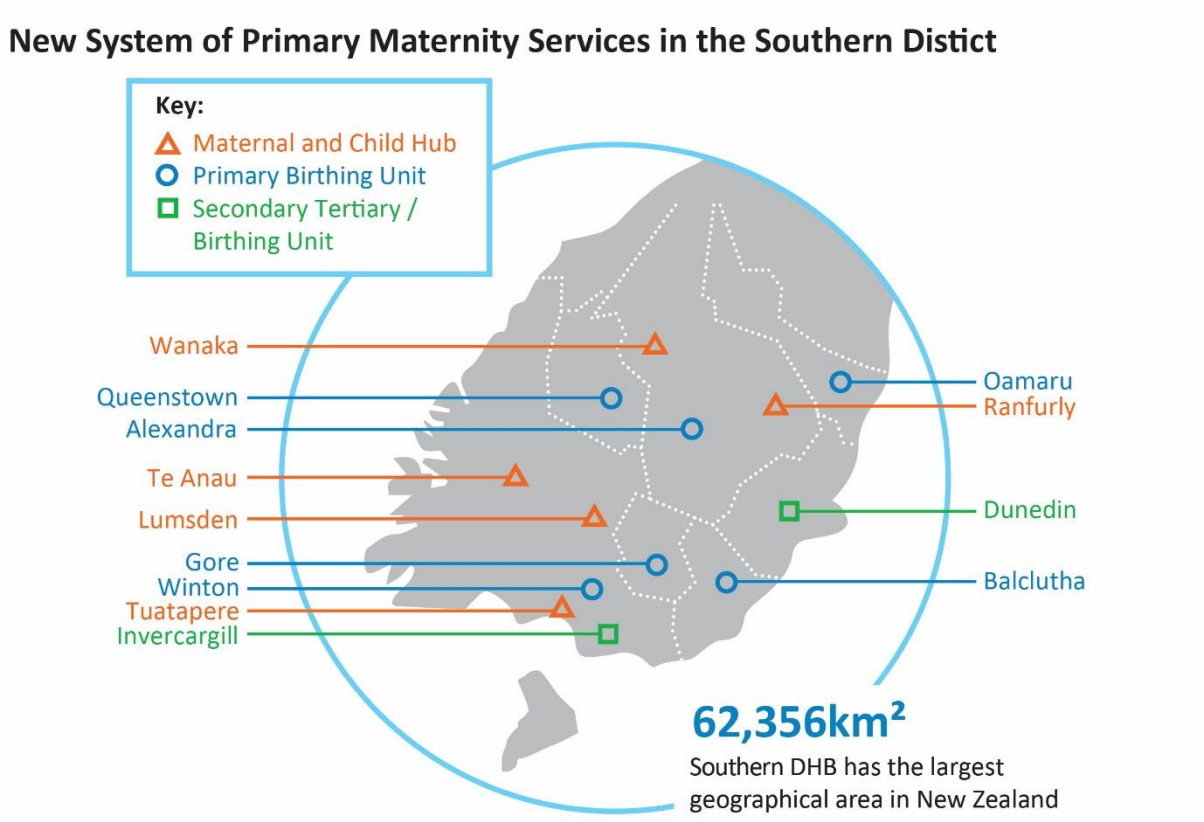
Primary birthing units are maintained at Lakes District Hospital in Queenstown, Gore Health, Oamaru Hospital and Clutha Health First in Balclutha, Winton Maternity Centre; and will continue at Charlotte Jean Maternity Hospital in Alexandra while the best long-term location of a primary birthing unit in Central Otago is explored.

Birthing units also continue alongside secondary and tertiary maternity services at Dunedin and Southland hospitals. The feasibility of a primary birthing unit in Dunedin will also be considered.

In all, the Southern district maternity system will have eight birthing units and five primary maternal and child hubs to support women and their babies, working with other complementary community and primary care services.

Changes from the current system are that:

- New maternity and child hubs will be established in Te Anau and Wanaka
- The Lumsden Maternity Centre will transition from a primary birthing unit to a maternity and child hub




**What is a maternal and child hub?**

A maternal and child hub is a centre focused on providing **antenatal and postnatal services** that meet the needs of women and their babies in the local community.

Each location will differ based on the needs of the local community and we will work with mothers, midwives, healthcare providers and other stakeholders to co-design a hub that is the best fit for women and families using the service.

It is possible that a hub might include rooms for consultations by midwives and other healthcare providers, including visiting specialists, equipment such as a homebirth kit, CTG for monitoring foetal heartrates and contractions, blood pressure monitoring, a resuscitation kit, and IT provisions for telehealth services.

A hub may also include offsite maternity and child services, such as breastfeeding and parenting support, and in-home postnatal care.

They will be fully equipped and accessible for urgent births, if needed.

These are designed to be flexible, and adaptable to the changing needs of the population. For example, they could be scaled up to become birthing units if demand and workforce availability require and allow for this. In the meantime they provide an infrastructure that offers greater support for homebirth and preparation for birthing in another centre, other aspects of antenatal and postnatal care, and greater integration with other primary healthcare services.

**Why has it been decided that Lumsden should transition from a primary birthing unit to a maternal and child hub?**

In 2017, there were 38 births at Lumsden Maternity Centre – less than one per week. It is also relatively close to two further primary birthing units, in Winton and Gore (around 35 and 45 minutes away respectively).

In this context, providing a fully-staffed 24/7 inpatient maternity service at this Centre does not make the best use of maternity resources to support a system of care across all of the Southern district.

Further, the centre services Te Anau, a larger population base an hour's drive from Lumsden, but there is no formal maternity infrastructure in that town to support women, families and LMC midwives.

This has led to a concentration of primary birthing units within a short distance from one other, accommodating a relatively low number of births, while other parts of the area and other aspects of maternity care are under-supported.

*Maternal and child hubs* in both Lumsden and Te Anau, with services focused on antenatal and postnatal care and facilities for urgent births, provide a better match for the level of demand for the services in this areas.

**Is the extra distance women could have to travel for a planned primary birth, to Gore or Winton, safe?**

In developing a new primary maternity system of care to meet the needs of the entire district, safety has been a paramount consideration.

Currently, there are gaps across the district with no facilities for urgent births. This model of care introduces two new facilities, in Wanaka and Te Anau.

Perhaps more importantly, however, the sustainability of the LMC services across the district has faced real threats to its viability. The most critical area we can focus on to improve the safety of women and babies is to support our LMC midwives. This system of care includes developing hubs for midwives to work from, alleviating costs and enabling greater integration with wider health services. It also offers remote rural midwives additional income, to acknowledge the wider range of services they perform compared with their urban counterparts.

Travel time is a part of the birth plan LMC midwives and expectant mothers would develop together. The majority of women and their midwives are managing this currently, as most are already travelling to birth in Invercargill or other facilities. We note that some years ago, when fewer women were choosing to birth in Lumsden for a range of other reasons and the facility supported as few as 10 births a year, women and their midwives managed this journey safely.

Women suitable for primary birthing are those at lowest risk, and so may also choose to birth at home if they do not wish to travel to the primary maternity facilities in Winton or Gore.

The hubs in Te Anau or Lumsden would be equipped, and accessible by midwives in the event of those quick births. So if there were concerns that the baby might not wait to make it to Winton or Gore, women and midwives could use the facilities in an urgent situation.

In the event of an emergency, there are processes in place that are activated. For example, a second midwife is on call and protocols for urgent maternity transfers have been developed with St John and other primary and secondary care providers.

The Primary and Community Strategy will further enhance community-based healthcare services to support community-based maternity services.

Due to the intense community interest in the impact of travel distances, external advice was sought from midwifery consultants to help us understand this risk. The external advisors provided their opinion that *'there is no additional clinical risk to moving Lumsden to a maternal and child hub (as opposed to a birthing facility), if SDHB implements the required mitigation.*' These mitigations include the provision of equipment and processes to support urgent and emergency births, and greater support to ensure the sustainability of LMC midwives, who can help women plan to manage the travel required.

**Does this meet the Ministry of Health's service schedule, which says a primary birthing unit needs to be available in areas where there are 100 pregnancies?**

The Ministry of Health has endorsed this plan as meeting service requirements.

Given the community interest in this matter, we have also sought a legal opinion to provide guidance on this, which concludes:

> *…we think SDHB's proposed interpretation of clause 4.8, applied to Lumsden, is reasonable and lawful. It follows that we do not think that SDHB is under an obligation to continue to fund the Lumsden facility as a primary maternity facility by virtue of clause 4.8 of the SCS.2.*

**Is this configuration of maternity services equitable?**

More so. The existing infrastructure for maternity services across the district have evolved from a range of historic circumstances and solutions. This has led to inconsistent service provision, does not clearly make the most effective use of resources, and has not provided a clear framework to guide further development.

The new system of care aims to provide more equitable care for women across the district by addressing service gaps and better distributing resources and facilities across our wide geographic area.

It also provides a principled framework for continuing to develop equitable maternity services.

**What is the funding difference between a maternal and child hub and a birthing centre?**

A key difference is that midwives are employed to provide 24/7 full-time cover at a birthing unit. This requires the unit to be fully staffed at all times. In some areas there may not be enough births to make this financially sustainable, or the workforce to make this possible.

A maternal and child hub, however, does not require a 24/7 on-call staffing commitment. Rather it provides the ongoing infrastructure to better support LMC midwives and others in their roles – which includes attending home births or women birthing at their nearest facility, and providing antenatal and postnatal care.

Investing in maternal and child hubs means resources can go further towards reaching more women and providing services in facilities closer to their homes.

Maternal and child hubs are intended to be flexible and scalable, to adapt to needs of changing populations. This could mean transitioning to becoming primary birthing units should this become necessary and possible in the future.

**How much money is the Southern DHB investing on this new system of care?**

The overall network is expected to cost approximately the same as the current primary maternity system, however it will reach more women and be better integrated into other health care services. We will work with our partners in the community to determine the right mix of primary maternity services and how they are delivered. From this mix of services, funding will be allocated and budgets determined.

**Where will the Te Anau Primary maternal and child hub be located? When will it open?**

The precise nature and locations of these hubs have not been determined and Southern DHB will be working with stakeholders to co-design services so they offer safe and sustainable primary maternity services.

The facilities or location and mode of delivering primary maternity services don't have to be exactly the same across the network – nor, in fact, should they be. How and where services are delivered in Wanaka, Te Anau, Ranfurly, Tuatapere and Lumsden will vary. There is flexibility to adjust the services delivered in each area so that they reflect the needs of the community they serve and we are committed to working with maternity service providers, trusts and others to co-design services so facilities and services are the best fit for their communities.

**Can maternity facilities in Winton, Gore and Invercargill handle the additional births?**

Yes, ensuring there is capacity to accommodate additional births at other birthing units has been part of this planning process.

Winton and Gore are the primary maternity options available in this district. We do not expect more people to choose to go to Southland Hospital in Invercargill if they were otherwise planning a birth in a primary birthing unit.

**What happens if population grows due to the subdivision proposed in Kingston?**

This system of care has built in flexibility and sustainability, so we can adjust according to changes in our populations, taking into consideration the demand for services and workforce availability. We have not closed off any options for the long term.

**What does this mean for women currently planning to birth at Lumsden Maternity Centre?**

The transition of Lumsden Maternity Centre to a maternal and child hub will be managed in conjunction with the Northern Southland Health Services Trust, to ensure those women currently booked in for a birth there are able to do so.

**What happens if the LMC midwife based in Lumsden leaves, as was signalled?**

As with other parts of the district where there have not been sufficient LMC midwives to meet the requirements of the community, Southern DHB has employed locum midwives to ensure women receive the care they need.

Southern DHB was advised in recent weeks that the current LMC midwife in Lumsden has ceased taking on new cases in this area. As such, we are looking at options to ensure midwifery services continue to be available.

The challenges of ensuring LMC midwives are able to practice sustainably in rural areas is an important feature of the plan, and the reason the system of care emphasises financial, professional and infrastructural support for those working in these important roles across the whole district.

**Why is there not a primary birthing unit in Wanaka, considering the growth in this population?**

While the population in the Central Lakes area is growing, the ability to sustain a primary maternity facility in this area is not clear. A maternal and child hub would provide an important step in building a more supportive infrastructure for women and midwives, provide facilities for urgent births, and support primary birthing options at home and at Alexandra's primary maternity facility, Charlotte Jean. It also offers the flexibility to scale up to a primary birthing unit should this be required in the future.

There are outstanding questions around the best location for a primary birthing unit for Central Otago in the long term, and we will establish a process to explore this question.

**How does this address the concerns raised that LMC midwifery is not sustainable in many parts of New Zealand, and midwives are leaving the profession?**

Improving the sustainability of LMC midwifery services right across the district has been a key motivation for this integrated primary maternity system of care.

Midwives perform an essential and enormously valuable service. While DHBs do not contract LMC midwives directly – midwifery income is set and paid directly by the Ministry of Health – DHBs can help provide an infrastructure to better support their ability to provide services.

By investing in maternal and child hubs, the system of care can alleviate some of the challenges LMC midwives face by enabling them greater access to equipment and resources, and ensuring they are well supported by colleagues in primary, secondary and community care.

In addition, following feedback during the consultation period for this proposal, the system of care now includes funding support for LMC midwives in remote rural areas through additional payments. LMCs caring for women in remote rural locations will receive additional payment of $300 per woman from Southern DHB, regardless of whether they birth locally or travel to a main centre for the birth. This aims to go some way to recognise the additional support they provide when compared to their urban counterparts.

Southern DHB continues to work with the Ministry of Health and NZ College of Midwives towards a funding model that ensures we have a sustainable midwifery workforce across the district.

**How was the new system of care developed?**

The proposed configuration of maternity facilities and services is drawn from research and extensive consultation. This includes exploring women's birthing, antenatal and postnatal care preferences, analysing population and demographic predictions for the district, and research into the national and international trends and best practices. Following a consultation process, the Southern DHB's initial Primary Maternity Services Project Report was released last June. This was followed by series of co-design workshops, establishing core principles and criteria for a primary maternity system. These were then shared with participants for their feedback in October and November 2017.

These processes involved engagement with the maternity care providers, lead maternity carers (LMCs), midwives and mothers, their families, other healthcare professionals and community members.

A proposed primary maternity system of care was released for consultation in March 2018, generating extensive feedback which further shaped the development of the system.

The primary maternity system of care has also been created within the context of the recently launched Primary and Community Strategy and Action Plan which is improving overall coordination of health services and enhancing access to healthcare across the Southern district.

The system of care has been endorsed by the Ministry of Health as having been developed via a robust process and meeting the service requirements for women in the district.

**What are the next steps? How will this be implemented?**

With the support of the Ministry of Health, a programme of work will be developed, an advisory group and project leader appointed. It is our aim to begin implementation within the coming months, starting with the introduction of the sustainability package for remote rural midwives, and creation of a maternal and child hub in Wanaka. Work will be ongoing and we anticipate there to be full implementation within three years.

There will be additional opportunities for women and families, the public, health care providers, and other stakeholders to have input and make contributions to this process. The new primary maternity system of care will also align with the broader Primary and Community Strategy.