

THE NSW FRAMEWORK FOR MATERNITY SERVICES



NSW Health Department

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The NSW Framework For Maternity Services.

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FOREWORD

The NSW Health Department convened a Maternity Services Advisory Committee to consider a range of issues regarding the provision of maternity services in NSW and to develop a five year plan for maternity services in NSW.

A range of issues impacting on the provision of integrated maternity services have been identified as requiring attention at both Departmental and Area Health Service level.

The NSW Framework for Maternity Services provides strategic objectives for the development and implementation of future services, and as such will require focused attention and concerted action on the part of all key stakeholders.

Since the release of the earlier discussion paper for comment, a number of important strategies have been progressed, including the Families First Initiative, The Aboriginal Perinatal Mortality Project, the review of the NSW Health Homebirth Policy and the review of professional indemnity.

The report has been amended where necessary to reflect these initiatives.

Area Health Services need to use this framework to plan their individual services.

The Framework has also been forwarded to the Clinical Implementation Working Groups who will develop the Metropolitan and Rural Health Plans as a result of the recommendation of the NSW Ministerial Advisory Committee on Health Services in Smaller Towns, Report to the NSW Minister for Health and the Report of the NSW Health Council.

Michael Reid
Director General

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EXECUTIVE SUMMARY

The NSW Maternity Services Advisory Committee was convened in November 1997 to develop a collaborative approach and strategic direction for providing maternity services over the next five years. This report, *The NSW Framework for Maternity Services*, is the result of the deliberations of the Committee following its assessment of current services and issues. A review of the contemporary literature was used to inform the development of this report.

Maternity services in New South Wales continue to be developed and refined in order to promote the best possible health outcomes for women and their babies. Since the release of the Shearman Report¹ in 1989, a large number of initiatives have been well received by women and have led to significant improvements in both clinical effectiveness and overall satisfaction with maternity care.

A range of issues affecting the provision of integrated maternity services have been identified as requiring attention at both Departmental and Area Health Service levels. A number of major recommendations have been made in attempting to address specific issues that have been highlighted as being of significant concern to consumers, health professionals and the NSW Health Department.

Differing attitudes, values and practices among midwifery and obstetric care providers within particular maternity units may influence the clinical effectiveness and cost-efficiency of those units as well as consumer and staff satisfaction. Given the importance of each of these factors to the provision of a quality maternity service, there is a need to ensure that midwives, obstetricians and general practitioners work within a collaborative and consultative framework which values the different yet complementary contributions of their respective roles. The ongoing education and training needs of all maternity health care workers continues to be an issue, especially in those units with low birth rates and minimal opportunities for staff to practise their clinical skills. This report provides strategies to assist Area Health Services in maintaining a skilled and competent workforce. Additional strategies, directed at longer term solutions are also suggested.

A range of necessary service changes have been identified which include:

- expanding the range of care models
- increasing the availability and accessibility of services, particularly for rural and remote communities

- improving the level and flexibility of available resources
- responding to consumer expectations.

It is generally agreed that further efforts are required to enhance the responsiveness of maternity services to the needs of women and their partners/families, particularly those from Aboriginal and Torres Strait Islander groups and non-English speaking backgrounds.

At the local level, professional indemnity issues affecting midwives and doctors, together with industrial relations structures, have in many instances acted as disincentives to the attainment of new directions in maternity care. In late 1999 interim indemnity arrangements have been agreed for specialist, visiting medical officers, obstetricians and gynaecologists. The NSW Government through the treasury managed fund, provides indemnity cover for public patient adverse events which have occurred on or after 23.2.99.

Other maternity service workforce issues have been assessed in detail and within the context of a recent national review of the obstetrics and gynaecology workforce. A slight shortage of obstetricians and gynaecologists exists, primarily because of a maldistribution between rural and metropolitan locations. However, a more challenging situation involves the number of midwives employed in the Area Health Services, and a range of strategies are identified that require urgent implementation.

The NSW Framework for Maternity Services provides strategic objectives for the development and implementation of future services. Meeting these objectives will require focused attention and concerted action on the part of all key stakeholders. The need for collaboration and consultation between service providers and consumers to better determine needs and priorities is paramount. This will be critical to ensuring that services are safe, efficient and effective, as well as respectful, personalised and rewarding for all concerned.

It is important that the five year goals, objectives and strategies are used in conjunction with the body of this report to move forward on the important task of planning and implementing maternity services that are flexible and responsive to all women in NSW.

MAJOR RECOMMENDATIONS

For *The NSW Framework for Maternity Services* to achieve its primary purpose of providing structure and direction for the future development of maternity services, a number of recommendations will require implementation in the first instance. These include that:

1. NSW Health adopt the five year goals, objectives and strategies of *The NSW Framework for Maternity Services* and implement these through the Area Maternity Services Plans.
2. NSW Health adopt the following philosophy statement for developing maternity services:

NSW Health recognises pregnancy, labour, birth and parenting as significant and meaningful life events and acknowledges the right of consumers to access safe maternity care and quality maternity services.

Continuity of care and consistent information is essential to the provision of care that is culturally sensitive and appropriate.

Collaboration between health workers at all levels plus the development of a competent and flexible workforce are critical factors in ensuring safe services and the availability of a range of models of care.

3. The NSW Health Department allocate designated resources within the Department to coordinate and oversee the implementation of *The NSW Framework for Maternity Services*.
4. The NSW Health Department review “early discharge programs” across NSW to determine their effectiveness and appropriateness, as well as the consistency of service guidelines, policies, terminology and reporting mechanisms. This should include evaluating the needs and priorities of women in accessing early discharge programs and the effectiveness of referral and follow-up procedures, particularly for women from marginalised or disadvantaged groups.

5. The NSW Health Department evaluate women's views of maternity care, including those of women from Aboriginal and Torres Strait Islander groups and non-English speaking backgrounds, with particular attention to addressing the specific needs of women from marginalised or disadvantaged groups.

1. Introduction

Maternity services in New South Wales continue to be developed and refined in order to promote the best possible health outcomes for women and their babies. Since the release of the Shearman Report¹ in 1989, a large number of initiatives have been well received by women and have led to significant improvements in both clinical effectiveness and overall satisfaction with maternity care.

This report outlines the strategic directions for NSW maternity services for the next five years. It summarises a process of consultation and review about a range of professional, service and consumer issues relating to the provision of maternity services in NSW. The issues discussed in this report build on and reflect matters raised by metropolitan and rural Area Health Services, obstetricians, midwives, professional organisations and the NSW Health Department in previous consultative forums, reports and professional literature. The report incorporates the strategic directions for NSW Health as outlined in *Strategic Directions for Health, 1998-2003, Better Health, Good Health Care*.²

Since 1989, three comprehensive reviews (*Maternity Services in New South Wales—The Final Report of the Ministerial Taskforce on Obstetric Services in NSW*, known as the Shearman Report¹ *Options for Effective Care in Childbirth*³ and the *NSW Midwifery Taskforce Final Report*⁴) have been conducted to consider, among other things, the implications of changing models of midwifery and obstetric practice for maternity service provision and consumer outcomes. The findings of each of these reviews have confirmed the need for midwifery and obstetric services to work within a collaborative and consultative framework to achieve positive health outcomes for consumers and a closer matching of services to consumer needs, preferences and expectations.

In November 1997, the NSW Maternity Services Advisory Committee was convened to develop a systematic approach to maternity service provision across NSW. The Committee's Terms of Reference were:

1. To develop a framework for implementing collaborative obstetric and midwifery practice across the continuum of maternity care, addressing issues relating to:
 - models of care
 - cultural awareness and sensitivity
 - public and private sector collaboration
 - consumer needs and choices.

2. To assess, evaluate and formulate options for improved management of human resources in delivering maternity services, addressing issues relating to:

- education and training
- professional indemnity
- independent midwifery accreditation/privileges
- collaboration between professional and collegiate groups
- rural and remote issues.

The principal objective for contemporary maternity services is to ensure choice, control, continuity of care and safety for all women in all phases of pregnancy and childbirth. This remained the basis for discussion and decision-making throughout the Committee's deliberations.

The Committee reviewed information from a number of sources including:

- current national and NSW reports that inform the development and delivery of maternity services (References and Bibliography).
- information provided by Area Health Services in response to the *Status Report – Maternity Services*, a survey undertaken to provide a profile of current maternity services (Appendices A and B)
- NSW Health departmental policies and circulars and other documents relating to maternity care
- discussion and debate between Committee members about a wide range of professional, service and consumer issues in maternity services.

2. Current Initiatives in NSW Health

Initiatives undertaken recently by the NSW Health Department which specifically or generally address the challenges experienced in maternity care include:

- the NSW Maternal and Perinatal Committee
- negotiating Performance Agreements between Area Health Services and the NSW Health Department
- the Rural Health Workforce Strategy
- perinatal seminars in rural health services
- funding initiatives through Alternative Birthing Services and National Women's Health Programs
- the Pilot Locum Service for rural obstetricians and gynaecologists
- Midwives Data Collection

- consultative forums with health services, professional organisations and educational providers regarding midwifery services
- consultation and review of medical indemnity for obstetricians in public health services
- developing maternity emergency guidelines for registered nurses
- funding of refresher midwifery programs
- transitional support funding for new graduate midwives
- development of guidelines and service models for Ethnic Obstetric Liaison Services.
- the NSW Pregnancy and Newborn Services Network

March 2000. Since the completion of this report a number of new initiatives have been progressed and include:

- ***the NSW Aboriginal Perinatal Health Project***
- ***review of the Homebirth Policy***
- ***implementation of the Families First Initiative.***
- ***interim indemnity arrangements have been agreed for specialist, sessional, visiting medical officers, obstetricians and gynaecologists.***

3. The Range of Maternity Services in NSW

NSW Health provides a range of maternity services to the community through the metropolitan and rural Area Health Services.

When considering the nature and scope of the maternity services available to the local population, it is evident that there is considerable variation within, as well as between, Area Health Services. Differences can arise from a number of factors including:

- geographical location
- demographic profile
- health workforce supply
- access to transport
- role delineation of local hospitals, including the level and mix of primary, secondary and tertiary services available
- appropriate utilisation of a skilled maternity workforce
- the extent of other support networks.

To determine the current status and range of services, a survey was conducted of all Area Health Services (*NSW Health Status Report – Maternity Services*, Appendix A). From the survey results, profiles of maternity services across the State were developed which assisted the Committee in determining the currently available services and systems of care. The *New South Wales Maternity Services Status Reports* (Appendix B) contain the resulting profiles for each Area Health Service.

The range and variation of services and systems of care reported in the *New South Wales Maternity Services Status Reports* reflects the uniqueness of each facility; however, the Committee considered that a number of services or systems should be essential to *all* facilities providing maternity care. These are included as a checklist in the *Status Reports* and provide a useful, quick reference for each Area Health Service to determine possible gaps in services, systems or policies. In particular, the Committee was concerned that systems should ensure adequate collaboration and consultation between consumers and members of the maternity health care team. Such systems are important in ensuring a seamless service and transition through the system and the best possible outcome for women and their babies.

It is important that all women are fully informed about the range of available maternity services. Maternity care providers have a duty to ensure that women receive sufficient information to make informed decisions about an appropriate birth setting and carer and about their preferred type of birth and subsequent care, as well as to know about the risks, benefits and indications for those choices. To this end, it is timely to reconceptualise the role, purpose and priorities for childbirth education services of the future.

The Maternity Services Advisory Committee was informed of the need for services providing information and advice about the use of medication in pregnancy and lactation. A number of initiatives are being explored at Area Health Service level and the committee offered in-principle support to the concept of developing a statewide service.

The overall picture of current maternity services across NSW provided by the profiles in Appendix B is one of a comprehensive system of services with a range of models of care being provided by a number of different types of health professionals. However, these models are not universally available, and the range of choices is greater in metropolitan than in rural and remote areas. Moreover, within some Area Health Services, there are some inconsistencies between facilities concerning their approaches to service delivery. In spite of

similar geographic and demographic profiles, there are a number of gaps in services and systems of care within Area Health Services that need to be addressed at the local and area levels. The strategic plan within *The NSW Health Framework for Maternity Services* provides a number of objectives and strategies designed to assist in addressing these issues.

4. Choice and Access Issues

Maternity early discharge

Early discharge programs were the focus of extensive discussion within the Committee. Discussions were held regarding the variable structures, systems and processes of each program and the need for any evaluation of the efficacy and appropriateness of the programs across NSW. The quality and quantity of information provided through the *New South Wales Maternity Services Status Reports* (Appendix B) has highlighted variances in criteria, protocols and terminology in use, as well as the lack of any consistent format for reporting activity and utilisation of the early discharge option.

Increasingly, early discharge is becoming standard practice in many units. Consequently, the lack of data to ascertain an accurate impression of the activity of this service has significant implications. Importantly, there is no evaluation tool to identify issues of concern to women regarding this practice, including the level of satisfaction or suitability for the majority. *The NSW Health Framework for Maternity Services* attempts to provide some objectives and strategies to address these issues in the context of quality improvement and meeting the needs of consumers and the community.

Homebirth Services

The Committee considered the model of care for women requesting homebirth. NSW Health acknowledges that women have the right to choose the place of birth and it is recognised that some women will choose homebirth. Therefore, it is important that Area Health Services develop appropriate policies and standards of care to minimise risk to mother and baby in the event of unforeseen complications requiring transfer to hospital. There is a responsibility on the part of the provider of care for home births to inform the woman of both risks and benefits of homebirth. Issues of preferred referral if clinically required, availability of adequate back up facilities and medical cover should also be discussed. It is the responsibility of the provider of care for homebirth to ensure maintenance of clinical competence through professional education and peer review.

The accreditation of independent midwives to practise in hospitals was a major recommendation of the Shearman Report ¹ and the responsibility to instigate this process was delegated to the Area Health Services. To date eight of the 17 Area Health Services report the existence of protocols in some of their facilities. Work continues to expand these opportunities.

A number of issues were discussed by the Committee as a result of the publication of data relating to perinatal death associated with homebirth in Australia and the recent decision of the Nurses' Tribunal relating to the practice of an independent midwife. Particular matters relating to perinatal deaths in NSW were referred to the NSW Maternal and Perinatal Services Committee for review and advice on policy. It was agreed that mechanisms within NSW Health need to be strengthened to allow women the choice of midwife or medical practitioner as the primary care provider for homebirth. In addition, specific service issues requiring attention within each Area Health Service have been addressed through *The NSW Framework for Maternity Services*. These issues include:

- the development of protocols in each Area Health Service enabling the accreditation of independent midwives as visiting midwives
- maintenance of essential minimum clinical skills in resuscitation and maternity emergencies for all maternity service providers
- review of the NSW Homebirth Policy Statement
- level of professional indemnity insurance for independent and visiting midwives
- protocol for care of a woman and/or her baby being transferred from a planned homebirth to hospital facilities
- increased participation of independent and visiting midwives in staff development, peer review, quality assurance and clinical case review meetings
- formal links and networks between Area Health Service-employed staff and independent and visiting midwives.

These matters were discussed by the committee and will be considered for inclusion in the revision of the Homebirth Policy, which is currently under way.

March, 2000. Since the completion of the report the Homebirth Policy circular has been reviewed and released for comment.

Women with additional needs

Providing accessible and culturally appropriate information and services to all women is a primary goal of NSW Health, and one that is critical to achieving desired health outcomes.

This is of particular importance during pregnancy for Aboriginal and Torres Strait Islander women, non-English speaking background (NESB) women, young women and women at psycho-social disadvantage because of the associated higher rates of perinatal mortality and morbidity.

That these groups of women have special needs in relation to maternity services has been confirmed by the three maternity services reviews referred to earlier.^{1,3,4} Those reviews emphasised the importance of ensuring that maternity services are responsive to the different culturally determined assumptions and expectations of individual women and their families, and that the models of care and available birthing options provide choice, facilitate access, enhance health outcomes, and promote consumer satisfaction. In addition, the need for all staff to attend cultural sensitivity training and increase their awareness of the needs of individual women was highlighted.

The health status of Aboriginal and Torres Strait Islander people is compromised at all stages of life. In 1996, the perinatal mortality rate in babies born to Aboriginal and Torres Strait Islander mothers was 17.4 per 1000, about double the rate of 8.9 per 1000 for NSW overall.

Apart from the stress of leaving their families to give birth in the nearest hospital, other factors that can present great hardship for pregnant Aboriginal and Torres Strait Islander women are the costs associated with transport, accommodation and childcare. If appropriate models of care are to work effectively, these associated issues need to be addressed to ensure that women not only have access to, but are supported in accessing, a full range of services.

The Shearman Report recommended a number of strategies regarding access and culturally appropriate maternity services for Aboriginal and Torres Strait Islander women. These included:

- expanding shared care arrangements between maternity units and Aboriginal Medical Services
- creating Aboriginal Liaison Officer positions in hospitals serving large Aboriginal and Torres Strait Islander communities
- providing suitable pre-confinement accommodation attached to country hospitals for women from remote areas

- greater acceptance and involvement of traditional Aboriginal and Torres Strait Islander birth attendants

A key strategy implemented by the NSW Health Department has been to provide funding assistance to community-controlled Aboriginal Medical Services to enable them to offer alternative birthing services or to complement existing birthing services.

The NSW Alternative Birthing Services Program (Second Phase) funded five Health Services for one-off innovative initiatives. Area Health Services with the highest Aboriginal and Torres Strait Islander and infant morbidity and mortality were identified and incentive funds provided to address the structural and service issues that inhibited Aboriginal and Torres Strait Islander women's access to existing maternity services. Examples of projects funded include:

- outreach midwifery services to isolated or remote areas
- antenatal and postnatal services provided by a midwife and/or Aboriginal or Torres Strait Islander health worker
- work with young homeless Aboriginal and Torres Strait Islander women to facilitate their access to mainstream health services
- a cultural awareness program for service providers.

An evaluation of this program, *Evaluation of the New South Wales Alternative Birthing Services Program, Second Phase 1993/94–1996/97*,⁵ was completed in 1998 and all recommendations have been integrated into the five-year plan contained in *The NSW Framework for Maternity Services*.

In late 1998, NSW Health Department allocated \$80,000 from the Aboriginal Enhancement Program (Aboriginal Health Branch) to develop a number of practical strategies and protocols to reduce Aboriginal and Torres Strait Islander perinatal mortality. The key issues to be addressed by this project include:

- identification of factors contributing to Aboriginal and Torres Strait Islander perinatal deaths
- a review of practices which have successfully reduced perinatal mortality rates in indigenous communities in Australia and internationally
- an evidence-based approach to planning and services delivery for Aboriginal and Torres Strait Islander maternal and child health.

March, 2000. The release of the NSW Aboriginal Perinatal Mortality Project Draft Report is anticipated shortly.

Planners of maternity services must work with leaders among local Aboriginal and Torres Strait Islander women to ensure that the services provided cater for the needs and expectations of those women. Encouragement and support should be given to enable Aboriginal and Torres Strait Islander women to become members of consumer liaison committees within maternity services. Opportunities for Aboriginal and Torres Strait Islander people to train as health workers, nurses, midwives and medical practitioners should also be energetically pursued.

Collaborative strategies that have the potential for a positive impact on the health and wellbeing of pregnant Aboriginal and Torres Strait Islander women, new mothers and babies include:

- pursuing and creating culturally relevant opportunities for education and information exchange regarding health and illness
- enhancing participation in community development programs that maximise Aboriginal and Torres Strait Islander women's personal involvement in decision-making regarding healthy lifestyles
- offering a support and liaison service for women with specific linguistic and cultural needs associated with pregnancy, childbirth and early parenting.

It is likely that members of local Aboriginal and Torres Strait Islander communities in some rural and remote areas of NSW will have a first language other than English. They may encounter communication barriers when interacting with the State's health services, and their experiences may be similar to those of others from a non-English speaking background. To provide adequately for the needs and preferences of all, maternity services must be culturally sensitive in the broadest and most encompassing sense.

A good example of a best practice model for NESB women is the Ethnic Obstetric Liaison Officer Program. The Committee has considered the report, *Guidelines and Service Models for Ethnic Obstetric Liaison Services in NSW—A Summary Report*,⁶ and recommends it as a framework for ongoing development of these programs. Other initiatives to improve maternity care for NESB women need to be explored and *The NSW Framework for Maternity Services* identifies a number of strategies to assist in this endeavour.

Another group with particular needs within maternity services are young women. It is especially important to take into account the complex psychological, social and economic issues that can be experienced by this

particular client group and the possible implications of these issues for the mother's and/or baby's health.

It is important that programs for pregnant and drug-dependent women are developed or continue to receive funding, particularly in areas with a high proportion of such women. Existing and proposed services should be responsive to the special medical and social needs of drug- and alcohol-dependent women by increasing the knowledge and awareness of health care providers regarding the relevant issues.

Others consumers requiring additional support and care are those women and families at extreme social disadvantage arising from poverty, isolation, lack of social support and/or homelessness. There is a convincing body of evidence that demonstrates that mothers and babies from disadvantaged groups are likely to have poorer maternity health outcomes than the population as a whole.

Women experiencing perinatal loss or relinquishing their babies for adoption, as well as those experiencing multiple births, may also require additional care and support that continues beyond the usual duration of maternity care. Service providers need to ensure women's access to the full range of services and community agencies to assist them and their families through these experiences.

Postnatal depression is a significant cause of maternal morbidity affecting 10 to 15 per cent of all new mothers. In 1994, NSW Health conducted a review of postnatal depression services and identified several major issues and a range of recommendations to assist the coordination of postnatal depression services across the state. Ongoing implementation of all of the recommendations from this report continues to be a priority.

The NSW Framework for Maternity Services provides a number of objectives and strategies to assist service providers to ensure timely identification of women at psycho-social risk during pregnancy and early parenting. Early detection and intervention for families experiencing difficulties and the provision of more intensive assistance from a multidisciplinary team of carers will assist in reducing the difficulties and morbidity for this particular client group. Strategies aimed at improving formal links and communication between acute hospital services, Early Childhood Health and Aboriginal Medical Services are essential if transition back into the community for each mother and her baby is to be seamless and effective.

The NSW Government's Families First strategy aims to strengthen and extend the parenting skills of every parent in NSW who has a child under eight years of age. Announced in May 1998, Families First is a government-funded prevention

and early intervention initiative to support families by providing them with the necessary knowledge, assistance and community networks to enable them to develop their parenting skills. The initial implementation of this strategy will commence in South Western Sydney, the Far North Coast and the Mid North Coast in 1998–1999. The Maternity Services Advisory Committee notes the initiative and recognises the important links that need to be developed between this strategy and maternity services to avoid overlap of services and to ensure continuity of care.

March, 2000. Since the completion of the report the initial implementation of this strategy has commenced in three Area Health Services. The strategy will be implemented in all areas of NSW over the next four years.

5. Workforce Issues

The NSW Health Department's 1996 *Workforce Planning Study For Maternity Service Nurses, Adult Critical and Intensive Care, and Operating Room Nurses*⁷ and the *NSW Midwifery Taskforce Final Report*⁴ highlighted a range of problems related to the recruitment, retention and education of midwifery students and midwives. Paralleling the recent decline in midwifery workforce numbers have been the growing difficulties experienced in recruiting and retaining obstetricians in rural/remote areas and a general shift among general practitioners away from providing obstetric care. These trends raise issues regarding the effective management and provision of maternity services across NSW and the availability of choice and access to a range of service options for the consumer.

Many factors affect the capacity to recruit and retain a midwifery and obstetric workforce and they need to be considered in the process of planning future maternity services. Such issues include:

- geographical location
- infrastructure and support for outreach services
- access to support services/staff
- family-friendly work practices
- opportunities for skills maintenance and development
- professional indemnity premiums
- the 'culture' in particular facilities
- organisational management issues
- the level of professional autonomy and skill mix of staff.

Medical Workforce Issues

The Australian Medical Workforce Advisory Committee (AMWAC) presented a report, *The Obstetrics and Gynaecology Workforce in Australia*,⁸ to the Australian Health Ministers Advisory Council in late 1998. The report concluded that, from a national perspective, there was a slight shortage of obstetricians and gynaecologists that was due primarily to maldistribution. The data is broken down by State, and rural and urban differences are reported. The report found that services provided by general practitioner obstetricians have decreased over the last decade, with 87 per cent of clients cared for by specialist obstetricians, and that there is increased growth in Medicare services. The report recommended that NSW should maintain intake numbers for trainees in obstetrics and gynaecology at the current level of 20 per year until 2002.

Other workforce issues affecting obstetricians and general practitioners and raised through discussion in the committee include:

Professional Indemnity

Concerns have been raised regarding increasing difficulties associated with the rising costs of medical indemnity premiums, particularly for those working in obstetrics. It is recognised that this may be a disincentive to providing obstetric care and may impede future recruitment into the obstetric workforce. The NSW Health Department is currently examining the issue of medical indemnity, which affects visiting obstetricians providing care to public patients. This issue is also being discussed with the Australian Medical Association (NSW Branch). The Department aims to find a fair, practical and appropriate approach to the issues, with a resolution being sought in the near future. It is important that consumers are informed of the need to establish that their care provider has indemnity insurance, as the Committee was made aware that a small number of practitioners do not carry any insurance.

March, 2000. Since the completion of the report interim indemnity arrangements have been agreed for specialist, sessional, visiting medical officers, obstetricians and gynaecologists. The NSW Government through the treasury managed fund, provides indemnity cover for public patient adverse events which have occurred on or after 23.2.99.

Decline in number of rural obstetricians and general practitioners

The committee discussed the difficulties in attracting and retaining an adequate rural medical workforce in obstetrics. There are a range of contributing factors, including skills attainment and maintenance, economic disincentives and lifestyle factors, and the increasing trend towards sub-specialisation within the

obstetric and gynaecology workforce. This, coupled with associated disincentives—for example, the long and unsociable hours of obstetricians and indemnity issues, will affect ongoing recruitment. Strategies to address the increasing difficulties in finding obstetricians to provide adequate cover in base and larger rural hospitals will need ongoing exploration. The committee identified some alternatives, including the employment of career obstetric medical officers who meet standards set by RANZCOG, as worthy of further exploration.

Locum Relief for Rural Obstetricians and Gynaecologists

A pilot program has commenced to provide short-term relief for rural specialist obstetricians and gynaecologists, with a view to retaining those specialists currently working in rural New South Wales and reducing the gaps in services. The pilot will run for six months until March 1999 and will enable specialists in one- or two-person practices to take leave for continuing education. The pilot project has commenced with the South Eastern Sydney Area Health Service and the Central Sydney Area Health Service coordinating locum relief for the Greater Murray and Southern Area Health Services. Feedback to date from the participants is positive.

Midwifery Workforce Issues

Registered Midwives

The AMWAC report⁸ attempted to include midwifery and nursing workforce issues in its review process. However, it acknowledged that it was not possible to determine national midwifery workforce numbers because of the absence of reliable national data and problems with workforce planning methodology. The number of practising midwives in Australia is not known, nor is there any reliable mechanism established to monitor the situation. In NSW, data from a variety of sources indicates an under supply of qualified midwives in the workforce, with a consistently high number of midwifery positions being actively recruited. In particular, reports from rural and remote areas identify a shortage of midwives and increasing use of staff without midwifery qualifications. While there is a statewide nursing labour force survey each year in NSW, it is not possible to determine the specific place of work of midwives because of the nature of the role and its interface with additional nursing roles, particularly in rural and remote areas. There is a need to further investigate the midwifery workforce in NSW to determine workforce planning issues and priorities for the next five years. Strategies identified in *The NSW Framework for Maternity Services* focus on this task and on providing flexible work practices, developing

new skills associated with new models of care and accessing refresher courses and ongoing educational opportunities that may assist in retaining certified midwives in maternity services.

Student Midwives

The *NSW Midwifery Taskforce Report Final Report*⁴ recommended a continued embargo on student midwifery numbers at the 1993 level of 313 per year. Since then, concerns about student midwifery workforce numbers have continued to be raised, most recently in the *NSW Health Workforce Planning Study For Maternity Service Nurses, Adult Critical and Intensive Care and Operating Room Nurses*⁷ and *The Obstetric and Gynaecology Workforce In Australia*.⁸

In September 1998, as part of the work of the Maternity Services Advisory Committee, each Area Health Service and university was surveyed by the NSW Health Department to establish current and projected numbers of student midwives. This survey highlighted a current shortfall of student midwives and that a decline in numbers can be expected unless strategies are developed to reverse the trend. The Nursing Branch of the NSW Department of Health is exploring the results of the survey. In conjunction with Area Health Services and universities, it will be developing a range of strategies to address the numbers and distribution of student midwives across the state.

Industrial issues

The continued development of new service models, particularly those involving midwives in providing continuity of care, poses particular challenges. To date, negotiations between Area Health Services and the NSW Nurses Association have resulted in the initiation of a small number of pilot roster projects.

There is a need for progression of industrial arrangements for midwives involved in the new models of care as these services expand and evolve. This is critical to both the development of the models and the ongoing professional growth of midwives.

Professional indemnity issues

NSW Health currently has a policy that recommends cover of \$5 million professional indemnity for visiting midwives. This is subject to ongoing review in the light of additional cover becoming available.

6. Models of Care and Collaborative Practice

The development of a collaborative and consultative framework and the achievement of increased continuity of care and improved access to midwifery services continues to be a major challenge within NSW maternity health services. With an increasing focus on evidence-based practice, the potential of

innovative models of maternity care that incorporate these features cannot be underestimated. Furthermore, there needs to be sufficient scope for women's views and choices to be taken into account and for decisions to be made based on women's informed choice.

There is a growing recognition of the desirability of offering a range of service options and models of practice in maternity services. Typically, such services are characterised by their distinctive adaptation to a local geographic area and the clinical needs and expressed preferences of the local population. They also demonstrate an appropriate balance between community- and hospital-based care and the incorporation of shared care arrangements and private practice. Within the context of availability of suitably qualified health care professionals and access to a tiered network of primary, secondary and tertiary health services (not all of which are necessarily provided locally), these services also need to reflect current evidence and best practice.

The Shearman Report ¹ supported the view that Area Health Services should adopt a program approach to providing maternity services based on evaluating local community needs and identifying an appropriate mix of hospital- and community-based antenatal, childbirth and postnatal care services, including comprehensive parenting education services. The National Health and Medical Research Council report, *Options for Effective Care in Childbirth*,³ further supports the need for health services to develop a range of options and different models of care that reflect local community need and increase the utilisation of midwives and general practitioners.

In addition, the Maternity Services Advisory Committee reviewed a further two reports pertaining to maternity services. The WHO publication, *Care in Normal Birth: A Practical Guide*,⁹ is the result of a group of international experts collaborating to determine what they consider to be appropriate care in normal birth. In late 1998, NSW Department of Health released a report entitled *Evaluation of New South Wales Alternative Birthing Services Program, Second Phase 1993/94–1996/97*,⁵ which contains recommendations that further assist efforts to improve maternity services and health outcomes for Aboriginal and Torres Strait Islander women and their families. Also, as previously discussed, the *Guidelines and Service Models for Ethnic Obstetric Liaison Services in NSW —A Summary Report* ⁶ provides an important adjunct and appropriate framework for developing maternity services for NESB women.

The committee endorses these recent reports and recommends them as a blueprint for the ongoing development of maternity policy, practices and philosophy and of new models of maternity care.

Innovative models of maternity care are being piloted and implemented in some Area Health Services in response to changing populations, service needs and available resources; however, it is not possible to determine the exact scope of these innovations. Information obtained from the *NSW Maternity Services Status Reports* illustrates that development and implementation of new models of care such as those recommended is not extensive, particularly in rural and remote areas of NSW. *The NSW Framework for Maternity Services* provides a systematic approach for reshaping maternity services over the next five years. The willingness of all stakeholders within health services to work collaboratively with consumers and members of the community is paramount in ensuring that services are developed in a way that is both efficient and appropriate, as well as safe and effective.

7. Rural Maternity Services

Women in rural and remote areas of NSW, especially those outside regional centres and those who experience difficulties accessing maternity services because of distance or lack of a full range of services, face specific challenges. Difficulties in recruiting health workers to rural areas further limits access to services. For a population with differences in linguistic and cultural backgrounds, the limited availability of Aboriginal and Torres Strait Islander health workers, interpreter services and bilingual health workers further contributes to the disadvantage that these women and families experience.

NSW Health recognises the need to develop a strategic approach to establishing, developing and maintaining rural maternity services. In this regard, the document, *Caring for Health: the NSW Government's Vision for Rural Health*,¹⁰ proposes that 'innovative options for childbirth' should be made available to rural women, and that 'rural health workers should receive training in the assessment and management of postnatal depression'.

Since 1996, NSW Health Department funding initiatives have enabled the development of several rural health workforce strategies. These include the Pilot Locum Service to provide leave relief for rural obstetricians and gynaecologists, recruitment of rural GPs, and support for expansion of the number of medical speciality and refresher training positions in rural areas. NSW Health has also developed several initiatives to support the maintenance and development of a skilled midwifery and nursing workforce in rural NSW. These include funding for two rural/remote professorial chairs, a Rural/Remote Nursing Scholarship Fund, the Maternity Emergencies Survival Package for

Registered Nurses (non-midwives), midwifery refresher courses and the development of careers marketing and recruitment materials.

To address issues relating to providing quality, safe and accessible services to women and babies in rural and remote areas, a range of community and practitioner issues require consideration. Specific matters warranting attention include transport services, cultural sensitivity of staff, the role and delineation of small units with low annual birth rates and the development of innovative options and models of care that move services closer to where women live. Further, the integration of maternity services, in particular those provided by midwives, into existing community/primary health care services such as Aboriginal Medical Services and general practitioner models of care, will be an ongoing challenge for NSW Health. *The NSW Framework for Maternity Services* identifies several strategies to improve the range, standard and availability of services as well as to increase equity of access for women seeking maternity services in rural and remote NSW.

8. Professional Development/Continuing Education

Issues relating to professional development/continuing education of the maternity workforce are multifaceted and influenced by such factors as funding availability, staffing levels and the availability of relief staff. The geographic location, accessibility and cost of programs, and the relevance of available courses to current practice and changing models of service are all factors that affect staff access to ongoing education and learning new skills.

Continuing education and professional development programs need to address both the specific clinical training needs and the broader career interests of the different professional groups that provide maternity care. *The NSW Framework for Maternity Services* includes strategies directed towards ensuring:

- access to regular in-service education programs for all personnel providing maternity care, including staff release to participate in hospital-exchange programs; short courses addressing new and emerging service-delivery issues; and regular hospital or community based in-service or clinical review meetings
- hospital-based accreditation with regular review for all practitioners providing maternity care, including independent and visiting midwives and medical practitioners

- availability of continuing education programs and courses of advanced training relevant to general practitioners who provide shared antenatal and postnatal care
- review of the content of undergraduate, postgraduate and continuing education programs for doctors and midwives to strengthen the development of communication and clinical skills required to provide culturally appropriate and sensitive maternity care, including practice in models of continuity of care.

The Committee considered the issues of ongoing competence and recency of practice of maternity care providers and identified gaps in the ability of Area Health Services to ensure minimum levels for safe practice. While it is recognised that both medical and midwifery colleges have or are developing credentialling systems for their members, it is important that health services also fulfil their role in this regard. *The NSW Framework for Maternity Services* provides a number of strategies that will assist in addressing the maintenance of skills to ensure safe and effective care by all staff. The Committee was informed of the midwifery supervision model in the United Kingdom¹¹ and recognised it as a good model that provides both employed and independent midwives with support, mentorship and guidance in clinical practice while fulfilling an important role in protecting the public.

9. Professional Organisations

In November 1995, the Royal Australian College of Obstetricians and Gynaecologists (RACOG) approved that advanced trainees could be trained in posts in major rural centres. The spirit of this resolution is to encourage trainees to acquire experience in country centres. This initiative may help to alleviate the increasing shortage of specialist obstetricians in country centres. It is recognised that more needs to be done to relieve the difficulties of providing services in rural areas. General practitioners wishing to provide a full obstetric service require the RANZCOG Diploma in Obstetrics, and this should continue to be the recognised qualification. The Joint Consultative Committee of RACOG (in late 1998 merged with New Zealand College of Obstetricians and Gynaecologists to form RANZCOG) and the Royal Australian College of General Practitioners (RACGP) have recently approved a three-level training system for general practitioner obstetricians.

The New South Wales Midwives Association, Inc., a branch of the Australian College of Midwives. Inc., (ACMI) conducts refresher programs for qualified

midwives who want to re-enter the workforce, as well as a range of educational activities including clinical skills workshops, seminars and conferences in rural and metropolitan locations. In consultation with and with funding from the NSW Health Department, it has also developed the *Maternity Emergency Guidelines for Registered Nurses*¹² for use in health services with limited or no maternity service options. The Association is also invited to participate on a number of NSW Health Department committees and meets regularly with the Chief Nursing Officer to keep her informed on midwifery issues.

The NSW College of Nursing conducts assessment of overseas-qualified midwives so they may gain recognition of their midwifery qualifications and authorisation to practise midwifery in NSW. A range of refresher and continuing education courses are open to midwives through the College.

10. Consumer and Non-Government Organisations

The value of consumer participation in developing and evaluating maternity services cannot be underestimated.

Various New South Wales consumer and non-government organisations undertake support, information and educational activities that supplement public- and private-sector maternity services. These activities are usually undertaken voluntarily and include:

- childbirth information
- breastfeeding advice
- promotion of alternatives to hospital maternity care
- support for families who experience multiple birth, diagnosis of fetal abnormality, miscarriage, stillbirth, neonatal and infant death, and birth of a child with a disability.

Some consumer and non-government organisations that provide information for women and their partners are the Nursing Mothers Association of Australia, the Australian Multiple Birth Association, and the Stillbirth and Neonatal Death Support (SANDS) group. Several other consumer and non-government organisations provide information for health professionals about families with special needs.

Increasingly, consumer organisations are receiving requests from educational institutions and continuing professional education programs—such as Charles Sturt University (Nursing), Sydney University (medical) and the NSW College of

Nursing (midwifery)—to share their particular expertise with health professionals at undergraduate and post-graduate levels.

Consumers throughout NSW actively participate in local and state maternity services advisory committees, and their role and contribution in this regard can be expected to grow considerably with the expansion of this initiative. Many consumers willingly participate in research activities undertaken to assess quality of care or to evaluate clinical effectiveness of interventions. Consumers have a vital role in enhancing communication and feedback and thereby enabling services to set priorities in areas that need improvement.

11. A Vision and Philosophy statement for NSW Maternity Services

Over the past few years, health service executives, planners, policy analysts, managers, providers and consumers have engaged in constructive and increasingly informed discussions and debates about the provision of maternity services in NSW. The deliberations of the Maternity Services Advisory Committee have enabled further informed and in-depth discussion. A general consensus has emerged about the need for Area Health Services to implement integrated and collaborative models of maternity care that:

- are safe, accessible and effective
- are culturally sensitive and responsive to the needs of individual consumers
- enhance continuity of care across antenatal, delivery and postnatal services
- promote consumer consultation and participation in planning and evaluating maternity services
- achieve an appropriate balance between community-based and hospital-based care
- have available the necessary levels of intervention and technology, in accordance with the service's/facility's delineated role
- are evidence-based
- are supported by an appropriate number and mix of health care professionals with the necessary knowledge, skills and experience
- enhance implementation of shared-care models between key service providers.

The committee endorsed the direction and principles for maternity care as outlined in the state and national reports discussed previously. A philosophy that reflects the intent and vision of these reports as well as the current

research evidence was developed to incorporate the seven goals of the strategic plan, namely:

NSW Health recognises pregnancy, labour, birth and parenting as significant and meaningful life events and acknowledges the right of consumers to access safe maternity care and quality maternity services.

Continuity of care and consistent information are essential to the provision of care that is culturally sensitive and appropriate.

Collaboration between health workers at all levels plus the development of a competent and flexible workforce are critical factors in ensuring safe services and the availability of a range of models of care.

12. Conclusion

This report has identified and explored the current issues in maternity services in NSW and provides strategic objectives for developing and implementing future services. To move forward in these strategic directions, a number of issues warrant focused attention and concerted action on the part of health professionals, Area Health Services and the NSW Health Department.

The five year goals, objectives and strategies for NSW Maternity Services set out in the following section provide a framework and systematic approach to assist this process.

The need for collaboration and consultation between service providers and consumers to better determine needs and priorities is paramount. This collaboration and consultation is not only to ensure that services are safe, efficient and effective, but also that they are respectful, personalised and rewarding for both consumers and providers of maternity care.



**FIVE YEAR
GOALS, OBJECTIVES AND STRATEGIES
FOR MATERNITY SERVICES
IN
NEW SOUTH WALES**

MAJOR RECOMMENDATIONS

For *The NSW Framework for Maternity Services* to achieve its primary purpose of providing structure and direction for the future development of maternity services, a number of recommendations will require implementation in the first instance. These include that:

1. NSW Health adopt the five year goals, objectives and strategies of *The NSW Framework for Maternity Services* and implement these through the Area Maternity Services Plans.

2. NSW Health adopt the following philosophy statement for developing maternity services:

NSW Health recognises pregnancy, labour, birth and parenting as significant and meaningful life events and acknowledges the right of consumers to access safe maternity care and quality maternity services.

Continuity of care and consistent information is essential to the provision of care that is culturally sensitive and appropriate.

Collaboration between health workers at all levels plus the development of a competent and flexible workforce are critical factors in ensuring safe services and the availability of a range of models of care.

3. The NSW Health Department allocate designated resources within the Department to coordinate and oversee the implementation of *The NSW Framework for Maternity Services*.

4. The NSW Health Department review early discharge programs across NSW to determine their effectiveness and appropriateness, as well as the consistency of service guidelines, policies, terminology and reporting mechanisms. This should include evaluating the needs and priorities of women in accessing early discharge programs and the effectiveness of referral and follow-up procedures, particularly for women from marginalised or disadvantaged groups.

5. The NSW Health Department evaluate women's views of maternity care, including those of women from Aboriginal and Torres Strait Islander groups and non-English speaking backgrounds, with particular attention to addressing the specific needs of women from marginalised or disadvantaged groups.

GOAL 1 CONSUMER CHOICE AND ACCESS TO CULTURALLY SENSITIVE MATERNITY CARE	
OBJECTIVES	ACTION BY
<p>(a) Increased knowledge and awareness among women of different options/models of maternity care</p> <p><i>STRATEGIES</i></p> <ul style="list-style-type: none"> (i) Develop a philosophy and guiding principles for maternity care in NSW (ii) Develop a brochure in community languages and available through GP clinics, hospitals, Aboriginal Health Services and midwifery clinics that informs women of the range of maternity services (iii) Develop and circulate a generic NSW Birth Plan for AHSs to adapt locally (iv) Ensure that education/information materials relating to maternity care and services are available in relevant community languages (v) Promote early booking-in service in maternity units that enables timely provision of information about services and options (vi) Review childbirth education services (Preparation for Parenthood Classes) in relation to the recent Upper House Inquiry into Parenting Education Services in NSW and to ensure appropriateness of content, target groups, access and equity, and minimum skills of educators (vii) Implement recommendations relevant to Maternity Services that arise from the Upper House Inquiry into Adoption Practices (1998) 	<p>NSW Health Department</p> <p>NSW Health Department</p> <p>NSW Health Department</p> <p>Area Health Services</p> <p>NSW Health</p> <p>NSW Health Department</p> <p>NSW Health Department</p>
<p>(b) Increased consultation with and participation by women in planning maternity services</p> <p><i>STRATEGIES</i></p> <ul style="list-style-type: none"> (i) Demonstrate the relationships between service providers and the community that strengthen involvement in developing maternity services, e.g. Area Maternity Services Liaison Committees (ii) Develop a Maternity Services Plan through consultation processes that reflect local populations 	<p>Area Health Services</p> <p>Area Health Services</p>

	ACTION BY
<p>(c) Increased match between women’s preferred choice and access to actual model of care</p> <p><i>STRATEGIES</i></p> <ul style="list-style-type: none"> (i) Conduct a survey to evaluate women’s views about whether maternity services are culturally sensitive and properly reflect the needs of Aboriginal and Torres Strait Islander women and young and NESB women (ii) Evaluate the appropriateness of client-held notes as a Best Practice Principle across NSW (iii) Develop options for delivering maternity care that increase access and improve equity for Aboriginal and Torres Strait Islander women and reflect their expressed need for midwifery-based care 	<p>Area Health Services</p> <p>NSW Health Department</p> <p>Area Health Services</p>
<p>(d) Health care professionals who are well informed about the benefits of the different options/models in maternity care</p> <p><i>STRATEGIES</i></p> <ul style="list-style-type: none"> (i) Endorse the NHMRC <i>Options for Effective Care in Childbirth</i>³ report and recommendations (ii) Plan and deliver services that reflect the relevant reports on maternity care as well as processes of consultation with consumers 	<p>NSW Health Department</p> <p>Area Health Services</p>
<p>(e) Maternity services that are culturally sensitive and reflect the needs of the local community</p> <p><i>STRATEGIES</i></p> <ul style="list-style-type: none"> (i) Ensure that all staff in Maternity Services, including clerical staff, have undergone cultural sensitivity training in relationship to Aboriginal and Torres Strait Islander and NESB cultures (ii) Investigate systems that link the Midwives Data Collection to data from the Registry of Births, Deaths and Marriages to improve overall reporting of Aboriginality (iii) Ensure that relevant sections of the NSW Aboriginal Health Strategic Plan (1999) are reflected in their Maternity Services Plans 	<p>Area Health Services</p> <p>NSW Health Department</p> <p>Area Health Services</p>

(f) Increased utilisation and availability of health care interpreter services in maternity care

STRATEGIES

- (i) Survey current trends and issues regarding use of health care interpreter services
- (ii) Implement educational strategies to ensure health professionals are proficient in utilising interpreter services

ACTION BY

Area Health Services

Area Health Services

(g) Increased satisfaction with maternity care among women

STRATEGIES

- (i) Conduct a survey to evaluate women's views about whether maternity services are culturally appropriate and properly reflect the needs of young women, NESB and Aboriginal and Torres Strait Islander women **[see 1(c)(i)]**
- (ii) Develop performance indicators for maternity services that reflect the level of women's satisfaction with access, information and equity in their choice of care

Area Health Services

NSW Health Department

GOAL 2 SAFETY & QUALITY	
OBJECTIVES	ACTION BY
<p>(a) Reduction in maternal and perinatal mortality and morbidity</p> <p><i>STRATEGIES</i></p> <ul style="list-style-type: none"> (i) Identify primary causes of maternal and perinatal mortality and morbidity through NSW Maternal and Perinatal Services Committee (ii) Implement the recommendations arising from the Aboriginal Perinatal Mortality Project (iii) Include key performance indicators and outcomes for maternity services in Health Service Performance Agreements (iv) Identify quality improvement processes that highlight safety and quality issues and strategies for improvement in Maternity Services Plans (v) Develop a set of evaluation criteria to determine outcomes from services funded by the Alternative Birthing Services Program (vi) Endorse the WHO report, <i>Care in Normal Birth: A Practical Guide</i>,⁹ as a framework for policy and planning of maternity services across NSW (vii) Ensure annual inservice and clinical practice for all clinical staff in neonatal and adult resuscitation methods and the management of obstetric emergencies (viii) Review Circular 94/66 in terms of management of obstetric emergencies 	<p>NSW Health Department</p> <p>NSW Health Department</p> <p>NSW Health Department Area Health Services</p> <p>Area Health Services</p> <p>NSW Health Department</p> <p>NSW Health Department</p> <p>Area Health Services</p> <p>NSW Health Department</p>
<p>(b) Appropriate levels of interventions in maternity care</p> <p><i>STRATEGIES</i></p> <ul style="list-style-type: none"> (i) Apply appropriate benchmarks for RANZCOG/ACHS obstetric clinical indicators in each AHS (ii) Develop peer review processes, benchmarked against RANZCOG/ACHS obstetric clinical indicators, to review obstetric intervention rates annually 	<p>Area Health Services</p> <p>Area Health Services</p>

		ACTION BY
(c) Maintenance of minimum clinical skills to ensure safe and effective care		
<i>STRATEGIES</i>		
(i)	Review issues related to ongoing competency, recency of practice and recertification processes for midwives	Nurses Registration Board
(ii)	Ensure ongoing competency of all providers of maternity care	Area Health Services
(iii)	Promote RANZCOG, RACGP and ACMI initiatives to develop credentialling systems for providers of maternity care	NSW Health Department
(d) Reduction in the incidence of postnatal depression		
<i>STRATEGIES</i>		
(i)	Implement NSW Health Department Postnatal Depression Education Packages across all maternity facilities	Area Health Services
(ii)	Evaluate the effectiveness of implementing recommendations from the NSW <i>Postnatal Depression Services Review</i> ¹³	NSW Health Department
(e) Ongoing development and evaluation of the quality of care provided to women in NSW maternity services		
<i>STRATEGIES</i>		
(i)	Develop performance indicators for maternity services that reflect the level of women's satisfaction with access, information and equity in their choice of care [see 1(g)(ii)], particularly for women with the poorest maternity health outcomes	NSW Health Department
(ii)	Develop strategies and formal links between Area Health Service-employed midwifery and obstetric staff and independent/visiting midwives that enable their participation in staff development, peer review and quality meetings	Area Health Services

(iii) Examine ways that a 'medication in pregnancy and lactation service' can be provided in NSW

NSW Health Department

GOAL 3 CONTINUITY OF CARE

OBJECTIVES

(a) Planned and coordinated transition from maternity service to community setting

STRATEGIES

- (i) Review early discharge programs across NSW to ensure effectiveness and consistency of standards and enable the development of universal guidelines and performance indicators for early discharge
- (ii) Review early discharge protocols and policies to ensure equity of access and to strengthen referral and follow-up procedures
- (iii) Develop strategies that allow information sharing between Maternity Services, Early Childhood Health Services and Aboriginal Medical Services
- (iv) Ensure hospital Maternity Units provide the MR44 (green copy) of the Midwives Data Collection Form to Early Childhood Health and/or Aboriginal and Torres Strait Islander health community midwifery service
- (v) Establish protocols to ensure that women and babies with known psycho-social risk factors receive effective intervention and follow-up in the antenatal and immediate postnatal period
- (vi) Implement the 'Families First Strategy' through a coordinated network of services to support parents and carers raising children and help them to solve problems early before those problems become entrenched

ACTION BY

- NSW Health Department
- Area Health Services
- Area Health Services
- Area Health Services
- Area Health Services
- Area Health Services

(b) Recognised models of best practice that are progressively implemented as reflected in AHS Maternity Services Plans

GOAL 3 CONTINUITY OF CARE

STRATEGIES

- (i) Implement service changes that improve continuity of care and carer, including when transferring women from one model of care to another (e.g. birth centre to labour ward, home to hospital)
- (ii) Review existing maternity services to ensure integration and consistency with relevant state and national reports **[see References and Bibliography]**

Area Health Services

Area Health Services

		ACTION BY
(c) Closer and more specific links between rural, remote, metropolitan district and tertiary care settings		
<i>STRATEGIES</i>		
(i)	Implement Perinatal Services Network 'Policy for Emergency Obstetric and Neonatal Referrals' in each facility	Area Health Services
(ii)	Recognise role of tertiary services in providing consultation and training for all maternity staff	NSW Health
(d) Maternity Services that reflect current research evidence and recommendations from relevant state and national reports		
<i>STRATEGIES</i>		
(i)	Endorse the NHMRC <i>Options for Effective Care in Childbirth</i> ³ report and recommendations [see 1(d)(i)]	NSW Health Department
(ii)	Ensure that the Clinical Information Access Project (CIAP) is available in each facility to enable all employees of NSW Health to access clinical information systems and data bases	Area Health Services
(iii)	Disseminate new information on relevant state government and national reports to assist in ongoing development and review of AHS Maternity Services Plans [see 3(b)(ii)]	NSW Health Department
(e) AHSs in compliance with appropriate standards for maternal and infant care		
<i>STRATEGIES</i>		
(i)	Consider implementing the revised ACHS <i>Guidelines for Maternal and Infant Care Services</i> ¹⁴	NSW Health
(ii)	Recommend inclusion of 'continuity of care' indicators in future reviews of the ACHS EQUIP standards	NSW Health Department

GOAL 4 COLLABORATION	
OBJECTIVES	ACTION BY
<p>(a) Evidence of a multidisciplinary consultative approach to maternity services planning, provision and evaluation</p> <p><i>STRATEGIES</i></p> <ul style="list-style-type: none"> (i) Establish Area Maternity Services Liaison Committees with representation from consumers and community members, GPs, midwives and obstetricians [see 1(b)(i)] (ii) Develop, implement and evaluate Maternity Services Plans in consultation with consumers and community members, GPs, midwives and obstetricians [see 1(b)(ii)] (iii) Continue to strengthen collaborative service partnerships with Aboriginal and Torres Strait Islander community-controlled health services and Aboriginal and Torres Strait Islander communities in developing and providing appropriate services for Aboriginal and Torres Strait Islander women 	<p>Area Health Services</p> <p>Area Health Services</p> <p>Area Health Services</p>
<p>(b) Increase the percentage of women who have planned coordinated care, including effective documentation and timely exchange of information</p> <p><i>STRATEGIES</i></p> <ul style="list-style-type: none"> (i) Develop a birth plan [see 1(a)(iii)] and offer it to all women (ii) Ensure that a booking-in service is available and accessible to all women in their first trimester of pregnancy [see 1(a)(v)] (iii) Utilise an Antenatal Record card for all women (iv) Develop effective management care plans (clinical guidelines) in all facilities for women experiencing high-risk pregnancies (v) Promote the principle of plain English client-held notes, including a birth plan for use in all AHSs [see 1(c)(ii)] 	<p>Area Health Services</p> <p>Area Health Services</p> <p>Area Health Services</p> <p>Area Health Services</p> <p>NSW Health</p>

(c) Agreed Shared-Care protocols for all maternity health care providers across each Area Health Service

STRATEGIES

- (i) Collaboratively develop protocols for Shared Care between all providers of maternity care
- (ii) Ensure clarity of professional indemnity insurance requirements for maternity service providers

ACTION BY

NSW Health Department

NSW Health Department

GOAL 6 AVAILABILITY OF A RANGE OF MODELS OF CARE	
OBJECTIVES	ACTION BY
<p>(a) Expanded range of and improved access to options of care in maternity services</p> <p><i>STRATEGIES</i></p> <ul style="list-style-type: none"> (i) Disseminate Area Profiles compiled from the Status Report – Maternity Services for each AHS to identify shortfalls in the range of local services and options of care offered (ii) Encourage innovative service models that provide continuity of care for women through pregnancy, labour, birth and the postnatal period and ensure a level of equity of care (iii) Facilitate indemnity arrangements that enable effective implementation of innovative models/options of care and promotion of existing models of best practice [see 4(c)(ii)] (iv) Develop protocols for accreditation of Visiting Midwives that enables their access to facilities (v) Develop protocols for transfer of women from homebirth to hospital (vi) Require Visiting Midwives to be accredited with the Australian College of Midwives, Inc. (vii) Implementation of the Health Departments Homebirth Policy (viii) Consider support for a pilot project to evaluate a homebirth model of care for low-risk women within an Area Health Service (ix) Include performance indicators for Maternity Service Plans that identify strategies to ensure the provision of the range of options for maternity care in Health Service Performance Agreements 	<p>NSW Health Department</p> <p>NSW Health</p> <p>NSW Health Department</p> <p>Area Health Services</p> <p>Area Health Services</p> <p>Area Health Services</p> <p>Area Health Services</p> <p>NSW Health Department</p> <p>Area Health Services</p>
<p>(b) Improved access to birthing services for women in rural and remote areas</p> <p><i>STRATEGIES</i></p> <ul style="list-style-type: none"> (i) Explore options for developing support services such as childcare, transport and accommodation to assist women and their families from rural and remote areas during the birth of their babies (ii) Explore the potential for mobilised antenatal services to be provided as an outreach service to women in areas that are geographically isolated or without adequate public transport 	<p>Area Health Services</p> <p>Area Health Services</p>

(c) Universal standards of accreditation for all providers of Shared Care in maternity services across NSW

STRATEGIES

- (i) Develop protocols and standards for shared care, including education and training programs, in consultation with the relevant professional organisations

ACTION BY

Area Health Services

GOAL 7 A COMPETENT AND FLEXIBLE WORKFORCE	
<p>OBJECTIVES</p> <p>(a) Sufficient numbers and equitable distribution of midwives, skilled obstetricians and GP obstetricians across NSW</p> <p><i>STRATEGIES</i></p> <ul style="list-style-type: none"> (i) Ensure that intake numbers in NSW for first-year trainees in obstetrics and gynaecology remain constant at 20 per year to 2002⁸ (ii) Develop strategies, in consultation with AHSs, universities and the private health sector, to ensure adequate numbers of qualified midwives to meet current and future maternity service requirements (iii) Monitor, analyse and evaluate ongoing reports on the midwifery and obstetric workforce (iv) Survey all certified midwives about: (a) hours currently worked in direct clinical midwifery care and (b) their intention to remain in, or return to, direct clinical midwifery care in the next five years (v) Continue recruitment strategies to promote midwifery as a career choice (vi) Encourage RANZCOG, RACGP and ACMI initiatives to implement credentialling systems, for all providers of maternity care (vii) Evaluate initiatives, such as transitional support, the Obstetrician Locum Relief Project, rural workforce strategies and incentive schemes, to attract staff to rural and remote areas (viii) In collaboration with the NSW Nurses Association, identify a range of innovative work practices that increase the flexibility and potential of the midwifery workforce to provide continuity of care and carer (ix) In consultation with the Australian Salaried Medical Officers Federation, explore employment options for Career Medical Officers in obstetrics (x) Explore and develop strategies with RANZCOG that will enable the appointment of Visiting Medical Officer in obstetrics as a single speciality (xi) Develop strategies with RANZCOG to provide training opportunities in obstetrics as a single speciality 	<p>ACTION BY</p> <p>NSW Health Department and RANZCOG</p> <p>NSW Health Department</p> <p>NSW Health Department</p> <p>NSW Health Department</p> <p>NSW Health Department</p> <p>NSW Health Department</p> <p>NSW Health Department</p> <p>NSW Health Department</p> <p>NSW Health Department</p> <p>NSW Health Department</p>

	ACTION BY
<p>(b) Equity of access to ongoing professional development for all providers of maternity care</p> <p><i>STRATEGIES</i></p> <p>(i) Explore strategies that will enable the development of:</p> <ul style="list-style-type: none"> -joint education programs that foster a multidisciplinary approach -exchange programs for rural midwives and rural GPs with metropolitan midwives and GPs -mobile education services, clinical update programs and incentives, e.g. scholarships <p>(ii) Investigate the development of a Midwifery Supervision Model, similar to that used in the UK,¹¹ that provides all midwives with support, mentorship and guidance in clinical practice</p> <p>(iii) Develop Maternity Services Plans to identify strategies that reflect the principle of equity of access to ongoing education for all staff</p>	<p>Area Health Services</p> <p>Area Health Services</p> <p>Area Health Services</p> <p>NSW Health Department</p> <p>Area Health Services</p>
<p>(c) A greater number of aboriginal and torres strait islander and nesb health professionals who provide maternity care</p> <p><i>STRATEGIES</i></p> <p>(i) Request NSW Nurses Registration Board to include Aboriginal and Torres Strait Islander and NESB profiles in their annual workforce survey</p> <p>(ii) Continue marketing and recruitment strategies to promote midwifery as a career choice to Aboriginal and Torres Strait Islander and NESB people</p> <p>(iii) Support applications from overseas health professionals with appropriate clinical and language skills in maternity care</p> <p>(iv) Continue initiatives in secondary schools that promote midwifery as a career to school leavers</p>	<p>NSW Health Department</p> <p>NSW Health Department</p> <p>NSW Health Department</p> <p>Area Health Services</p> <p>Area Health Services</p>

(d) A sufficient number of trained Aboriginal and Torres Strait Islander and NESB health care workers who provide education, advocacy and support in maternity care

STRATEGIES

- (i) Employ Aboriginal Health Workers to work in partnership with community midwives to provide appropriate maternity care to Aboriginal and Torres Strait Islander women
- (ii) Ensure that Aboriginal Health Workers undertake accredited training in women's business and birthing
- (iii) Seek and develop a range of options from GPs and obstetricians to provide professional support to Aboriginal and NESB Health Workers
- (iv) Consult with tertiary educational institutions and other providers, e.g. RANZCOG and ACMI, about educational initiatives and opportunities to increase the number of maternity health care workers

ACTION BY

Area Health Services and
Aboriginal Medical Services

Area Health Services and
Aboriginal Medical Services

Area Health Services and
Aboriginal Medical Services

Area Health Services and
Aboriginal Medical Services

LIST OF APPENDICES

APPENDIX A

Form used for NSW Health Status Report – Maternity Services

APPENDIX B

NSW Maternity Services Status Reports



STATUS REPORT - MATERNITY SERVICES

Please return the completed form to:

Maternity Services Project Officer
Nursing Branch, NSW Health Department
Locked Mail Bag 961, North Sydney NSW 2059

By: **FRIDAY 28 AUGUST, 1998**

Contact Persons: Pat Brodie / Anne O'Donoghue Ph: (02) 9391 9515
or Dr Steevie Chan Ph: (02) 9391 9481 or Dr Elizabeth Murphy Ph: (02) 9391 9475

Area Health Service:

Date survey completed:

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Contact Person's Name, Position and Telephone Number:

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Please enter all public facilities which provide acute maternity care in your AHS. This should include facilities with Obstetric Role Delineation of Level 2 & above.

Code	Facility Name	No. of designated maternity beds	Total births 1 July 1997 to 30 June 1998
A			
B			
C			
D			
E			
F			
G			
H			
I			
J			

Attach a separate page if more than 10 facilities in your AHS

Specific Services / Programs	A	B	C	D	E	F	G	H	I	J
Booking in clinics										
Parenting education classes										
Parenting education classes in community languages										
Printed information about maternity service										
Printed information about maternity service in community languages										
Printed information re: choices/options for maternity care										
Use of combined antenatal care card										
Interpreter services										
Formal protocol for perinatal death										
Telephone interpreter services										
Ethnic Obstetric Liaison Officer / designated midwife										
Aboriginal Liaison worker / midwife										
Translated educational materials										

Section 2.

SYSTEMS OF CARE ACROSS THE AHS.

Please provide brief comments, summarised on an area basis, regarding existing systems of care under the following headings.

It is acknowledged that in some AHS these systems may not be in place or may not be necessary. DO NOT ATTACH EXTRA PAGES OF INFORMATION UNLESS SPECIFICALLY ASKED TO DO SO

2a. Does your AHS have a current strategic plan for maternity services?

(Please tick the appropriate box)

YES NO

Please attach a copy or precis

2b. Briefly outline protocols / strategies for women identified 'at risk' of postnatal depression.

2c. Describe criteria and protocols used for selection of women for early discharge / community based post natal midwifery care.

2d. Describe mechanisms used for referral of women for early discharge/ community based post natal midwifery care to another locality or AHS. Are they satisfactory?

2e. Summarise briefly the current utilisation / activity report for early discharge / community midwifery service. eg, % of all births, average no. of home visits, average postnatal day that women are discharged from care on program. Attach a single page summary if necessary.

Section 3.

EDUCATION AND STAFF DEVELOPMENT

3a. Briefly outline any program / schedule of inservice education and training opportunities related to Maternity Care, for staff under the following headings.

Certified Midwives:

Registered / Enrolled Nurses:

General Practitioners:

Residents / Registrars:

Specialist Obstetricians:

3b. Do you have any minimum requirements for maintenance of clinical skills for staff? This could include attending at least x number of births per year. Please give examples under the following headings.

Certified Midwives:

General Practitioners:

Residents / Registrars:

Specialist Obstetricians:

Section 4.

REVIEW AND EVALUATION

4a. Have any maternity client satisfaction surveys been conducted in the past three years in any facility or across the AHS? Please include type, number and any results. Attach a sample of your survey if possible.

4b. Outline any internal audit or quality review mechanisms in maternity services.

4c. Describe use of any Nursing / Midwifery workload or staffing methodologies. Is there in use any 'patient acuity' systems in maternity services anywhere in the AHS?

4d. (i) Does your AHS or any facility have a Maternity Services Liaison Committee?

(Please tick the appropriate box)

YES NO

Comments:

(ii) If yes, does the committee include maternity consumer representation?

(Please tick the appropriate box)

YES NO

4e. Does your AHS or any facility have a Maternity Consumer Advisory Committee?

(Please tick the appropriate box)

YES NO

Comments:

4f. Are there any new initiatives in maternity services in your AHS that you would recommend to others?

Thank you for taking the time to complete this survey.
Please return it in the enclosed pre-paid envelope by Friday 28 August, 1998

NSW

MATERNITY SERVICES

STATUS REPORTS

**Profiles based on information
provided by Area Health Services**

Prepared for the Maternity Services Advisory Committee
November 1998

APPENDIX B

SOUTH EASTERN SYDNEY AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	3
Annual birth rate to June 98	7250
Number of maternity beds	127
Number of labour ward beds	24
AHS Strategic Plan for Maternity Services	NO

Service outline

Primary maternity care provided by specialist obstetricians and midwives	-	Early discharge/community midwifery programs	-
Access to paediatric services	-	Booking in clinics	-
Access to anaesthetic services	-	Midwives clinics	-
Availability of female specialist/GP obstetrician	-	Birth Centre	2
GP antenatal shared care	-	Team midwifery program	1
Antenatal clinics	-	Accredited/visiting independent midwives	1

Systems and processes

Protocol for perinatal death	-	Communication between remote/rural/metropolitan/tertiary services effective	-
GP shared care protocols	-	Protocol for the transfer of women from homebirths	-
Use of combined antenatal care card	-	Protocol for accreditation of independent midwives	1
Formal liaison between maternity and ECHS staff	-	Routine notification of births and/or discharge to GPs	2
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	-	Maternity services liaison/advisory committees	1
Women informed of nearest ECHS	-	Maternity committees with consumer involvement	1

Specific services/programs

Postnatal depression: No AHS protocol. Strategies for identification and referral antenatally and postnatally; staff inservices provided.

Early discharge/community midwifery: *Criteria:* <72 hours or <5 days (LSCS), no medical risks. *Cross referral mechanisms:* mostly effective - first priority given to facility's women; AHS meetings quarterly. *Activity:* rates 25-58%, average number home visits per woman: 3-4, average postnatal day of discharge from program: 6-7.

Other: parenting education classes (_); printed information regarding maternity care choices (_); access to interpreter services (_); translated educational materials (_); parenting education in community languages (_); ethnic obstetric liaison staff (2).

Staff education and training

Midwives: inservice, external education courses. **GPs:** Shared care program initiatives, RACOG/RACGP CME program. **Specialist obstetricians and trainees:** RACOG/RACGP CME program, perinatal, clinical and quality meetings.

Maintenance of clinical skills/minimum requirements:

Midwives: annual CPR (neonate and adult); fire and safety; rotation program and extended skills training (eg. cannulation, suturing) in some facilities. GPs: RACGP requirements, minimum of 2 update sessions annually are required in some facilities. Specialist obstetricians and trainees: RACOG/RACGP requirements.

Evaluation/audit/quality activities

Some form of client satisfaction measured. Comprehensive audit and review processes including perinatal mortality meetings. No workload methodologies used: historical staffing methods only.

Any new initiatives/suggestions

Include increasing continuity of care by midwives, evidence-based practice. Suggestions for the future include advisory service for drug use in pregnancy and student midwives working as unpaid supernumerary staff.

GREATER MURRAY AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	12
Annual birth rate to June 98	2332
Number of maternity beds	82
Number of labour ward beds	20
AHS Strategic Plan for Maternity Services	NO

Service outline

Primary maternity care provided by specialist obstetricians (2), GPs and midwives	–	Bookings in clinics	10
Access to paediatric services	6	Antenatal clinics	4
Access to anaesthetic services	8	Midwives clinics	1
Availability of female specialist/GP obstetrician	5	Early discharge/community midwifery programs	9
GP antenatal shared care	5	Accredited/visiting independent midwives	–

Systems and processes

Protocol for perinatal death	10	Protocol for the transfer of women from homebirths	–
Use of combined antenatal care card	5	Protocol for accreditation of independent midwives	–
Formal liaison between maternity and ECHS staff	–	GP shared care protocols	–
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	–	Routine notification of births and/or discharge to GPs	10
Women informed of nearest ECHS	11	Maternity services liaison/advisory committees	–
Effective communication between remote/rural/metropolitan/tertiary services	8	Maternity services liaison/advisory committees with consumer involvement	–

Specific services/programs

Postnatal depression: No AHS protocol. Risk factors noted at booking; referral based on need and availability of services.

Early discharge/community midwifery: Not offered to all women and not available at all facilities; Monday to Friday only in some facilities. Criteria: <3 days or <5 days (LSCS) others based on need. Cross referral mechanisms: by phone; linked with community nurses or midwifery service if available. Activity: rates 38-42%; average number home visits per woman: 3.5, average postnatal day of discharge from program: 8.

Other: parenting education classes (10); printed information regarding maternity care choices (5); access to interpreter services (5); translated educational materials (2); parenting education in community languages (1); ethnic obstetric liaison staff (1); aboriginal liaison staff (2).

Staff education and training

Midwives: inservice at Base Hospital, external education courses and conferences, recent midwifery refresher course. GPs: RACOG/RACGP CME programs. Specialist obstetricians and trainees: clinical meetings; RACOG CME program.

Maintenance of clinical skills/minimum requirements

Midwives: some facilities – competency assessments (eg. neonatal CPR); rotation for some midwives to larger units. GPs: RACGP requirements, 40 deliveries in 3 years. Specialist obstetricians and trainees: RACOG/RACGP requirements.

Evaluation/audit/quality activities

Some form of client satisfaction measured (11). Midwives committees review and action survey findings; quality improvement activities; clinical indicators. Workload methodologies: PAIS in larger facilities otherwise historical staffing methods.

Any new initiatives/suggestions

Request was made for an AHS CNC for maternity services.

FAR WEST AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	2
Annual birth rate to June 98	373
Number of maternity beds	14
Number of labour ward beds	3
AHS Strategic Plan for Maternity Services	NO

Service outline

Primary maternity care provided by specialist obstetricians (1), GPs (1) and midwives	–	Team midwifery	1
Access to paediatric services	1	Booking in clinics	2
Access to anaesthetic services	1	Antenatal clinic	1
Availability of female specialist/GP obstetrician	1	Midwives clinics	2
GP antenatal shared care	1	Early discharge or community midwifery programs	1
Accredited/visiting independent midwives	–		

Systems and processes

Protocol for perinatal death	1	Protocol for the transfer of women from homebirths	–
GP shared care protocols	1	Protocol for accreditation of independent midwives	–
Use of combined antenatal care card	1	GP shared care protocols	–
Formal liaison between maternity and ECHS staff	–	Routine notification of births and/or discharge to GPs	1
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	–	Maternity services liaison/advisory committees	–
Women informed of nearest ECHS	–	Maternity services liaison/advisory committees with consumer involvement	–
Effective communication between remote/rural/metropolitan/tertiary services	1		

Specific services/programs

Postnatal depression: No AHS protocol. Refer and consult with GP and Mental Health Team (1); Nil strategies (1).

Early discharge/community midwifery: Criteria: nil. Cross referral mechanisms: effective (1). Activity: up to 95% of women seen weekly for up to 6 weeks (1).

Other: parenting education classes (2); printed information regarding maternity care choices (1); access to telephone interpreter services (1); aboriginal obstetric liaison staff (1).

Staff education and training

Midwives: organise own in-service. GPs: Annual clinical updates, RACOG/RACGP CME program. Specialist obstetrician: RACOG CME program.

Maintenance of clinical skills/minimum requirements

Midwives: nil. GPs: RACGP requirements. Specialist obstetricians: RACOG requirements.

Evaluation/audit/quality activities

Client satisfaction measured (1). Other facility has measured satisfaction in community midwifery program only. Audit and review processes: nil (1); no information given (1). No workload methodologies used: historical staffing methods only.

Any new initiatives/suggestions

Team midwifery program.

SOUTHERN AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	10
Annual birth rate to June 98	1763
Number of maternity beds	67
Number of labour ward beds	17
AHS Strategic Plan for Maternity Services	NO

Service outline

Primary maternity care provided by specialist obstetricians (3) and GPs (10) and midwives	–	Booking in clinics	–
Access to paediatric services	–	Antenatal clinic	1
Access to anaesthetic services	–	Midwives clinics	2
Availability of female specialist/GP obstetrician	2	Early discharge or community midwifery programs	7
GP antenatal shared care	3	Accredited/visiting independent midwives	–

Systems and processes

Protocol for perinatal death	–	Protocol for the transfer of women from homebirths	–
Use of combined antenatal care card	–	Protocol for accreditation of independent midwives	10
Formal liaison between maternity and ECHS staff	–	GP shared care protocols	1
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	–	Routine notification of births and/or discharge to GPs	–
Women informed of nearest ECHS	–	Maternity services liaison/advisory committees	–
Effective communication between remote/rural/metropolitan/tertiary services	–	Maternity services liaison/advisory committees with consumer involvement	–

Specific services/programs

Postnatal depression: AHS protocol. PND project officer in place for 12 months.

Early discharge/community midwifery: Criteria: all women based on need and choice. Cross referral mechanisms: effective. Activity: rates 60-80%, average number home visits per woman: 2.5, average postnatal day of discharge from program: 5-10.

Other: parenting education classes (–); access to telephone interpreter services (–); translated educational materials (1); parenting education in community languages (1); aboriginal obstetric liaison staff (9). Printed information regarding maternity care choices (–).

Staff education and training

Midwives: inservice and refresher programs offered. GPs: RACGP/RACOG CME program. Specialist obstetricians: RACOG CME program.

Maintenance of clinical skill/minimum requirements

Code: _ = all facilities have this item – = no facilities have this item; number = number of facilities with this item.

Based on information provided by AHS August 1998

Midwives: nil. GPs: RACGP requirements. Specialist obstetricians: RACOG requirements.

Evaluation/audit/quality activities

Client satisfaction surveys in all facilities. Audit and review processes : broad range including clinical indicators and case reviews. No workload methodologies used: historical staffing methods only; aim for at least one midwife per shift.

Any new initiatives/suggestions

Koori maternity access program, midwife and GP shared antenatal care program, 'Grannies' volunteer support program.

NORTHERN SYDNEY AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	5
Annual birth rate to June 98	6157
Number of maternity beds	116
Number of labour ward beds	21
AHS Strategic Plan for Maternity Services	NO

Service outline

Primary maternity care provided by specialist obstetricians and GPs (2) and midwives	–	Team midwifery	2
Access to paediatric services	–	Bookings in clinics	–
Access to anaesthetic services	–	Antenatal clinic	3
Availability of female specialist/GP obstetrician	4	Midwives clinics	4
GP antenatal shared care	4	Early discharge or community midwifery programs	–
Accredited/visiting independent midwives	–		

Systems and processes

Protocol for perinatal death	–	Protocol for the transfer of women from homebirths	3
Use of combined antenatal care card	–	Protocol for accreditation of independent midwives	1
Formal liaison between maternity and ECHS staff	–	GP shared care protocols	3
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	–	Routine notification of births and/or discharge to GPs	3
Women informed of nearest ECHS	–	Maternity services liaison/advisory committees	1
Effective communication between remote/rural/metropolitan/tertiary services	4	Maternity services liaison/advisory committees with consumer involvement	1

Specific services/programs

Postnatal depression: Strategies for identification and referral antenatally and postnatally; register of 'at risk' antenatal women used as cross-reference when women present at support services. No AHS protocol exists.

Early discharge/community midwifery: Criteria: <3 days or <4 days (LSCS), no medical risks; geographic boundaries. Cross referral mechanisms: effective; direct referral to other programs. Activity: rates 15-46%, average number home visits per woman: 2-5; average postnatal day of discharge from program: 4-7

Other: parenting education classes (4); printed information regarding maternity care choices (2); access to interpreter services (–); translated educational materials (–); parenting education in community languages (3); ethnic obstetric liaison staff (1).

Staff education and training

Midwives: inservice, rotation programs, promotion and support of external education. GPs: Variable between hospitals, eg. learning packages, perinatal and quality meetings; shared care programs; RACGP CME

program. Specialist obstetricians and trainees: RACOG CME program, perinatal, clinical and quality meetings; utilise award allowance of 25 study days annually.

Maintenance of clinical skills/minimum requirements

Midwives: annual CPR (neonate and adult); fire and safety; rotation program. GPs: Shared care accreditation programs; 20 deliveries per year, RACOG/RACGP requirements. Specialist obstetricians and trainees: RACOG/RACGP requirements.

Evaluation/audit/quality activities

Some form of client satisfaction measured. Comprehensive audit and review processes including perinatal mortality meetings. Workload methodology: PAIS until July 1998 otherwise historical staffing methods.

Any new initiatives/suggestions

Team midwifery, spa bath in labour, postnatal aqua-aerobics, inclusion of antenatal domiciliary visits for high-risk women.

MACQUARIE AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	8
Annual birth rate to June 98	1609
Number of maternity beds	48
Number of labour ward beds	13
AHS Strategic Plan for Maternity Services	NO

Service outline

Primary maternity care provided by specialist obstetricians (2), GPs (5) and midwives	–	Bookings in clinics	6
Access to paediatric services	1	Antenatal clinic	3
Access to anaesthetic services	2	Midwives clinics	–
Availability of female specialist/GP obstetrician	2	Early discharge or community midwifery programs	–
GP antenatal shared care	5	Accredited/visiting independent midwives	–

Systems and processes

Protocol for perinatal death	–	Protocol for the transfer of women from homebirths	2
Use of combined antenatal care card	–	Protocol for accreditation of independent midwives	–
Formal liaison between maternity and ECHS staff	6	GP shared care protocols	1
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	–	Routine notification of births and/or discharge to GPs	–
Women informed of nearest ECHS	–	Maternity services liaison/advisory committees	–
Effective communication between remote/rural/metropolitan/tertiary services	–	Maternity services liaison/advisory committees with consumer involvement	–

Specific services/programs

Postnatal depression: Early identification and referral antenatally and postnatally. No AHS protocol.

Early discharge/community midwifery: Little data given due to lack of information systems.

Other: parenting education classes (–); access to telephone interpreter services (6); translated educational materials (1); aboriginal obstetric liaison staff (2); printed information regarding maternity care choices (2).

Staff education and training

Midwives: inservice; some exchange programs available across AHS and between Dubbo and St George Hospital. GPs: Division of GP offers regular programs, RACOG/RACGP CME program. Specialist obstetricians and trainees: RACOG CME program.

Maintenance of clinical skill/minimum requirements

Midwives: none formal. GPs: RACGP requirements, Division of Rural Practice Guidelines and Credentialling Process. Specialist obstetricians and trainees: RACOG/RACGP requirements, initial credentialling.

Evaluation/audit/quality activities

Client satisfaction survey (1) in 1995. Audit and review processes: local review mechanisms. Workload methodologies used: modified PAIS.

Any new initiatives/suggestions

Nil

CENTRAL SYDNEY AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	2
Annual birth rate to June 98	4695
Number of maternity beds	103
Number of labour ward beds	15
AHS Strategic Plan for Maternity Services	YES

Service outline

Primary maternity care provided by specialist obstetricians, GPs and midwives	-	Booking in clinics	-
Access to paediatric services	-	Birth Centre	1
Access to anaesthetic services	-	Antenatal clinic	-
Availability of female specialist/GP obstetrician	-	Midwives clinics	-
GP antenatal shared care	-	Early discharge/community midwifery programs	-
Accredited/visiting independent midwives	1	Team midwifery	1

Systems and processes

Protocol for perinatal death	-	Protocol for the transfer of women from homebirths	-
Use of combined antenatal care card	-	Protocol for accreditation of independent midwives	1
Formal liaison between maternity and ECHS staff	-	GP shared care protocols	-
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	-	Routine notification of births and/or discharge to GPs	-
Women informed of nearest ECHS	-	Maternity services liaison/advisory committees	-
Effective communication between remote/rural/metropolitan/tertiary services	-	Maternity services liaison/advisory committees with consumer involvement	-

Specific services/programs

Postnatal depression: No AHS protocol exists. Strategies for identification and referral antenatally and postnatally; staff inservices provided; discussed in parenting education classes.

Early discharge/community midwifery: Criteria: available to all women based on needs and choice. Cross referral mechanisms: mostly effective. Activity: rates 30%, average number home visits per woman: 4, average postnatal day of discharge from program: 6.

Other: parenting education classes (_); printed information regarding maternity care choices (_); access to interpreter services (_); translated educational materials (_); parenting education in community languages (_); ethnic obstetric liaison staff (1), Aboriginal liaison staff (1).

Staff education and training

Midwives: inservice, ongoing education courses. GPs: Shared care one-day session twice yearly; Division of GP education program, RACOG/RACGP CME program. Specialist obstetricians and trainees: RACOG CME program.

Maintenance of clinical skills/minimum requirements

Midwives: annual CPR (neonate and adult); fire and safety; extended skills training (eg. cannulation, suturing). GPs: RACGP requirements, minimum of two thirds of the update sessions annually. Specialist obstetricians and trainees: RACOG/RACGP requirements; 30 clients per year.

Evaluation/audit/quality activities

Some form of survey in various aspects of service delivery. Comprehensive audit and review processes including perinatal mortality meetings. No workload methodologies used: historical staffing methods only.

Any new initiatives/suggestions

NESB programs, lactation unit, Birth Centre, neonatal EDP, accreditation of independent midwives.

NEW ENGLAND AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	13
Annual birth rate to June 98	2357
Number of maternity beds	84
Number of labour ward beds	20
AHS Strategic Plan for Maternity Services	NO

Service outline

Primary maternity care provided by specialist obstetricians (5), GPs (9) and midwives	–	Bookings in clinics	–
Access to paediatric services	8	Antenatal clinic	1
Access to anaesthetic services	7	Midwives clinics	2
Availability of female specialist/GP obstetrician	5	Early discharge or community midwifery programs	1
GP antenatal shared care	2	Accredited/visiting independent midwives	–

Systems and processes

Protocol for perinatal death	1 1	Protocol for the transfer of women from homebirths	–
Use of combined antenatal care card	1 1	Protocol for accreditation of independent midwives	–
Formal liaison between maternity and ECHS staff	–	GP shared care protocols	–
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	–	Routine notification of births and/or discharge to GPs	12
Women informed of nearest ECHS	–	Maternity services liaison/advisory committees	–
Effective communication between remote/rural/metropolitan/tertiary services	–	Maternity services liaison/advisory committees with consumer involvement	–

Specific services/programs

Postnatal depression: Developing AHS protocol. . Strategies for identification and referral antenatally and postnatally.

Early discharge/community midwifery: Formal program (1). Criteria: <2 days or <4 days (LSCS), < 20kms; remaining facilities ad hoc services. Cross referral mechanisms: problematic – boundary issues; other NGOs offer service for a fee. Activity: rates 35%, average number of visits per woman: 3, average postnatal day of discharge from program: 5-7.

Other: parenting education classes (–); access to telephone interpreter services (–); translated educational materials (1); aboriginal obstetric liaison staff (11). Printed information regarding maternity care choices (–).

Staff education and training

Midwives: inservice, updates, extended skills program (2). GPs: occasional seminars every 1-2 years, RACOG/RACGP CME program Specialist obstetricians and trainees: tutorials, meetings, journal club, RACOG CME program.

Maintenance of clinical skill/minimum requirements

Midwives: nil. GPs: RACGP requirements. Specialist obstetricians and trainees: RACOG/RACGP requirements.

Evaluation/audit/quality activities

Client satisfaction measured in larger units, wide variation in focus in other facilities; clinical indicators; audit; policy review. Workload methodologies used: mostly PAIS; historical staffing methods also.

Any new initiatives/suggestions

Rural midwives clinic

WENTWORTH AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	3
Annual birth rate to June 98	4412
Number of maternity beds	88
Number of labour ward beds	13
AHS Strategic Plan for Maternity Services	YES

Service outline

Primary maternity care provided by specialist obstetricians, GPs (2) and midwives	–	Booking in clinics	–
Access to paediatric services	–	Antenatal clinic	–
Access to anaesthetic services	–	Midwives clinics	–
Availability of female specialist/GP obstetrician	2	Early discharge or community midwifery programs	–
GP antenatal shared care	–	Accredited/visiting independent midwives	–

Systems and processes

Protocol for perinatal death	–	Protocol for the transfer of women from homebirths	2
Use of combined antenatal care card	–	Protocol for accreditation of independent midwives	–
Formal liaison between maternity and ECHS staff	2	GP shared care protocols	2
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	–	Routine notification of births and/or discharge to GPs	1
Women informed of nearest ECHS	–	Maternity services liaison/advisory committees	–
Effective communication between remote/rural/metropolitan/tertiary services	2	Maternity services liaison/advisory committees with consumer involvement	–

Specific services/programs

Postnatal depression: No AHS protocol. Strategies for identification and referral antenatally and postnatally; staff inservices provided.

Early discharge/community midwifery: Criteria: variable: <2 days or <4 days (LSCS); geographic boundaries. Cross referral mechanisms: mostly effective subject to availability; AHS protocol in place. Activity: rates (no information for 2 facilities) 31%, average number home visits per woman: 3, average postnatal day of discharge from program: 6.

Other: parenting education classes (–); printed information regarding maternity care choices (–); access to interpreter services (–); translated educational materials (–); parenting education in community languages (–); ethnic obstetric liaison staff (2).

Staff education and training

Midwives: inservice, training and seminars offered, conference leave supported. GPs: RACOG/RACGP CME program. Specialist obstetricians and trainees: perinatal, clinical and quality meetings, RACOG CME program.

Maintenance of clinical skills/minimum requirements:

Midwives: annual CPR (neonate and adult); fire and safety; rotation program and extended skills training (eg. cannulation, suturing) in some facilities. GPs: RACGP requirements, considering accreditation program (1). Specialist obstetricians and trainees: RACOG/RACGP requirements.

Evaluation/audit/quality activities

Range of surveys on various aspects of care. Review processes including perinatal mortality meetings, clinical indicators, EQUIP, clinical audit, external review (1). Workload methodologies used: PAIS until August (1); considering 'Birthrate plus' (1); mainly historical staffing methods and benchmarking with other units.

Any new initiatives/suggestions

Best practice antenatal midwifery care, 'Cultures in the Workplace', adolescent pregnancy program, 'Listening intervention as a PND strategy', day stay unit.

SOUTH WESTERN SYDNEY AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	6
Annual birth rate to June 98	11187
Number of maternity beds	168
Number of labour ward beds	38
AHS Strategic Plan for Maternity Services	NO

Service outline

Primary maternity care provided by specialist obstetricians, GPs (2) and midwives	-	Booking in clinics	-
Access to paediatric services	-	Antenatal clinic	5
Access to anaesthetic services	5	Midwives clinics	5
Availability of female specialist/GP obstetrician	5	Birth centre	1
GP antenatal shared care	-	Early discharge or community midwifery programs	-
Team midwifery/case load	1	Accredited/visiting independent midwives	-

Systems and processes

Protocol for perinatal death	-	Communication between remote/rural/metropolitan/tertiary services effective	-
GP shared care protocols	5	Protocol for the transfer of women from homebirths	1
Use of combined antenatal care card	5	Protocol for accreditation of independent midwives	5
Formal liaison between maternity and ECHS staff	-	Routine notification of births and/or discharge to GPs	3
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	-	Maternity services liaison/advisory committees	-
Women informed of nearest ECHS	-	Maternity committees with consumer involvement	-

Specific services/programs

Postnatal depression: AHS protocol. Strategies for identification and referral antenatally and postnatally.

Early discharge/community midwifery: AHS policy. Criteria: all women who are medically suitable. Cross referral mechanisms: system works well; subject to availability. Activity: rates 47-51%, average number home visits per woman: 3.5, average postnatal day of discharge from program: 5-6.

Other: parenting education classes (_); printed information regarding maternity care choices (4); access to interpreter services (_); translated educational materials (_); parenting education in community languages (3); ethnic obstetric liaison staff (3), aboriginal liaison staff (2).

Staff education and training

Midwives: AHS inservice and extended skills programs. GPs: Weekly training and teaching programs and clinical meetings; RACGP CME program. Specialist obstetricians and trainees: RACOG CME program.

Maintenance of clinical skills/minimum requirements:

Midwives: varied educational opportunities, 10 perineal suturing per year. GPs: RACGP requirements, 40 deliveries in 3 years. Specialist obstetricians and trainees: RACOG/RACGP requirements.

Evaluation/audit/quality activities

Variety of surveys on individual aspects of maternity services conducted. Comprehensive audit and review processes including perinatal mortality meetings, clinical pathways, clinical audits, clinical indicators, incident monitoring. No workload methodologies used.

Any new initiatives/suggestions

Ethnic speaking midwives clinic, neonatal early discharge, Vietnamese health officer, team clinic, pregnancy day assessment, Primary Health (caseload) Midwifery Program.

HUNTER AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	6
Annual birth rate to June 98	5799
Number of maternity beds	146
Number of labour ward beds	26
AHS Strategic Plan for Maternity Services	NO

Service outline

Primary maternity care provided by specialist obstetricians (3), GPs (5) and midwives	–	Early discharge/community midwifery programs	–
Access to paediatric services	3	Booking in clinics	2
Access to anaesthetic services	–	Midwives clinics	3
Availability of female specialist/GP obstetrician	1	Birth Centre	1
GP antenatal shared care	4	Team midwifery program	1
Antenatal clinics	3	Accredited/visiting independent midwives	1

Systems and processes

Protocol for perinatal death	4	Communication between remote/rural/metropolitan/tertiary services effective	4
GP shared care protocols	2	Protocol for the transfer of women from homebirths	1
Use of combined antenatal care card	3	Protocol for accreditation of independent midwives	2
Formal liaison between maternity and ECHS staff	2	Routine notification of births and/or discharge to GPs	3
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	–	Maternity services liaison/advisory committees	1
Women informed of nearest ECHS	–	Maternity committees with consumer involvement	1

Specific services/programs

Postnatal depression: No AHS protocol. Strategies for identification and referral antenatally and postnatally; printed information available.

Early discharge/community midwifery: Criteria: <72 hours; no medical risks; geographic boundaries. Cross referral mechanisms: phone referrals system. Activity: rates 34-67%%, average number home visits per woman: 2-5, average postnatal day of discharge from program: 5-6.

Other: parenting education classes (_); printed information regarding maternity care choices (3); access to interpreter services (4); telephone interpreter services (_); translated educational materials (3); parenting education in community languages (2); ethnic obstetric liaison staff (1); aboriginal liaison staff (3).

Staff education and training

Midwives: self-directed learning, external education courses and seminars. GPs: RACOG/RACGP CME program. Specialist obstetricians and trainees: RACOG CME program.

Maintenance of clinical skills/minimum requirements:

Midwives: annual CPR (neonate and adult); fire and safety; skills relevant to clinical area; visiting midwives – 20 births per year. GPs: RACGP requirements, 20 births per year, Specialist obstetricians and trainees: RACOG requirements.

Evaluation/audit/quality activities

Extensive range of client satisfaction surveys conducted. Audit and review processes including perinatal mortality meetings, clinical meetings, activity data reports. Workload methodologies used: “English” system (1).

Any new initiatives/suggestions

Team midwifery, midwives clinics, antenatal day stay, postnatal day stay, high-risk team.

ILLAWARRA AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	4
Annual birth rate to June 98	4079
Number of maternity beds	63
Number of labour ward beds	14
AHS Strategic Plan for Maternity Services	NO

Service outline

Primary maternity care provided by specialist obstetricians (3), GPs (2) and midwives	-	Booking in clinics	-
Access to paediatric services	3	Antenatal clinic	2
Access to anaesthetic services	3	Midwives clinics	2
Availability of female specialist/GP obstetrician	1	Birth centre	1
GP antenatal shared care	4	Early discharge or community midwifery programs	-
Accredited/visiting independent midwives	-		

Systems and processes

Protocol for perinatal death	3	Communication between remote/rural/metropolitan/tertiary services effective	-
GP shared care protocols	2	Protocol for the transfer of women from homebirths	-
Use of combined antenatal care card	3	Protocol for accreditation of independent midwives	1
Formal liaison between maternity and ECHS staff	-	Routine notification of births and/or discharge to GPs	3
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	-	Maternity services liaison/advisory committees	-
Women informed of nearest ECHS	-	Maternity committees with consumer involvement	-

Specific services/programs

Postnatal depression: No AHS protocol. Strategies for identification and referral antenatally and postnatally.

Early discharge/community midwifery: Criteria: all women based on need. Cross referral mechanisms: sometimes difficult, especially at weekends if other service cannot accommodate. Activity: rates 35-100%, average number home visits per woman: 4; average postnatal day of discharge from program: 5-7.

Other: parenting education classes (_); printed information regarding maternity care choices (3); access to interpreter services (3); telephone interpreter services; translated educational materials (3); parenting education in community languages (_); ethnic obstetric liaison staff (_), aboriginal liaison staff (3).

Staff education and training

Midwives: inservice and education programs; study leave. GPs: Shared care inservice evenings biannually, RACOG/RACGP CME program. Specialist obstetricians and trainees: RACOG CME program, perinatal and divisional meetings monthly.

Maintenance of clinical skills/minimum requirements:

Midwives: annual CPR; fire and safety; cannulation and suturing. GPs: Attend information sessions; RACGP requirements. Specialist obstetricians and trainees: RACOG/RACGP requirements.

Evaluation/audit/quality activities

Range of facility wide surveys conducted; Audit and review processes including clinical indicators, obstetric review committee meeting. Workload methodologies used: awaiting 'PCIS' system (1); interest in 'Birthrate plus' (1), mainly historical data.

Any new initiatives/suggestions

Shared care with GPs, midwives clinics, antenatal outreach service (including service to Koori women), 'Young mothers living skills program'.

CENTRAL COAST AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	2
Annual birth rate to June 98	2531
Number of maternity beds	46
Number of labour ward beds	12
AHS Strategic Plan for Maternity Services	NO

Service outline

Primary maternity care provided by specialist obstetricians, GPs (1) and midwives	–	Early discharge/community midwifery programs	–
Access to paediatric services	–	Booking in clinics	–
Access to anaesthetic services	–	Midwives clinics	1
Availability of female specialist/GP obstetrician	–	Team midwifery program	–
GP antenatal shared care	–	Accredited/visiting independent midwives	–
Antenatal clinics	–		

Systems and processes

Protocol for perinatal death	–	Communication between remote/rural/metropolitan/tertiary services effective	–
GP shared care protocols	–	Protocol for the transfer of women from homebirths	–
Use of combined antenatal care card	–	Protocol for accreditation of independent midwives	–
Formal liaison between maternity and ECHS staff	–	Routine notification of births and/or discharge to GPs	–
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	–	Maternity services liaison/advisory committees	1
Women informed of nearest ECHS	–	Maternity committees with consumer involvement	1

Specific services/programs

Postnatal depression: AHS protocol. Strategies for identification and referral antenatally and postnatally; full time PND coordinator; staff education 30% to date, postnatal 'debriefing' used.

Early discharge/community midwifery: Criteria: <3 days or <5 days (LSCS); 'other' referrals up to day 10. Cross referral mechanisms: phone referrals system and documentation processes work well. Activity: rates 74%, average number home visits per woman: 2, average postnatal day of discharge from program: 5.

Other: parenting education classes (–); printed information regarding maternity care choices (–); access to interpreter services (–); translated educational materials (–).

Staff education and training

Midwives: inservice; beginning midwife practitioner support program; leaning packages and mentorship; clinical team leader program, extended skills program (cannulation, suturing etc). GPs: RACGP CME program. Specialist obstetricians and trainees: obstetric updates, clinical tutorials, weekly inservices, RACOG CME program.

Maintenance of clinical skills/minimum requirements:

Midwives: rotation program of 10-12 weeks unless core staff; maintain number of extended skills. GPs: 40 births each 3 years; attend at least 50% of divisional meetings, RACGP requirements. Specialist obstetricians and trainees: RACOG/RACOG requirements.

Evaluation/audit/quality activities

Comprehensive client satisfaction surveys conducted. Range of quality activities including benchmarking , weekly quality meetings and perinatal mortality meetings. Workload methodologies used: PAIS until June 1998, "Birthrate plus' has been reviewed; otherwise historical staffing methods.

Any new initiatives/suggestions

Postnatal 'debriefing' offered to all women; peer support programs for midwives following a critical incident; multidisciplinary case reviews; flexible roster, annualised salary for team midwives; case load midwifery model.

NORTHERN RIVERS AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	8
Annual birth rate to June 98	3317
Number of maternity beds	81
Number of labour ward beds	22
AHS Strategic Plan for Maternity Services	YES

Service outline

Primary maternity care provided by specialist obstetricians (5), GPs and midwives	–	Early discharge/community midwifery programs	7
Access to paediatric services	2	Booking in clinics	–
Access to anaesthetic services	4	Midwives clinics	1
Availability of female specialist/GP obstetrician	2	Antenatal clinics	1
GP antenatal shared care	4	Accredited/visiting independent midwives	1

Systems and processes

Protocol for perinatal death	–	Communication between remote/rural/metropolitan/tertiary services effective	4
GP shared care protocols	2	Protocol for the transfer of women from homebirths	4
Use of combined antenatal care card	5	Protocol for accreditation of independent midwives	–
Formal liaison between maternity and ECHS staff	–	Routine notification of births and/or discharge to GPs	7
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	–	Maternity services liaison/advisory committees	2
Women informed of nearest ECHS	–	Maternity committees with consumer involvement	–

Specific services/programs

Postnatal depression: No AHS protocol. Discussed in classes in some facilities; Strategies for identification and referral antenatally and postnatally.

Maintenance of clinical skills/minimum requirements:

Midwives: annual CPR (neonate and adult); some facilities developing extended role skills (suturing, cannulation); competency-based log book (1). GPs: RACGP requirements, Specialist obstetricians and trainees: RACOG/RACGP requirements.

Evaluation/audit/quality activities

Most facilities have a survey. Range of quality activities: clinical indicators and audit activities in some. Workload methodologies used: PAIS in some, keen to trial 'Birthrate plus' (1); mostly historical staffing methods.

Any new initiatives/suggestions

'Midwifery-led' care and continuity of care initiatives; request for Area CNC Midwifery.

MID NORTH COAST AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	7
Annual birth rate to June 98	1017
Number of maternity beds	29
Number of labour ward beds	11
AHS Strategic Plan for Maternity Services	NO

Service outline

Primary maternity care provided by specialist obstetricians (1), GPs (5) and midwives	–	Early discharge/community midwifery programs	4
Access to paediatric services	5	Booking in clinics	4
Access to anaesthetic services	6	Midwives clinics	–
Availability of female specialist/GP obstetrician	2	Birth centre	1
GP antenatal shared care	2	Accredited/visiting independent midwives	–
Antenatal clinics	–		

Systems and processes

Protocol for perinatal death	5	Communication between remote/rural/metropolitan/tertiary services effective	6
GP shared care protocols	1	Protocol for the transfer of women from homebirths	1
Use of combined antenatal care card	3	Protocol for accreditation of independent midwives	–
Formal liaison between maternity and ECHS staff	6	Routine notification of births and/or discharge to GPs	6
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	6	Maternity services liaison/advisory committees	–
Women informed of nearest ECHS	6	Maternity committees with consumer involvement	–

Specific services/programs

Postnatal depression: No AHS protocol. Referral when identified to child and family health, mental health team or ECHS; PND support group; PND booklet.

Early discharge/community midwifery: Criteria: uncomplicated, well supported and prepared, dependant on social conditions and age in some facilities, geographical boundaries. Cross referral mechanisms: not available in all facilities; phone referrals. Activity: rates 5-61%, average number home visits per woman: 2-3; "phone visits" only (1), average postnatal day of discharge from program: 5-6.

Other: parenting education classes (6); printed information regarding maternity care choices (2); access to interpreter services (4); telephone interpreter services (5); translated educational materials (1), aboriginal liaison staff (4).

Staff education and training

Midwives: self motivated education, suturing program. GPs: RACGP/RACOG CME program, Rural Doctors and Division of GP education programs. Specialist obstetricians: RACOG CME program.

Maintenance of clinical skills/minimum requirements:

Midwives: annual CPR; attend minimum 5 births per year; suturing X 6 per year in some facilities. GPs: RACGP requirements, 20 births per year, Specialist obstetricians: RACOG requirements.

Evaluation/audit/quality activities

Client satisfaction surveys in some facilities; some general AHS surveys. Clinical indicators, clinical care audits, staff meetings, perinatal mortality meetings twice yearly. Workload methodologies used: PAIS.

Any new initiatives/suggestions

Considering midwifery-based service when second GP no longer available (1).

MIDWESTERN AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	7
Annual birth rate to June 98	2271
Number of maternity beds	81
Number of labour ward beds	16
AHS Strategic Plan for Maternity Services	NO

Service outline

Primary maternity care provided by specialist obstetricians (4), GPs and midwives	–	Booking in clinics	6
Access to paediatric services	4	Antenatal clinic	1
Access to anaesthetic services	–	Midwives clinics	1
Availability of female specialist/GP obstetrician	3	Early discharge or community midwifery programs	1
GP antenatal shared care	5	Accredited/visiting independent midwives	1

Systems and processes

Protocol for perinatal death	–	Protocol for the transfer of women from homebirths	1
Use of combined antenatal care card	5	Protocol for accreditation of independent midwives	2
Formal liaison between maternity and ECHS staff	–	GP shared care protocols	2
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	–	Routine notification of births and/or discharge to GPs	6
Women informed of nearest ECHS	–	Maternity services liaison/advisory committees	1
Effective communication between remote/rural/metropolitan/tertiary services	–	Maternity services liaison/advisory committees with consumer involvement	1

Specific services/programs

Postnatal depression: No AHS protocol. Strategies vary across AHS, include documentation of those 'at risk'; PND support group; 2 home visits postnatally if 'at risk'.

Early discharge/community midwifery: Criteria: uncomplicated, well supported and prepared, geographic limit <20km. Cross referral mechanisms: formal process – phone and documentation. Activity: rate (1): 9%, average number of visits per woman: 2-3, average postnatal day of discharge from program: 5. One facility reported 98% of women return for postnatal visits.

Other: parenting education classes (–); printed information regarding maternity care choices (2); access to interpreter services (3); telephone interpreter services (6); translated educational materials (3), aboriginal liaison staff (4).

Staff education and training

Midwives: inservice, AHS education program. GPs: RACGP/RACOG CME program. Specialist obstetricians and trainees: RACOG/RACGP CME program.

Maintenance of clinical skill/minimum requirements

Midwives: annual accreditation of cannulation, CPR and IV drugs GPs: RACGP requirements. Specialist obstetricians and trainees: RACOG/RACGP requirements.

Evaluation/audit/quality activities

Broad range of client satisfaction surveys. Clinical indicators used.

Workload methodologies used: PAIS (2); otherwise historical staffing methods.

Any new initiatives/suggestions

Lactation clinic, midwives clinic.

WESTERN SYDNEY AREA HEALTH SERVICE (AS AT NOVEMBER 1998)

Overview

Number of facilities providing maternity services	3
Annual birth rate to June 98	7923
Number of maternity beds	154
Number of labour ward beds	44
AHS Strategic Plan for Maternity Services	NO

Service outline

Primary maternity care provided by specialist obstetricians, GPs and midwives	-	Early discharge/community midwifery programs	-
Access to paediatric services	-	Booking in clinics	-
Access to anaesthetic services	-	Midwives clinics	-
Availability of female specialist/GP obstetrician	-	Birth Centre	1
GP antenatal shared care	-	Team midwifery program	1
Antenatal clinics	-	Accredited/visiting independent midwives	-

Systems and processes

Protocol for perinatal death	-	Communication between remote/rural/metropolitan/tertiary services effective	-
GP shared care protocols	-	Protocol for the transfer of women from homebirths	-
Use of combined antenatal care card	-	Protocol for accreditation of independent midwives	-
Formal liaison between maternity and ECHS staff	-	Routine notification of births and/or discharge to GPs	-
Green copy of MR 44 (MDC) distributed to ECHS/placed in Personal Health Record	-	Maternity services liaison/advisory committees	-
Women informed of nearest ECHS	-	Maternity committees with consumer involvement	-

Specific services/programs

Postnatal depression: No AHS protocol exists. Strategies for identification and referral antenatally and postnatally (2); close observation (1).

Early discharge/community midwifery: Criteria: mostly by choice, 6-48 hours or <5 days (LSCS), no medical risks. Cross referral mechanisms: problematic with inconsistency in accepting referrals and different criteria for each facility; first priority given to facility's women. Activity: rates 32-50%, average number home visits per woman: 2-3, average postnatal day of discharge from program: 4-6.

Other: parenting education classes (_); printed information regarding maternity care choices (_); access to interpreter services (_); translated educational materials (_); parenting education in community languages (2); printed information regarding maternity care service in community languages (2); ethnic obstetric liaison staff (2), aboriginal liaison staff (1).

Staff education and training

Midwives: inservice, extended skills (suturing and cannulation) and education workshops. GPs: Education program across three sites, RACOG/RACGP CME program. Specialist obstetricians and trainees: regular perinatal, clinical and quality meetings, RACOG/RACGP CME program.

Maintenance of clinical skills/minimum requirements:

Midwives: rotation program; clinical and leadership competency testing (1). GPs: RACGP requirements.

Specialist obstetricians and trainees: RACOG/RACGP requirements.

Evaluation/audit/quality activities

Client satisfaction surveys not currently being conducted; some aspects of service being evaluated. Range of audit and review processes including perinatal mortality, clinical indicators, ad hoc quality projects. Workload methodologies used: PAIS and daily census in PROACT.

Any new initiatives/suggestions

Aboriginal Birthing Project proposed; redeveloping clinical and obstetric databases.

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GLOSSARY

Aboriginal health	In the context of the health of Aboriginal people, the definition of health is expanded to include the total wellbeing of a whole community and not just individuals. 'Aboriginal health means not just the physical wellbeing of an individual but also the socio-economic, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their community'. ¹⁵
ABSP	Alternative Birthing Services Program, funded by the Commonwealth Department of Health and Family Services and the NSW Department of Health
ACHS	Australian Council of Healthcare Standards
ACMI	Australian College of Midwives, Inc.
AHS	Area Health Service
AMWAC	Australian Medical Workforce Advisory Committee
Birth plan	A plan, developed between a pregnant woman and a midwife, of the woman's preferences for her care and that of her unborn child during labour and childbirth
Childbirth Education Services	The provision of a structured program of education/information about pregnancy, labour, birth and early parenting to women and their partners
CIAP	Clinical Information Access Project
Consumers	Users of maternity services, e.g. the pregnant woman and her family
Continuity of Care	Care which enables child-bearing women to develop a relationship with the same caregiver(s) throughout pregnancy, birth and the postnatal

period. Continuity of care can be provided in different ways and to varying degrees. Very few models actually provide complete continuity of care throughout all stages¹⁶

Early discharge	Discharge from a maternity unit within 48 hours of giving birth
EOLO	Ethnic Obstetric Liaison Officer
EQuIP	Evaluation and Quality Improvement Program of the ACHS
FTE	Full-time equivalent
GP	General Practitioner
Independent midwife	A person authorised to practise midwifery in NSW who works privately and independently of a hospital or health service. Independent midwives may be accredited with the Australian College of Midwives, Inc.
Midwifery models of care	Models of maternity services in which midwives are the primary caregivers. These services may include midwife clinics, domiciliary midwifery, team midwifery, independent midwifery and birth centres. These models of maternity care are based on a primary health care philosophy and principles
MSLC	Maternity Services Liaison Committee
NESB	Non-English speaking background
NHMRC	National Health and Medical Research Council
Normal birth	Spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. This infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth, mother and infant are in good condition ⁹
NSW Health	All employees of the NSW public health system
NSW Health Department	Central administrative office of NSW Health, based at North Sydney

PND	Postnatal depression
Primary health care	<p>As defined by the World Health Organisation, 'essential health care made universally acceptable to individuals and families in the community by means acceptable to them, through their participation and at a cost that the community can afford. It forms an integral part of both the country's health system of which it is the nucleus and of the overall social and economic development of the community'¹⁷</p> <p>Primary health care is defined and understood as:</p> <ul style="list-style-type: none">• a philosophical approach to the development and delivery of health care and health care systems. It is based on a broad concept of health that is characterised by social justice, equality and self-responsibility for one's health maintenance• a framework for the development of services that are appropriate and relevant to the needs of local communities and are affordable, integrated and characterised by inter-sectorial collaboration. The participation of communities and individuals in the planning, organisation, operation and control of their health services is a key feature of the primary health care approach to service development• a level of care, which is the first point of contact with the health care system• a set of activities that address the main health problems identified in a country providing promotive, preventative, curative and rehabilitative services. It may include health education, nutrition promotion, clean water supplies, immunisation, family planning, major infectious disease control, etc.^{4,17}
RACGP	Royal Australian College of General Practitioners
RANZCOG	Royal Australian and New Zealand College of

	Obstetricians and Gynaecologists
Shared care	In the context of this report, the provision of care that is shared between general practitioners, obstetricians, midwives and/or Aboriginal or Torres Strait Islander health workers
Team midwifery	A model of maternity care provided by a small team of midwives in collaboration with an obstetrician that focuses on continuity of care through all stages of pregnancy, labour, birth and early parenting
TQI	Total quality improvement
Visiting Midwife	An independent midwife accredited by agreement with a particular health service to provide care to her own clients within the hospital or health service
VMO	Visiting medical officer
WHO	World Health Organisation

MEMBERS OF THE NSW MATERNITY SERVICES ADVISORY COMMITTEE

This report represents a collaborative effort of a number of individuals representing maternity health service providers, consumers, policy makers, clinicians and professional organisations. The NSW Maternity Services Advisory Committee was convened by NSW Health Department to address some important challenges in maternity care. The Committee discussed, debated and exchanged knowledge, experiences and opinions regarding maternity services across New South Wales in the context of national and international trends and were able to reach consensus on a wide range of important issues and strategic directions for future maternity services in NSW.

Dr Andrew Wilson	Deputy Director-General, Public Health (Chairperson)
Ms Pat Brodie	Midwifery Consultant (Project Officer)
Ms Judith Meppem	Chief Nursing Officer
Ms Kathy Meleady	Director, Statewide Services Development Branch
Dr Steevie Chan	Manager, Clinical Services Planning Unit
Dr Lis Murphy	Clinical Consultant, Health Services Policy Branch
Ms Penny Waterson	Consumer representative, Maternity Alliance, Inc.
Ms Geraldine Wilson	Senior Project Officer, Aboriginal Health
Dr Marie-Louise Stokes	Policy Officer, Clinical Policy and Practice
Ms Lynette Pugh	Senior Policy Analyst
Ms Dare Kavanagh	Project Officer, Women's Health
Ms Ann Grieve	President, NSW Midwives Association, Inc.
Mr Dennis Moulds	Rural Midwifery Consultant
Dr Andrew Child	Obstetrician and representative from Tertiary Maternity Hospitals
Prof Michael Chapman	Professor of Obstetrics & Gynaecology (Academic)
Prof Marie Chamberlain	Professor of Midwifery (Academic)
Dr Penny Knowlden	Royal Australian College of General Practitioners
Prof William Walters	Professor of Obstetrics & Gynaecology (Chairperson, NSW Maternal and Perinatal Committee),
Dr Michael O'Connor	Royal Australian and New Zealand College of Obstetricians & Gynaecologists (until August 1998)
Dr Vijay Roach	Royal Australian and New Zealand College of Obstetricians & Gynaecologists (from August 1998)
Ms Maria Fenn	Project Officer, Nursing Branch
Ms Lisa Mandicos	Policy Analyst, Clinical Services Planning Unit

CORRESPONDING MEMBER

Ms Vicky Gransden Rural Health Services Manager, Bourke Hospital