



Australian Government
National Health and Medical Research Council
Department of Health and Ageing

NATIONAL GUIDANCE
ON COLLABORATIVE
Maternity Care





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WORKING TO BUILD A HEALTHY AUSTRALIA

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■ Acronyms and abbreviations

ACM	Australian College of Midwives
CRAN <i>Aplus</i>	the professional body for remote and isolated health providers
DoHA	Australian Government Department of Health and Ageing
GP	General Practitioner
the Guidance	National Guidance on Collaborative Maternity Care
MOU	Memorandum of Understanding
NHMRC	National Health and Medical Research Council
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists

■ Executive Summary

The *National Guidance on Collaborative Maternity Care* (the Guidance) has been developed by the National Health and Medical Research Council (NHMRC) to provide a resource to support collaborative maternity care in Australia. It is intended to assist maternity service professionals set in place and maintain collaborative arrangements appropriate for the local context and the model of care. In this way, it will support the delivery of maternity care and ensure that women receive access to appropriate expertise and treatment, as the need arises.

Maternity care collaboration: definition and principles

A shared definition and understanding of what collaboration means for maternity care is an important first step to establishing successful collaborations. The following definition and principles of maternity care collaboration have been developed by a range of maternity care service providers and users for this Guidance document.

Definition

In maternity care, collaboration is a dynamic process of facilitating communication, trust and pathways that enable health professionals to provide safe, woman-centred care. Collaborative maternity care enables women to be active participants in their care.

Collaboration includes clearly defined roles and responsibilities for everyone involved in the woman's care, especially for the person the woman sees as her maternity care coordinator.

Principles

1. Maternity care collaboration places the woman at the centre of her own care, while supporting the professionals who are caring for her (her carers). Such care is coordinated according to the woman's needs, including her cultural, emotional, psychosocial and clinical needs.
2. Collaboration enables women to choose care that is based on the best evidence and is appropriate for themselves and for their local environment.
3. Collaboration enables women to make informed decisions by ensuring that they are given information about all of their options. This information should be based on the best evidence, and agreed to and endorsed by professional and consumer groups.
4. Collaborating professionals, regardless of the model of care, establish a clearly defined and inclusive reciprocal communication strategy using sensitive language to support professional trust.
5. Collaboration has an underpinning safety and quality framework that includes monitoring health outcomes for mothers and babies, regular multidisciplinary discussions about how the collaboration is working (involving women who have used the service) and public reporting.
6. Collaborating professionals respect and value each other's roles, provide support to each other in their work and provide education to meet each other's needs.
7. Collaboration is committed to joint education and training, following a consistent, agreed care plan and research focused on improving outcomes.



8. Collaboration aims to maximise a woman's continuity of care and carer, throughout pregnancy, birth and the early postnatal period.
9. Collaboration aims to maximise a woman's continuity of carer by providing a clear description of roles and responsibilities to support the person that a woman nominates to coordinate her care (her 'maternity care coordinator').

The full Guidance has more information about collaboration in health care, in particular in Australia's maternity care.

Key elements of collaboration: translating evidence into clinical practice

Maternity care collaboration is based on a set of commonly understood and agreed elements. Best-practice collaboration is based on implementation of the following key elements, which are expanded in Section 2.1–2.10 of the Guidance:

- woman-centred care and communication
- communication among professionals
- awareness of disciplines and autonomy
- responsibility and accountability
- cooperation and coordination
- mutual trust and respect
- policy, procedures and protocols
- interprofessional learning
- organisational support
- systems.

Important concepts for woman-centred communication include informed choice, informed consent and informed refusal of recommendations for care.

Establishing a collaboration

To improve collaboration within Australia's maternity sector, the needs of women and maternity health care professionals must be met within the public and private sector, in rural, remote, regional and urban settings, and in all states and territories. When establishing collaboration, it is important for maternity service providers to complete the following tasks:

- define or clarify the service delivery context
- clarify the services and skill mix of the collaborating partners
- identify issues for women within this context, ensuring flexibility to meet the needs of individual women on a case-by-case basis
- identify how a collaboration can work
- identify the service policies or issues that might need to be negotiated or addressed (e.g. access rights, credentialing, audit and peer review, professional development).



For collaboration to be effective, the following issues also need to be considered by maternity care providers and hospitals in each care context:

- roles and responsibilities
- shared documentation
- transfer plans
- care pathways
- access to hospitals
- credentialing/clinical privileging (as appropriate)
- hospital bookings
- admission status
- postnatal care
- competition
- dealing with conflict.

Collaborative care can be provided across primary, secondary and tertiary levels, and in different models of maternity care. Responsibility for care and any collaboration between maternity care providers may impact the above differently.

Within each issue, there are considerations common to all settings and particular to specific settings such as rural and remote areas, metropolitan public hospitals, and private hospitals. These are discussed in Sections 3.2 and 3.3 of the Guidance.

Clinical resources for collaboration

The Australian and international clinical practice guidelines that are currently available to health care professionals are discussed in Chapter 4 of the Guidance. The key Australian guidelines are:

- *Suitability Criteria for Models of Care and Indications for Referral Within and Between Models of Care*, Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) 2009.
- *National Midwifery Guidelines for Consultation and Referral*, Australian College of Midwives (ACM) 2008.

Such professional guidelines are important for promoting consistency of practice, but consistent facility or team policies and standards are also important. These policies or protocols usually cover:

- identifying risk
- developing and implementing integrated care pathways
- ensuring best-practice communication, meetings and documentation
- other tools.

Collaborative arrangements require communication to build trust and mutual respect, which can also help relieve concerns about accountability and perceptions of risk. Protocols to help improve communication and relieve concerns about accountability include: regular team meetings, interprofessional education or training activities, and clearly documented patient records that include signatures or initials of care providers on the patient notes when an entry is made.

Documentation should include clear and consistent records of: information provided to the woman and indications that the messages have been understood, informed consent, responsibility and accountability for decisions, and the woman's understanding of risk and her responsibility for her own choices and decisions about care, especially if these decisions are in conflict with professional



advice (in such circumstances it must be clearly documented that the woman has accepted a certain level of risk).

The importance of improving communication flows between clinicians and those involved in a woman and baby's community care after the birth (e.g. general practitioners, child and family health nurses, community services, allied health) should also be taken into account.

Monitoring and evaluation

To ensure women have access to high-quality, safe and collaborative maternity care, it is vital that collaboration is monitored, evaluated and reviewed. This usually involves:

- individual professional development and review of practice; for example
 - the ACM continuing professional development program (Midplus)
 - the ACM Midwifery Practice Review
 - the RANZCOG mandatory program of continuing education across four aspects of practice and recertification in a three-year cycle
- peer and case review, which is often linked with professional development schemes. Improving collaborative maternity care may provide opportunities to participate in multidisciplinary peer review, where collaborating partners contribute to each other's practice and collaboration activities
- audit processes, which should create an environment of transparency of practice and involve all maternity clinicians regardless of practice setting; these include
 - informal case review for cases with both good and adverse outcomes
 - processes that identify, as much as possible, 'near misses' occurring in care provided, so there is recognition of the possible implications these incidents have for becoming serious adverse outcomes
 - morbidity and mortality review that is multidisciplinary, and preferably represented or led by all staff involved
 - analysis of more serious adverse outcomes using tools such as root cause analysis
 - assessment of the impact of collaboration on 'core maternity indicators'; for example breastfeeding rates, or smoking cessation advice and decreased smoking rates in pregnancy.

Clinical practice guidelines for perinatal mortality

The Perinatal Mortality Group of the Perinatal Society of Australia and New Zealand has published *Clinical Practice Guidelines for Perinatal Mortality* (PSANZ 2009) to assist clinicians when investigating and evaluating causes of perinatal deaths. These guidelines provide a systematic approach to support audit and research activities that aim to reduce perinatal deaths.

■ Introduction

The *National Guidance on Collaborative Maternity Care* (the Guidance) has been developed by the National Health and Medical Research Council (NHMRC) to provide a resource to support collaborative maternity care in Australia. The Guidance defines collaborative maternity care, outlines principles for collaboration, and suggests tools and processes for facilitating collaboration. It aims to assist maternity care providers to establish and maintain collaborative arrangements, to ensure that women receive care appropriate to their needs.

In response to a review of Australian maternity services published in February 2009 (DoHA 2009), the Australian Government 2009–10 Health and Ageing Portfolio Budget included a package of measures that aimed to improve choice and access to maternity services, give families greater choice in the type of care they receive when having a baby, and recognise the important role played by qualified midwives in the birthing experience of many Australian women.

This maternity reform package includes:

- Medicare Benefits Schedule—subsidised services and Pharmaceutical Benefits Scheme—subsidised medicines provided or prescribed by eligible midwives working in collaboration
- a government-supported professional indemnity insurance scheme for eligible midwives
- increased services for rural and remote communities through an expansion of the successful Medical Specialist Outreach Assistance Program
- additional training support for general practitioners (GPs) and midwives to expand the maternity workforce, particularly in rural and remote Australia
- the expansion and improvement of the National Pregnancy Support Helpline to deliver a 24-hour, seven-days-a-week telephone counselling and information service.

To access these new provisions, which will come into effect in the latter half of 2010, midwives will be expected to demonstrate that they are working in collaborative arrangements. The Australian Government Department of Health and Ageing (DoHA) commissioned the NHMRC to develop the Guidance to support these changes.

The NHMRC appointed a multidisciplinary reference group, the Maternity Collaboration Project Reference Group (the Reference Group), to oversee development of the Guidance. The Reference Group members represent a diverse range of clinicians involved in maternity services, and the women and families who use these services. The chair was Professor Chris Baggoley of the Australian Commission on Safety and Quality in Health Care. The Reference Group also received advice from the NHMRC Health Care Committee and the DoHA Maternity Services Advisory Group.

The Guidance is based on existing Australian and international documents on collaboration, a review of the literature, and consultation with maternity care providers and consumers. A list of the Reference Group members and further details of the Guidance development process are included in Appendix 1.

The Guidance is not a clinical practice guideline as it does not have specific evidence-based recommendations. Rather, it is intended to assist maternity service professionals to set in place and maintain collaborative arrangements appropriate for their local context and model of care. In this way, it will support the delivery of maternity care and ensure that women receive access to appropriate expertise and treatment, as the need arises. It also provides information for women about how good collaboration between maternity service professionals should work.

The Guidance has been developed in an environment of long-standing, cross-professional debate over roles and responsibilities in maternity services. Cross-professional cooperation and agreement on client care, particularly referrals, is critical to achieving effective collaborative multidisciplinary care.

I Maternity care collaboration: definition and principles

This chapter provides information about collaboration in health care, how this applies to maternity care, as well as some background to maternity services and models of care in Australia. It also describes the development of the definition and principles of collaborative maternity care shown in Boxes 1.1 and 1.2.

Box 1.1 Definition of maternity care collaboration

In maternity care, collaboration is a dynamic process of facilitating communication, trust and pathways that enable health professionals to provide safe, woman-centred care. Collaborative maternity care enables women to be active participants in their care.

Collaboration includes clearly defined roles and responsibilities for everyone involved in the woman's care, especially for the person the woman sees as her maternity care coordinator.

Box 1.2 Principles of maternity care collaboration

1. Maternity care collaboration places the woman at the centre of her own care, while supporting the professionals who are caring for her (her carers). Such care is coordinated according to the woman's needs, including her cultural, emotional, psychosocial and clinical needs.
2. Collaboration enables women to choose care that is based on the best evidence and is appropriate for themselves and for their local environment.
3. Collaboration enables women to make informed decisions by ensuring that they are given information about all of their options. This information should be based on the best evidence, and agreed to and endorsed by professional and consumer groups.
4. Collaborating professionals, regardless of the model of care, establish a clearly defined and inclusive reciprocal communication strategy using sensitive language to support professional trust.
5. Collaboration has an underpinning safety and quality framework that includes monitoring health outcomes for mothers and babies, regular multidisciplinary discussions about how the collaboration is working (involving women who have used the service) and public reporting.
6. Collaborating professionals respect and value each other's roles, provide support to each other in their work and provide education to meet each other's needs.
7. Collaboration is committed to joint education and training, following a consistent, agreed care plan and research focused on improving outcomes.
8. Collaboration aims to maximise a woman's continuity of care and carer, throughout pregnancy, birth and the early postnatal period.
9. Collaboration aims to maximise a woman's continuity of carer by providing a clear description of roles and responsibilities to support the person that a woman nominates to coordinate her care (her 'maternity care coordinator').

1.1. Collaboration in health care

Collaboration has become increasingly important in health care. There is general agreement that increasing interprofessional collaboration improves outcomes for health care overall; conversely, poor collaboration, referral and handover between professionals and organisations can decrease the quality and safety of care (UK Department of Health 2005, 2009). Improving interprofessional collaboration has also been suggested as a way to improve access to care in rural and remote areas, and as a way for providers to make the most of their skill sets (CIHI 2004).

Despite these clear benefits, interprofessional collaboration remains a challenge. Collaboration is not easy—it requires flexibility, progressive approaches and effort (CIHI 2004, MCEP 2004:33). Health care professionals need training, information and experience in working in a collaborative environment (MCEP 2004:33). Collaboration also involves working within established care networks and systems to enable access to safe, effective services (AHMAC 2008).

Collaboration can be challenging to establish; a potential barrier is a lack of a consistent definition of collaboration (NHMRC consultations 2009, 2010). Different team members may have different understandings of collaboration and different levels of commitment to working collaboratively. In 2000, a Canadian research team reviewed the medical and nursing literature, and consulted widely to develop the following definition of interprofessional collaboration in health care:

Collaborative practice is an interprofessional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided (Way et al 2000:3).

These researchers also noted that collaboration is about more than just positive working relationships among professionals. It is a way of working, organising and operating within a practice or group network in a manner that effectively uses the provider resources to deliver cost-effective, comprehensive primary health care that meets the needs of the specific practice population (Way et al 2000).

The practical aspects of establishing collaboration are also challenging. A single model for collaboration would be too rigid to suit the unique needs of different communities, so guidelines cannot be too inflexible or prescriptive. In addition, issues of funding, insurance and liability need to be clarified for those working in collaborative models (Way et al 2000).

1.2 Collaborative maternity care in Australia

Comprehensive reviews of Australian maternity services have confirmed that collaboration is an important component of achieving positive maternity outcomes in line with women's needs, preferences and expectations (AHMAC 2008).

Primary Maternity Services in Australia—A Framework for Implementation (referred to in this document as the Maternity Services Framework; AHMAC 2008), which was endorsed by the Australian Health Ministers' Council in 2008, emphasises the importance of collaboration in maternity care as follows:

Care is best provided by qualified health professionals who work collaboratively within a high-quality, tiered health service, to ensure that women receive appropriate and timely care (AHMAC 2008:1).

Collaboration between health workers at all levels is critical for enabling safe services (AHMAC 2008:7). A collaborative approach has also been promoted by both the Australian College of Midwives (ACM 2008) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG 2009a;b).

1.2.1 Definition of maternity care collaboration

A shared definition and understanding of what collaboration means for maternity care is an important first step to establishing successful collaborations. A definition of maternity care collaboration has been developed for the Guidance in consultation with maternity care providers and consumers (see Box 1.1 on page 3).

The definition means that collaboration among maternity care providers (including, but not limited to, midwives and obstetricians) allows a woman's carers to support her wishes about how she wants to manage her pregnancy and birthing experience, while maximising safety for herself and her baby.

By definition, collaborating professionals trust each other, use careful and sensitive communication, and follow agreed processes for collaboration. They support the person the woman has nominated as her maternity care coordinator, and recognise clearly defined roles and responsibilities for everyone involved in the woman's care.

Some common terms used in the Guidance are defined in Box 1.3.

1.2.2 Principles of maternity care collaboration

Principles provide a framework for action—a commitment to the shared principles of collaboration provides collaborators with a framework for service policy development and individual professional behaviour that, when implemented successfully and effectively, enable best-practice maternity care. A set of nine principles of maternity care collaboration has been developed for the Guidance in consultation with maternity care providers and consumers (see Box 1.2 on page 3). These principles capture the elements of collaborative maternity care that are described in more detail in Chapter 2.

1.3 Diverse collaborations for diverse needs

There is no single way to collaborate in maternity care. Collaborations must be flexible, to meet the needs of diverse communities, service environments, consumers and maternity care providers. Two factors that influence how collaborations work are the level of care provided (primary, secondary and tertiary care) and the model of maternity care used.

Box 1.3 Terminology used in the Guidance

Collaborating partners are maternity care professionals who are actively collaborating (i.e. not in an employee–employer relationship). Collaborating partners refer women to each other as the need arises.

Collaboration is a process where two or more professionals work together with the woman to achieve common goals by sharing knowledge, learning and building consensus.

Collaborative agreement or arrangement is an informal and/or formal recognition of the terms of a collaboration. (See Chapter 2 for more information about the essential elements for any collaboration).

Collaborative practice refers to a group of maternity care professionals who collaborate with each other and with women in the planning and delivery of their maternity care (see also Section 1.1).

Continuity of care describes a situation where a woman is cared for by a group of professionals who share common ways of working and a common philosophy.

Continuity of carer means care provided, or supervised, over time by the same trusted carer (usually including backup arrangements).

Coordinator of care is the person nominated by a woman to coordinate her maternity care.

Maternity care professionals are registered clinicians who provide care for women during antenatal, intrapartum or postnatal stages of maternity care (e.g. midwives, GP obstetricians, obstetricians and GPs).



1.3.1 Primary, secondary and tertiary care

Australian maternity care is structured into three levels: primary, secondary and tertiary. The level of care indicates whether the woman is in the right place, at the right time, and is seeing the right carer depending on her clinical needs (AHMAC 2008). As the *Primary Maternity Services in Australia—A Framework for Implementation* explains:

Primary maternity care is healthcare provided for women not experiencing complications. It covers pregnancy, labour and birth and the postnatal period. Primary care is usually provided by midwives or general practitioners. Obstetricians principally provide secondary and tertiary care along with other relevant medical colleagues and midwives. GP obstetricians provide primary and secondary care along with other relevant medical colleagues and midwives. Where women have identified risks or have developed complications, they are referred to secondary or tertiary services, where care is managed by medical professionals or specialists, and midwives or general practitioners provide assistance as required (AHMAC 2008:1).

Primary care is the preferred approach to providing pregnancy and birthing services to women with uncomplicated pregnancies. This approach recognises that pregnancy and childbirth are normal processes, not an illness or disease. It also recognises that quick responses to complications and emergencies may be required, as well as a referral to the next level of care.

In secondary maternity care, responsibility for medical care rests with a general practitioner (GP) obstetrician, specialist obstetrician, or the medical staff on duty in the referral hospital (ACM 2008:10; AHMAC 2008), working in collaboration with a midwife or midwives who continue to provide midwifery care:

The safety and effectiveness of primary maternity services is underpinned by a collaborative services framework amongst care providers that ensures appropriate assessment, timely referral and access to secondary services (AHMAC 2008).

Tertiary settings provide multidisciplinary specialist care for women and babies with more complex and/or rare medical needs. Collaboration and coordination of a woman's care is possibly even more essential in these settings as there are likely to be more providers involved and increased clinical complications that will need regular monitoring and review throughout a woman's care.

A woman's carers in secondary and tertiary situations could include specialist obstetricians and subspecialists within obstetrics, in addition to her nominated care coordinator, to ensure continuity of care. Other carers may be a GP obstetrician (especially in rural or remote areas), disease specialists, anaesthetists, allied health providers such as dietitians and Aboriginal and Torres Strait Islander health care providers, as well as the woman's usual GP and midwives.

Effective communication must occur between all care providers in secondary and tertiary services and can be improved by a number of mechanisms, including case management meetings and retrospective reviews, and education sessions related to specific clinical conditions. In addition, timely regular updates on the woman's condition and possible care, together with shared attendance of appointments (e.g. by a midwife when the woman has a specialist appointment), can foster good collaboration and improve clinical outcomes (Brooten et al 2005; NHMRC consultations 2009).

1.3.2 Models of primary maternity care

Primary maternity services can be organised according to many different and varied models of care to suit the needs of individual communities. Primary maternity services in Australia are provided in public maternity units, birth centres, in the community, or in a combination of these settings. These various models of maternity care mean that collaboration will look different in different settings. Each model of primary maternity care needs a risk assessment methodology to identify the processes, training and guidelines required to minimise harm and maximise the safety of mothers and babies (AHMAC 2008).

Primary maternity models aim to offer continuity of care for women, provided by a midwife or GP obstetrician in collaboration with specialists to refer to or consult with as required. Continuity of care describes a situation where a woman is cared for by a group of professionals who share common ways of working and a common philosophy. Many models of care also aim for continuity of carer, where the same health professional or professionals provide care throughout a woman's contact with maternity services, including pregnancy, birth and the postbirth period.

The Primary Maternity Services Framework notes that in Australia:

... the majority of antenatal care is provided in the private sector including obstetricians and general practitioners, even if the woman has chosen to birth in a public maternity service. Care is generally managed by medical professionals (regardless of the level of risk of the women) with midwives providing secondary assistance (AHMAC 2008:3).

In the Primary Maternity Services Framework, Australia's health ministers committed to extending and enhancing primary care maternity service models—this may include changes to the roles of midwives working in a collaborative environment. Studies have demonstrated that continuity of midwifery care in pregnancy, birth and the postnatal period is as safe as traditional Australian medical models of care and can have beneficial outcomes (Homer et al 2001, Payne 2002, Jackson et al 2003, Sandall et al 2009).

Midwifery models of care that improve continuity of carer include caseload (where one midwife takes on the primary or lead care role throughout the pregnancy), team (where a small team of midwives care for the woman), stand-alone and birth-centre models of care (where a woman is cared for in a health care facility staffed by midwives and other health professionals; some birth centres are attached to hospitals, while others are located further away) (AHMAC 2008).

Models of maternity care vary from country to country. Compared to Australia, some countries place more or less emphasis on aspects of care, such as a woman's choice of care and the roles of midwives. For example, in the United Kingdom, a guiding principle for modern maternity services is that 'all women will need a midwife, and some need doctors too' (UK Department of Health 2007:15). The United Kingdom Department of Health has stated that four national choice guarantees will be available to all women by the end of 2009; one of these choices is 'choice of place of birth', including homebirth, birth in a local facility under the care of a midwife, or birth in a hospital supported by a local maternity care team including midwives, anaesthetists and obstetricians:

Depending on their circumstances, women and their partners will be able to choose between midwifery care or care provided by a team of maternity health professionals including midwives and obstetricians (UK Department of Health 2007).

An element of choice in this system is that women and their partners will have the choice between self-referral to the local midwifery service or accessing this service via their GP (UK Department of Health 2007).



Other countries also have a greater role for midwives. In New Zealand, more than 70% of women choose a midwife as their ‘primary maternity carer’.¹ In the Netherlands, ‘first-line’ midwives work in practice or alone to care for low-risk pregnancies; 90% of births are attended by a midwife and one-third of all babies are born at home. Higher risk pregnancies are attended by a midwife in a hospital, under the supervision of a gynaecologist who takes over in the case of more serious complications.² In contrast, in Canada, only 2% of births are attended by midwives, although Canada is looking at how an increased role for midwives could help resolve the shortage of maternity services in that country (British Columbia Centre of Excellence for Women’s Health 2003, CIHI 2004, NZ Ministry of Health 2008).

1.3.3 Models of private maternity care in Australia

As previously stated, women often choose private obstetric care in Australia which involves a model of continuity of care with one main doctor—either a specialist obstetrician or, in a rural setting, a GP obstetrician.

Within this model, many specialists have a midwife in their rooms providing antenatal education and other aspects of the woman’s care. In this case, intrapartum and postnatal care is provided in the woman’s hospital of choice by a team of staff midwives who work collaboratively with the woman’s doctor.

Privately practising midwives also provide maternity care in a continuity of care model throughout pregnancy, birth and the early postnatal period in a variety of settings. In addition, some private midwives provide care in hospitals to their private clients under different arrangements, such as by also being employed by a hospital service (NHMRC consultations 2009, 2010) for intrapartum care. See Section 3.3.1 for more information on private practice midwives and collaboration.

An effective collaborative working relationship between the hospital staff and the private practitioner is essential, and ensures accurate and timely communication between them, which is a fundamental element of safe care (Hatten-Masterson and Griffiths 2009).

1 New Zealand College of Midwives, www.midwife.org.nz/index.cfm/1.100.html. (Accessed 17 February 2010).

2 Royal Dutch Organisation of Midwives, unofficial translation, www.parentinginholland.com/pregnancy-and-birth/midwives.php (Accessed 17 February 2010). Accessed 17 February 2010)

2 Key elements of collaboration: translating evidence into clinical practice

Maternity care collaboration is based on a set of commonly understood and agreed elements.

This chapter provides details of the key elements that:

- underpin collaboration
- ensure continued and improved safe delivery of maternity services
- build interprofessional trust and respect
- facilitate resolution of contentious issues and conflicts if they arise.

The information is based on NHMRC consultations with maternity care providers and consumers, existing maternity services, and a review of the literature (see Appendix 1). A summary of the key elements identified through these processes is shown in Box 2.1 and described in further detail in Section 2.1. Best-practice collaboration is based on implementation of these key elements. Further detail about each element is provided in Sections 2.1–2.10.

Box 2.1 Key elements of maternity care collaboration

- Woman-centred care and communication
- Communication among professionals
- Awareness of disciplines and autonomy
- Responsibility and accountability
- Cooperation and coordination
- Mutual trust and respect
- Policy, procedures and protocols
- Interprofessional learning
- Organisational support
- Systems

Maternity services in Australia already incorporate many of the elements identified in Box 2.1 into their practice; a selection of case studies and personal accounts in Appendix 2 provide examples of how services are already displaying some of these individual elements. However, a goal for those involved in maternity care collaborations would be to fully implement all of the elements.

2.1 Woman-centred care and communication

Women want to make their own decisions about their pregnancy and birth experience, and strongly prefer a woman-centred approach to maternity care. Key issues for women are having a safe birth, feeling in control within the birth environment, developing supportive relationships with their carers, and being treated with dignity and respect (Walsh 2004, Brown et al 2005, Lee et al 2005, Main and Bingham 2008). Key terminology associated with this issue is shown in Box 2.2.

Box 2.2 Important terminology for woman-centred communication

Family is used in this document to mean the woman's spouse, husband, defacto, partner, sibling, kin, parent, guardian or community.

Informed choice occurs when a woman has the autonomy and control to make decisions about her care after a process of information exchange that involves providing her with sufficient, evidence-based information about all the options for her care, in the absence of coercion or withholding any options by any party (NHMRC consultations 2010).

Informed consent is when a woman consents to a recommendation about her care after a process of information exchange that involves providing her with sufficient, evidence-based information about all her options so that she can make a decision, in the absence of coercion or withholding any options by any party, that reflects self-determination, autonomy and control.

Informed refusal is when a woman refuses a recommendation about her care after a process of information exchange that involves providing the woman with sufficient, evidence-based information so that she can make a decision that reflects self-determination, autonomy and control.

Woman-centred care is focused on the woman's individual, unique needs, expectations and aspirations, rather than the needs of institutions or maternity service professionals. This type of care recognises the woman's right to self-determination in terms of choice, control and continuity of care.

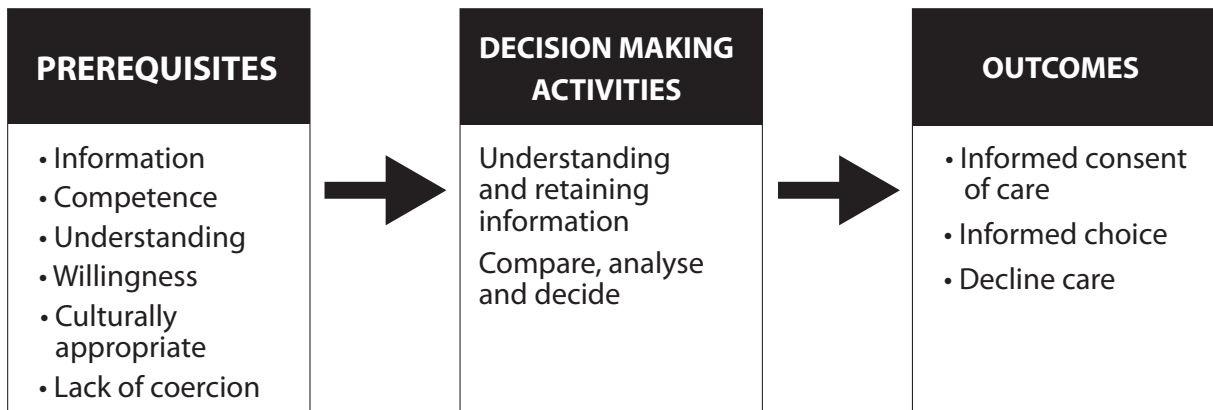
A woman has an integral role in developing her own care management plan and needs to be actively involved in the decision-making processes throughout all stages of her pregnancy (Lane 2005; Figure 2.1). To do this, she requires up-to-date, unbiased information about her full range of options from all health care providers to enable her to make appropriate choices and, subsequently, major decisions about her care (Payne 2002, Dyas and Burr 2003, Curtis et al 2006, ACOG 2007a, Saxell et al 2009, UK Department of Health 2009; NHMRC consultations 2009). The intrapartum period should not be the only or main focus of the relationship between the woman and her carers—antenatal care has important implications for the actual birth, as does postnatal care for bonding and early parenting (NHMRC consultations 2009). A resource for women that captures the essential issues relating to collaborative maternity care and her role in any collaboration, is provided at Appendix 3.

A woman decides who she involves in this decision-making process, be it a health professional, partner, doula, her extended family, friends or community (see Box 2.2), and should be free to consider their advice without being pressured, coerced, induced or forced into care that is not what she desires (McLean and Petersen 1996).

Women have the right to decline care or advice if they choose, or to withdraw consent at any time. Therefore, if a woman declines care or advice based on the information provided, her choice must be respected (UNESCO 2005). Importantly, women should not be 'abandoned' because of their choice (FPA Health and Read 2006, Faunce 2008; NHMRC consultations 2009). Several Australian states and territories have schedules that include refusal of treatment certificates as part of their health legislation³ that may help in recording decisions avoiding confusion if care is transferred, and outlines health practitioners' obligations and protections in this circumstance (FPA Health and Read 2006; see also Section 3.2.11). Making a choice or consenting should be an ongoing process of discussion between a woman and her health providers throughout her care. Having a coordinator of care to provide a consistent, clear point of contact is integral to this approach (NHMRC consultations 2009).

³ Australian Commonwealth, state and territory legislation can be accessed online via: www.austlii.edu.au (as at 1 May 2010), or through the relevant jurisdictions.

Figure 2.1 The process of making an informed choice



Source: Modified from Leino-Kilpi et al (2000) by the Victorian Healthcare Association (2009) and the Reference Group/NHMRC.

Maternity care providers and women need to communicate and collaborate in a team approach to ensure that women receive safe, quality care throughout the continuum of maternity care (Kryzanasuskas 2005, NZ Ministry of Health 2008). The woman's input—and her family's when she chooses—is an important part of this process (NHMRC consultations 2009). Consistency of information, even if this is provided by different professionals, is very important (Jones et al 1999, Price et al 2005), and this is best facilitated when there is a nominated coordinator of care (NHMRC consultations 2009).

Women also value maternity service providers who are sensitive and understanding, have time to spend with them, and who listen to and acknowledge specific concerns (Brown et al 2005). This includes considering the needs of the whole family (Price et al 2005), such as who will care for other children if a woman is away for a long time or has to travel a long distance, or prohibitive costs involved in transfers and multiple consultations. Collaboration aims to reduce inequalities and improve access for women and therefore should not involve extra costs to women compared to traditional models of care (AHMAC 2008; NHMRC consultations 2010). Providers who are supportive, nonjudgemental and empathetic, and who recognise that women may have had previous traumatic experiences associated with hospital or childbirth, are highly valued by women (Price et al 2005, ACOG 2007a; NHMRC consultations 2009). Friendly facility staff are also positively received (Wellingham et al 2003, Jackson et al 2006), as is time allocated for questions during appointments (Price et al 2005).

Acting on these issues is challenging. It requires a greater focus on communication and listening skills, and for services and maternity carers to promote woman-centred care. It is critical to provide a service to each woman that is suited to her emotional, social, cultural, psychological, spiritual and physical needs (Schofield 2009). Unfortunately, inflexible hospital policies or systems, and an overemphasis on risk management, can be a barrier to collaboration and have the unintended side effect of decreasing women's choices (ACOG 2007b, Baird 2008; NHMRC consultations 2009).

The use of a woman-held pregnancy record has been identified as an excellent way to improve communication. A woman-held record means the woman has a better chance of controlling her health information, encouraging respectful language and, as a result, enabling her to feel more in control during her maternity care (NHMRC 2006; NHMRC consultations 2009; Box 2.3).

Box 2.3 Examples of approaches that support woman-centred communication

The **Great Southern Aboriginal Health Service** and the **Great Southern General Practice Network**, in southwestern Western Australia, have developed a comprehensive program and information packages for Aboriginal women and their families in the Great Southern region. The program and tools were designed in collaboration with the Noongar Yorkas women from the region, and aim to promote and encourage healthy pregnancies and strong families in the Aboriginal community. Some examples of the tools developed include an information package on pregnancy, a maternity services directory for the Great Southern region, handheld antenatal records, nutritional guidelines, and antenatal, childbirth and postnatal services for Aboriginal women and their families. (See Appendix 2 for further information about this service.)

Following a two-year pilot completed in 1995, the **South Australian Department of Health** provided South Australian women with a handheld pregnancy record. This record is now considered to be the woman's main record and is used by most pregnant women with support from all publicly funded antenatal clinics and GPs accredited with the South Australian GP Shared Care Program. The aim of the woman-held record is to improve continuity of care, improve women's participation in their care, and promote early and appropriate use of antenatal services, particularly among disadvantaged groups. The record is created and issued by either the woman's GP or other care provider (e.g. hospital clinic or midwife) at the time of her first antenatal visit after confirmation of pregnancy. After her baby has been born, the record is filed in the woman's medical record, which is created by the hospital where she gives birth. A photocopy of the record is offered to the woman. The South Australian Department of Health is exploring opportunities to extend the South Australian Pregnancy Record in a web-based format, complementing the current hard-copy version that is accessible to pregnant women and those providing perinatal health care. This will provide a real-time patient record, while maintaining appropriate principles of confidentiality and privacy. It is envisaged that this proposal may take 1–2 years to come to fruition.

2.2 Communication among professionals

Communication is arguably one of the most important aspects of maternity care. Without timely and effective communication, care is likely to lack meaningful human connection and rely instead on stereotypes and guesswork (Dunlop and Holosko 2004, Cross-Sudworth 2007).

A study by Knaus and colleagues in 1986 of 5030 patients in 13 intensive care units indicated that the most powerful determinant of reduced mortality was better communication and collaboration in patient care between physicians and nurses (Brooten et al 2005).

Key components of effective communication are mutual support and affirmation that the partnership is working well (Jones et al 1999, Knight 2004, Wilson et al 2005). Talking fosters relationship building—successful partners in collaboration build regular opportunities for talking to each other into their practice (Schofield 2009).

Each professional is responsible for sharing accurate and appropriate information that will affect decision making with the other team members (WA Department of Health 2007). Traditional hierarchical relationships can make trust and communication difficult. Therefore, best-practice collaborative communication is reciprocal (i.e. each professional receives and provides information).

Sharing and effective transfer of case information is important to ensure safety and quality of care (Haller et al 2008). The development of a collaboration requires clinicians to present relevant, concise and timely information in an appropriate style at handover (Dyas and Burr 2003). Arrangements for communication need to be flexible and creative, especially when meeting needs in rural and remote areas (NHMRC consultations 2009).

Any communication process must include the woman and her community (if she chooses)—information and knowledge must use language that is useful and pragmatic for both the professionals and the woman. Communication should not only focus on antenatal and birth care, but also on how to effectively discharge the woman to community care and provide postnatal care in the community. This may involve having to improve referrals and connections with the woman's

GP, regional community services, early childhood services, allied health professionals or further specialist care (NHMRC consultations 2009; Box 2.4).

All communications should also be underpinned by the ethical codes of the professionals involved. The footnote links below provide some examples of professional codes of ethics and codes of conduct, and a recommended textbook.^{4,5,6}

Box 2.4 Examples of approaches that support interprofessional communication

The **Peel Maternity and Family Practice** in Western Australia is a general practice that provides a coordinated and holistic team approach by GP obstetricians and midwives, with a GP anaesthetist available when required, within a small holistic team. The practice provides comprehensive management from conception through the antenatal period, delivery and during postnatal checkups. This reflects good interprofessional communication between a range of medical practitioners and midwives to meet the needs of women in the area. There is also a free clinic for disadvantaged women in the region. Rosters and regular meetings further improve the communication. (See Appendix 2 for further information about this service.)

At the **Women's and Children's Hospital (Adelaide) Midwifery Group Practice**, midwives have six-weekly case conference meetings with obstetricians to discuss any issues that have arisen, as well as their own weekly meetings. These meetings are all minuted and the minutes are provided to the specialists as a way of maintaining communication links.

At the **Belmont Birthing Service**, midwives meet on a weekly basis to review each aspect of care for the women allocated to them. They exchange information and charts in the format of 'peer review'. In addition to this, midwives, medical staff (including neonatologists) and allied staff meet at the tertiary referral hospital each week to review any complicated cases, including all inductions of labour and caesarean sections.

2.3 Awareness of disciplines and autonomy

Collaboration requires professional roles to be defined and distinct, but also flexible according to the context. For example, GPs and GP obstetricians may have a greater role in rural and remote areas than they do in urban areas (Payne 2002, Jones 2006, Yates et al 2007; NHMRC consultations 2009).

Carefully defined roles create an improved working environment because each professional understands their place in providing the service. This is important because each profession cannot be everything to all women. Each professional needs to foster an understanding of the roles of other maternity care disciplines, including awareness of each discipline's practices, expertise, responsibilities, skills and values (Kryzanoskas 2005, Wilson et al 2005, Matthews et al 2006, Jansen 2008; NHMRC consultations 2009).

Importantly, maternity care professionals should fully respect each other's professional autonomy. As regulated health practitioners, each clinician is responsible for working within and to their scope of practice, as defined by their profession, and in line with their professional and organisational codes and guidelines. Maternity care collaboration does not include one profession controlling the practice of another.

Practising mutual respect for each other's professional autonomy, and developing a consistent approach and consistent information provides those in a collaborative network with the confidence and ability to work together to achieve the best outcomes for mothers, their babies and families (Wilson et al 2005, Matthews et al 2006, Saxell et al 2009; Box 2.5).

4 www.anmc.org.au/professional_standards

5 www.ama.com.au/codeofethics

6 A Jonsen, M Siegler and W Winslade, *Clinical Ethics*, 6th edition, McGraw-Hill, 2006

Box 2.5 Examples of approaches that show interdisciplinary awareness and autonomy

Midwives at the Women's and Children's Hospital (Adelaide) Midwifery Group Practice

can refer directly to obstetricians. Midwives and obstetricians have six-weekly case conference meetings to discuss any issues that have arisen, as well as their own weekly meetings.

The **St George Outreach Maternity Program (STOMP)**, St George Hospital Sydney, provides care for women with two groups of midwives who collaborate as needed with a staff obstetrician. (See Appendix 2 for further information about this service.)

2.4 Responsibility and accountability

When key decisions are made jointly by collaborating professionals, there should be shared responsibility for these decisions. Clearly documenting details of all referrals, consultations and decisions can help avoid any blurring of responsibilities. Joint accountability also helps allay maternity care professionals' fear of being held responsible for something going wrong (Yates et al 2007; NHMRC consultations 2009). The woman and her family also need to know their roles and responsibilities in relation to any decisions they make about their maternity care (NHMRC consultations 2009).

When a woman declines advice, or chooses not to follow recommendations of maternity care professionals, all collaborating clinicians need to respect the woman's decision and provide care for her, even if they disagree with her choice. The carer must be supported professionally and the multidisciplinary discussion regarding the woman's decision should be clearly documented in an appropriate and relevant manner. This prevents the woman being 'abandoned' without care. When a maternity care professional continues a woman's care in this situation, there is an urgent need for professional support. A formal system, such as the 'supervisor of midwives' in the United Kingdom, provides comprehensive and effective professional guidance and support in all areas of practice, but particularly when a woman chooses to reject the advice of a maternity care professional. Many maternity clinicians are strongly in favour of a scheme such as the United Kingdom model being introduced into Australia (NHMRC consultations 2009).

All health care professionals who actively participate in decisions about patient care outcomes are responsible and accountable for their own actions. Shared responsibility for care of women, involving established referral pathways, means improved continuity of care for women and improved ability to meet their needs in short timeframes (Docherty et al 2003, Hadjistavropoulos et al 2003, Huby and Rees 2005, UK Department of Health 2005; Box 2.6). See Chapter 4 for further details on clinical resources to assist collaboration.

Box 2.6 Examples of approaches that highlight responsibility and accountability

Ryde Midwifery Group Practice in New South Wales is a stand-alone service that requires a high level of understanding about responsibility and accountability. The service was highly commended in the New South Wales State Treasury Managed Funds Risk Management Awards.

The **Natural Birth Education and Research Centre** in Lismore in New South Wales is an innovative not-for-profit centre that has the aim of providing more birthing options for women in the Northern Rivers area. It has a framework for midwifery collaborative practice for women and their midwives to ensure a high standard of care. The framework emphasises professional accountability and processes for timely referral and transfer of care to Lismore Base Hospital.

2.5 Cooperation and coordination

Collaborating partners need to make joint decisions about who will be responsible for different aspects of a woman's care. This ensures an integrated plan is implemented in a way that prevents duplication of effort and fragmentation of care. Cooperation and coordination are needed to promote the use of each professional's skills and to improve productivity (Wellingham et al 2003).

Assertiveness also goes hand in hand with cooperation. Respect for one another's professional approach includes being able to present opinions and viewpoints in a manner that fosters the integration of all approaches and results in a solution. The ability of all collaborating partners to speak up about their concerns is critically important for safe, high-quality care (Wellingham et al 2003, Walsh and Gamble 2005).

If all team members or collaborating partners are cooperative and assertive, decisions will be made based on consensus. Each clinician should agree to support each decision and the resulting integrated plan (Docherty et al 2003).

Having a care coordinator who is nominated by the woman and has a respectful leadership approach, and working with, rather than against, personality differences, can improve the way that clinicians work together (NHMRC consultations 2009). Medical practitioners and midwives each have a professional responsibility to collaborate to meet the needs of women and their babies. The responsibility to collaborate in the interests of women is contained in the codes and standards of each regulated profession. Collaborative practice should not discriminate against or deny women care because of their choices.

Creating opportunities for interprofessional learning, regular multidisciplinary discussions, and clinical reviews and audits, improves team dynamics and cooperation. It is important to schedule case reviews, team meetings or forums to accommodate the personal needs of collaborating partners, such as parenting, family responsibility and travel time in rural and remote areas. Regular meetings of all participants in a collaborative network may be relatively easy in an urban area, where travel times are reduced and other staff may be able to assist with clinical duties, but much more difficult in regional, rural and remote areas (NHMRC consultations 2009; Box 2.7). See Section 3.2 for more detail on these considerations in different settings and circumstances.

Box 2.7 Examples of approaches that show cooperation and coordination

The **Kilmore and District Hospital** in Victoria has a shared care collaborative model comprising midwives at the public hospital, consulting obstetricians and the community GP. It also has a relationship with **Northern Hospital** in the case of emergency transfers.

Clinicians at **Northern Women's Community Midwifery Program** and **Lyell McEwin Hospital** in South Australia have regular meetings that include midwives, doctors and social workers. This fosters effective working relationships and reduces clinic waiting times, because some care issues have already been discussed. In the case of higher risk women, the discussion of issues might be increased.

2.6 Mutual trust and respect

Mutual trust and respect are two of the most important factors in successful collaboration and they facilitate all the other elements described in this section (Lane 2005, Wilson et al 2005, Lockhart 2006, Brown et al 2009, Reiger and Lane 2009).

Without trust and respect, cooperation cannot exist. Trust and an understanding of different professional skills and knowledge can facilitate better use of a team's professional expertise. Each provider must be able to depend on the integrity of the other providers as the foundation for professional relationships (Crozier 2003, Dunlop and Holosko 2004).



According to McWilliam and colleagues (2003), building mutual trust and respect among participants in maternity care collaborations:

- enhances productivity by focusing attention on the work
- encourages both individual and group innovation
- reduces feelings that individual participants need to monitor each others' practice.

Another way of building trust and respect in collaborations is by providing opportunities to view the situation from another's perspective, including that of the woman. Some services in the United Kingdom do this as a regular educational activity. Providing positive feedback to collaborating partners can build stronger relationships, fostering further mutual respect and trust (NHMRC consultations 2009).

For maternity care collaborations to be successful in Australia, the culture in maternity services will need to change. The current lack of trust is proving a major barrier. Trust and respect must be earned, rather than just assumed (NHMRC consultations 2009; Box 2.8).

Box 2.8 Examples of approaches that show mutual trust and respect among professionals

At the **Kilmore and District Hospital** in Victoria, the midwives and doctors working within the midwifery practice and hospital appear to have very good relationships, due to the good coordination and cooperation mentioned in the previous examples (Box 2.7).

Aboriginal maternal and infant care workers and midwives at the **Anangu Bibi Family Birthing Program** in regional South Australia value the different roles and perspectives they each bring to the women's care. (See Appendix 2 for further information about this service.)

2.7 Policy, procedures and protocols

Services should be developed in line with policy directions and general principles that place women, children and families at the centre of care. Policy, procedures and protocols should be based on evidence of their effectiveness in meeting the needs of women and families. Policies that promote open communication and decentralised decision making facilitate trust and collaborative relationships among local networks (Dunlop and Holosko 2004, Reiger 2006, Homer et al 2009). Publicly available health outcomes for each service would provide a transparency of reporting and would contribute to greater trust in the service (NHMRC consultations 2009).

Consistent facility or service policies and standards help create an environment where staff have predictable expectations about standards of care and procedures for consultation and transfer (NHMRC consultations 2009). User-friendly guidelines, policies, protocols and procedures facilitate nationally consistent practice and can encourage providers to work within their scope of practice. It is essential to establish transparent protocols and documented responsibility that matches the scope of practice (Kryzanskas 2005, Main and Bingham 2008; NHMRC consultations 2009). Clear memoranda of understanding between services would also be useful to provide an overt statement of capabilities and roles (NHMRC consultations 2009).

A woman's physical, social and psychological needs should be taken into account in the development of guidelines, protocols and procedures (WA Department of Health 2007; NHMRC consultations 2009). All partners should be involved in the development of such policies and procedures, including consumers where possible. All clinicians should agree on any guidelines or guidance (including format and content), while adhering to the standards of their relevant professional bodies. Guiding resources and any models of collaborative care should allow flexibility so that they remain appropriate in different contexts (NHMRC consultations 2009).

Collaborating partners may be required to audit how guidelines, clinical care and the collaboration itself are implemented in their services (Atwal and Caldwell 2002; NHMRC consultations 2009). This may comprise three tiers of auditing: informal clinical reviews of both positive and adverse outcomes, morbidity and mortality reviews, and assessment of more critical adverse events. These audit processes should create an environment of transparency of practice and involve all maternity clinicians regardless of practice setting (NHMRC consultations 2009).

Audit processes that highlight and celebrate good outcomes, especially the ‘unexpected or unusually good’ should be captured in any review of clinical outcomes (NHMRC consultations 2009). An approach of ‘appreciative enquiry’ is recommended for reviews—this approach focuses on positives and what works in an organisation in terms of problem solving. This is opposed to the more usual approach of looking for problems (NHMRC consultations 2009).

As mentioned in Sections 2.1.1 and 2.1.2, collaboration requirements relating to the discharge of a woman and her baby back to the community need to be strengthened. This includes stronger linkages to a woman’s GP, community services or allied health professional services, where relevant and appropriate (NHMRC consultations 2009; Box 2.9).

Box 2.9 Examples of approaches that show the use of policy, procedures and protocols to improve collaboration

Under the **Healthy for Life Program**⁷ funded by the Australian Government, over 80 primary health care services operate through more than 50 sites with the aim of improving the health of Aboriginal and Torres Strait Islander mothers, infants and children (as well as aiming to improve chronic disease care). The Healthy for Life Program allows time and resources for health services to review child and maternal health service delivery and identify areas for improvement. It recognises the importance of factors such as infrastructure to support linkages between services like community health centres and maternity hospitals. It also allows for service providers to come together and share information and learn from each other’s experiences.

The **3Centres Collaboration** is a multidisciplinary collaborative network of midwifery and obstetric leaders from the three tertiary maternity services in Victoria (**Royal Women’s Hospital, Mercy Hospital for Women and Monash Medical Centre**). The collaboration has developed evidence-based guidelines for the provision of antenatal care for women with low-risk pregnancies. The collaboration has also audited the implementation of the guidelines within their own services.

At **Northern Women’s Community Midwifery Program** in South Australia, women are screened using an antenatal risk assessment (from the **Lyell McEwin Hospital**—the collaborating hospital service). This allows the woman’s care to be identified as being midwifery, obstetric or multidisciplinary. The midwife always accompanies the woman to hospital and has regular meetings with other clinicians to coordinate care. The practice has a caseload of women from diverse cultures, who are often socially and economically disadvantaged. Clear policies are used to ensure effective collaboration and continuity of care.

2.8 Interprofessional learning

A barrier to effective collaboration may occur when team members do not understand each others’ scope of practice (see also Sections 2.3). One way to break down this barrier is through interprofessional learning, which can help build trust and establish collaborative working relationships. An aim of this learning is to develop skills, knowledge and attitudes that can be used in interprofessional decision making and problem solving. Another aim is to dispel stereotypes and prejudices, which often get in the way of collaboration (Curtis et al 2006). Improving trust in and understanding of others’ professional skills and knowledge enables each provider to better use the expertise of others (Crozier 2003, While et al 2006, Jansen 2008; NHMRC consultations 2009).

7 www.health.gov.au/healthyforlife



In essence, interprofessional learning should aim to improve the quality of maternity care by developing a shared philosophy and by promoting teamwork. The needs of women should be at the centre of this approach (Crozier 2003).

Interprofessional learning should help maternity care professionals to develop a greater understanding of roles within a collaborative team and of their own roles. Through this learning, clinicians can further develop the skills required to work collaboratively, making referrals between providers more effective. Important components of interprofessional learning are clinical expertise and shared professional competencies. A valuable example of interprofessional learning is joint maternity and neonatal emergency training (Walsh and Gamble 2005; NHMRC consultations 2009).

Involving consumers when planning professional development programs can help providers to see the value of including consumers in the collaborative process (Lane 2005). The exploration of the differences within clinical cultures should help clinicians to agree on best practice (Saxell et al 2009).

Having consistent expectations about the level and standard of education activities for all collaborating partners helps to build trust, manage risk effectively and improve compliance with standards and competencies (Statham et al 2003; NHMRC consultations 2009; Box 2.10).

Box 2.10 Examples of approaches that support interprofessional learning

King Edward Memorial Hospital in Perth provides a multidisciplinary obstetric emergency drill 'In Time' course. This course includes group learning workshops and reflective practice on aspects of clinical care that should be implemented during an emergency, such as those involving advanced life support, maternal collapse, pre-eclampsia and eclampsia, postpartum haemorrhage, breech presentation, shoulder dystocia and cord prolapse. This theoretical learning is followed by practical semi-simulated drills.

Victoria's **Maternity Emergency Education Program**⁸ delivers multidisciplinary, team-based training, enabling each participating hospital to hone team responses to obstetric emergencies. The Pregnancy Care Program provides opportunities to refresh and improve skills, particularly for midwives, to enable all professionals to work fully within their scope of practice.

The **ALSO (Advanced Life Support in Obstetrics)**⁹ course is used in New Zealand, the United States, United Kingdom and Canada. It has been adapted and modified for Australia and is now used widely in many Australian jurisdictions.

2.9 Organisational support

Organisations should provide support, financial assistance and leadership to facilitate changes to work practices. Support could include educational opportunities, sufficient meeting time to allow good communication, shared learning and team building. Study days and stress management strategies, organised flexibly as part of shared governance, can assist providers to cope with the added load that is part of implementing collaborations (West and Sacramento 2004).

Any maternity care collaboration must have organisational support, including the information, resources and opportunities to enable providers to deliver holistic care to women. Collaborating teams need to be integrated into the broad clinical governance structure of any organisation and members need to understand their roles (Walker et al 2004).

Evaluation and audit will also be required to provide feedback on team performance, patient benefits and net costs. Goal-setting plans are helpful for evaluating both progress and changes to women's needs during their care (Atwal and Caldwell 2002, Keleher et al 2002,

⁸ www.health.vic.gov.au/maternitycare/progs.htm#pcmeep

⁹ www.also.net.au

Wellingham et al 2003, Simoens 2004; Box 2.11). Evaluation and audit of clinical and collaborative indicators, using standardised data collection and reporting mechanisms, facilitates continual quality and safety improvement. These data, if standardised and shared beyond individual organisations or jurisdictions, can allow more informative comparisons, more effective scrutiny of approaches and wider improvements in the varying services across Australia (NHMRC consultations 2009).

Box 2.11 Examples of approaches that show organisational support

The model of care provided by **Ryde Midwifery Group Practice (MGP)** at Ryde Hospital in New South Wales (see Box 2.6) reflects organisational support of midwifery care as a safe alternative to tertiary hospital-based obstetric care. The MGP has a supportive obstetrician and gynaecologist at Royal North Shore Hospital, where women can be transferred if necessary. The collaborating partners use the United Kingdom National Institute for Health and Clinical Excellence and ACM guidelines for consultation and referral (Demott et al 2006; NCCWCH 2007, 2008; ACM 2008). The Royal North Shore Hospital supports continuity of care and shows flexibility for clinicians and women, based on agreed guidelines and policies about a woman's care.

Kilmore and District Hospital participates in the obstetric registrar training program at the Northern Hospital in Epping. Northern Hospital registrars attend the Kilmore and District Hospital antenatal clinics and provide some of the on-call service for the district. This builds relationships between staff at the two sites and provides valuable multidisciplinary and clinical experience for the registrars. (NHMRC consultations 2009, 2010)

Optimising the processes of care for a woman needing an urgent caesarean section is an important aspect in the provision of safe maternity services. Good team work is vital. Clinical audit is an important component of monitoring and improving these processes and many maternity units throughout the country audit their decision to delivery times to monitor these processes. At the **Women's and Children's Hospital** in Adelaide, a specific session is included in the orientation program of obstetric and anaesthetic registrars, where a senior anaesthetist, obstetrician and midwife work through the various issues involved in organising urgent caesarean sections with group activities. In addition, there are monthly multidisciplinary clinical review meetings where these cases and any management issues are discussed. These forums have been very beneficial in developing better teamwork and communication.

Source: Provided by the Australian and New Zealand College of Anaesthetists (ANZCA).

2.10 Systems

In addition to core organisational support, facility services and teams require several systems to maximise collaboration and achieve good patient outcomes. These include:

- information sharing systems (Yates et al 2007)
- recall and reminder systems (Yates et al 2007)
- reporting systems for administration (Knight 2004)
- financial systems (Wellingham et al 2003)
- inhouse review of performance and continuing improvement (Wellingham et al 2003)
- education and quality improvement activities, and the time to attend them (Wellingham et al 2003)
- a single clinical record to capture all aspects of care, decisions and advice, ideally held by the woman (NHMRC consultations 2009)
- a database or electronic record (e.g. ObstetriX)¹⁰ to provide a shared clinical record (NHMRC consultations 2009)
- effective discharge records and communication systems for maximising collaboration (NHMRC consultations 2009).

¹⁰ Currently being trialled and developed by the New South Wales Government Department of Health, www.health.nsw.gov.au/pubs/2007/pdf/dom_voil_snap_28-40.pdf (Accessed 17 February 2010)



Many practices require extra funding and support to develop skills and find time for developing and managing these systems (Hadjistavropoulos et al 2003; Box 2.12). Practices also need direction and support for the training of their staff members in these processes (McWilliam et al 2003, Wellingham et al 2003).

Box 2.12 Examples of approaches that show the use of supporting systems

A multidisciplinary **Fetal Surveillance Education Program** is being implemented to promote correct and evidence-informed use of technology and the accurate interpretation of results in circumstances where intrapartum fetal surveillance is required. The program, auspiced by RANZCOG, is available nationally.

Several services and practices have educational and quality improvement activities; for example, RANZCOG has **detailed information sheets for women about various aspects of care**. The obstetrician gives these to the woman, and a sticky label from the information sheet is pasted in her record to show that the information has been provided.

At the **Mercy Hospital for Women in Melbourne** women are given a questionnaire antenatally to complete, either by the booking clerk or a midwife, which is specifically designed to identify potential anaesthetic issues. A nurse screens these questionnaires and consults with one of the anaesthetists to decide which women require anaesthetic review in the antenatal period or notification when the woman is admitted in labour. The antenatal review process assists in the multidisciplinary planning for delivery of women with significant issues. Examples of these issues include morbid obesity, substance abuse and cardiac disease.

An alerting function process has also been developed, which is linked to the electronic patient admission process. When a woman is admitted who requires notification to an anaesthetist (e.g. a woman with cardiac disease) the admission clerk is alerted to contact the Duty Anaesthetist. This simple process has assisted in ensuring more timely consultation with anaesthetists for these labouring women and improved the communication between other members of the birthing suite team and anaesthetists.

Source: Adapted by Australian and New Zealand College of Anaesthetists, from Lewis (2007).

Some reports have highlighted the need for training environments that provide adequate and appropriate training for emerging models of collaborative care (AHMAC 2008:7).

It is also important to acknowledge and separate system issues (e.g. access arrangements with private and public hospitals) and collaboration issues. Individual clinicians may strive to practise collaboratively, but are often impeded by existing models of care, systems, and national, jurisdictional or service policies (Thompson et al 2008).

Another critical issue is the possible financial disincentives for health professionals, either related to providing referral consultations or the possible transfer of a woman's care. This is a potential barrier to effective maternity care collaborations (NHMRC consultations 2009). Collaboration should also not create a financial disincentive for women by creating more consultations, but rather an appropriately streamlined continuity of care.

3 Establishing collaboration

To improve collaboration within Australia's maternity sector, the needs of women and maternity health care professionals must be met within the public and private sector, in rural, remote, regional and urban settings, and in all states and territories—this is a challenge. Box 3.1 lists key areas that need to be addressed when establishing a collaboration.

Box 3.1 Key areas to consider when establishing collaboration

- Define or clarify the service delivery context.
- Clarify the services and skill mix of the collaborating partners.
- Identify issues for women within this context, ensuring flexibility to meet the needs of individual women on a case-by-case basis.
- Identify how collaboration can work.
- Identify the 'service' policies or issues that might need to be negotiated or addressed (access rights, credentialing, audit and peer review, professional development, etc.).

Source: Way et al (2000); NHMRC consultations (2009).

Each of these key areas is described in more detail in Section 3.1. The remainder of this chapter describes a range of practical issues that need to be considered by maternity care providers and hospitals in all settings (Section 3.2), and that are specific for different settings (Section 3.3).

3.1 Steps to establishing collaborative practice

As discussed in Chapters 1 and 2, the model for maternity care that is being promoted in most developed countries is that of woman-focused, midwife-led primary services underpinned by a collaborative services framework that ensures appropriate assessment, timely referral and access to secondary and tertiary services. Under such arrangements, women can be referred as required to secondary or tertiary-level services that provide a higher level of medical care. These services may be provided at the same health care facility or through the transfer of the woman to another health care facility, either antenatally, during labour or in the postnatal period (Morano et al 2007, Sandall et al 2009).

When establishing collaboration, it is important to consider each of the issues in this chapter, particularly those that are relevant to the service context. These steps will facilitate collaborations that are uniquely suited to the woman, the setting, and the skills and preferences of the clinical collaborating partners. Each step is discussed in more detail below.

3.1.1 Define the context of service delivery

A woman's location and the local population will influence her needs during pregnancy and birth. Local legislation and policies can influence the nature of the services offered in different localities. It is important that these are taken into consideration so that a woman is able to give birth as close as possible to her place of residence, if that is her choice. Health care providers should consider the regional setting (i.e. metropolitan, rural or remote) when defining the context of service delivery and whether the woman belongs to a specific population group. For example:

- an Aboriginal or Torres Strait Islander community
- a particular socioeconomic group that may require specific attention
- a culturally or linguistically diverse group.



Other logistics, including the physical location of the service partners (who may be in a single centre or in different locations over a large rural area) and the nature of the facilities available (e.g. buildings, resources, transport, access to other specialist services) will also affect any collaboration.

In Australia's more remote areas, the availability and time taken for transport will affect a woman's access to services and decisions about care. Models of care will also need to adapt to the local circumstances; for example, GP obstetricians and outreach services have a greater role in rural settings.

For more information on context-specific considerations, see Sections 3.2 and 3.3.

3.1.2 Clarify the services and skill mix of partners

An important step in establishing collaboration is for collaborating partners to acknowledge each other's scope of practice and expertise, recognising professional competencies, roles and responsibilities. The collaborating partners should identify the knowledge, skills and preferences that each brings to the practice, so that they can decide who will do what, under what circumstances. If a woman has a regular GP, he or she should also be acknowledged when establishing collaboration. With the woman's permission, background health information may be obtained, and communication should be maintained with her GP, especially when establishing links back to the community to help provide continuity into postnatal care.

Listing the primary, secondary and tertiary health care services that might be used in specific circumstances can be a useful process.

When reviewing the roles of various maternity care providers, it is important to consider both the gaps and overlapping strengths of each group, with the aim of providing the woman with optimal continuity of care. A memorandum of understanding, including a clear statement of capabilities and roles, may be required between services.

3.1.3 Identify general and specific issues for women in the service region

After defining the context of service delivery and clarifying the services and skills mix of partners, it should be possible for the collaborating partners to identify issues that affect women accessing maternity care in their geographical or service region. It is also important that the women are included in the planning process. Some examples of general and specific issues are listed below:

- Consumer representatives should be recognised as collaborative partners in the development and ongoing oversight of maternity services.
- In Aboriginal and Torres Strait Island communities, elders should be acknowledged and included as part of wider planning processes for maternity care. In some cases, the woman's family and community may be involved in her individual care, because women may defer to their elders.
- If a woman is transferred to a secondary or tertiary service, family members may need to travel long distances to provide support.
- Women may be reluctant to enter hospital without a known carer, may be concerned about how they will be treated in hospital or may have had traumatic experiences relating to hospitals and giving birth.
- Women whose first language is not English may need access to an interpreter or additional family support. The cultural suitability of interpreters should also be considered, to ensure that the woman feels in control as far as possible, to enable her to have a safe and positive pregnancy and birth. Where possible, printed information should also be made available in the woman's language.
- When caring for a woman with complex needs (such as lower socioeconomic status, substance use, isolation or known domestic violence), the collaborating partners should identify other services to provide support, especially support that will continue beyond the early postnatal period. The availability and options for accessing these services should be discussed with the woman.



3.1.4 Identify how collaboration can work

To establish and maintain collaboration, the following questions need to be addressed:

- Who will be the coordinator of care?
- How will you communicate? (For example, weekly, fortnightly or monthly updates by teleconferences, physical meetings or case conferences).
- Given the local context and needs of the woman and clinicians, what are the issues that need to be addressed? For example:
 - Are arrangements in place for all partners to contribute to decision making and to share responsibility?
 - Is there a care plan that can be carried out in a manner that reduces duplication and fragmentation of care?
 - Have clinicians fully considered needs of the woman, the ‘team’, the operational logistics and the policies of their area of practice?
- How will collaborating clinicians record and document the woman’s maternity service history, and communicate this record to other carers in the collaborative network? (See comments on woman-held records in Sections 2.1, 3.2.2 and 4.3.1).
- What are the opportunities for case conferencing, clinical review and clinical audit?
- What are the opportunities for joint professional development and peer review?

3.1.5 Negotiate service policies, activities and issues

It is not just midwives who should participate in these activities and assume that GP obstetricians and specialists are already involved.

A wide range of services across Australia provide maternity care with many health care professionals. There are variations between jurisdictions, and collaborating clinicians may encounter many different policies, procedures activities and issues. This can be particularly challenging for health carers who work in collaboration with several services, individuals and possibly across jurisdictions.

As previously mentioned, it is important to clarify roles. Collaborating partners may have varying experiences of different procedures or systems, so as part of the process, the professionals (and services where relevant) need to negotiate policies, activities and issues to ensure consistency and to avoid potential conflicts created by any misunderstandings. See Box 3.2 for an example of establishing a collaborative maternity unit.

This negotiation may include access to procedures for documenting informed choice, care pathways and an agreed referral and consultation guideline.

All professionals providing maternity care in collaboration with a local service must participate in activities such as:

- audit and peer review
- professional development
- clinical privileging for access to hospitals for all stages of care
- joining any credentialing processes and activities provided by a hospital or service.



Box 3.2 An example of establishing a collaborative maternity unit

Nambour Selangor Private Hospital Maternity Unit, on the Sunshine Coast in Queensland, started with a collaborative model of care. The obstetricians and midwives were united in the view that the best care for women came from different health professionals bringing different skills for woman-centred care.

The maternity unit protocols and policies were developed collaboratively from best current evidence, with input from all staff working in the unit and other interested parties. There were many disagreements in this process, but working together provided a good experience for professionals in learning and understanding each others' points of view. As the unit evolved, the policies have been regularly created and reviewed, leading to the development of a waterbirth policy, postnatal depression clinic and links with antenatal education, all of which are multidisciplinary and use a collaborative model.

3.2 Considering collaborative care: issues common across regions and services

For collaboration to be effective, a number of detailed systems and protocols need to be considered by maternity care providers and hospitals in each care context. Contributors to the Guidance have identified the following issues based on the principles of maternity care collaboration described in Chapter 1 (Box 1.2):

- roles and responsibilities
- shared documentation
- transfer plans
- care pathways
- access to hospitals
- credentialing
- hospital bookings
- admission status
- postnatal care
- competition
- dealing with conflict.

Collaborative care can be provided across primary, secondary and tertiary levels and models of maternity care (noting that the responsibility for care and the collaboration between maternity care providers may impact the above differently).

Within each issue, there are considerations common to all settings and particular to specific settings. This section discusses these issues in terms of how they need to be applied across most settings. Section 3.3 provides specific information relevant for each of the main settings and areas where collaboration might occur. Key definitions are shown in Box 3.3.

Box 3.3 Access to hospitals

Clinical privileging is the process by which a health care professional is granted permission by a health service (e.g. a hospital) to provide care services within defined limits. These limits are based on an individual's qualifications, experience and registration status.

Memoranda of understanding (MOU) provide a written statement of agreement about the roles and functions of, for example, a hospital or health service and the visiting midwife. It will highlight their joint commitment to women's care and agreed objectives of both parties to achieve this care. For an example of an MOU, see Box 3.6.



3.2.1 Roles and responsibilities

The roles and responsibilities of each collaborating partner should be clearly defined, and the maternity care coordinator should be identified, as nominated by the woman receiving care. Members of the collaboration may include Aboriginal health workers, midwives, obstetricians, a woman's GP, allied health workers, community services and other specialists depending on the situation. Referrals and transfers may also occur across the spectrum of primary, secondary and tertiary services. Reciprocal communication in a timely manner is expected regardless of the setting to provide best practice continuity of care, including the woman in these discussions. Where possible, a woman's care coordinator should maintain their role in her care.

Relevant accountability, legal liabilities and health insurance issues should be clarified with the service, jurisdiction or insurance provider. This should include how these issues may affect each collaborating partner's roles and responsibilities in each setting or circumstance.

Doulas, strong women workers, and family who may be supporting the woman should discuss her preferences for care, expectations and legal or consent requirements in case they arise. For further discussion of choice, consent and the responsibilities of women, see Section 2.1.

3.2.2 Shared documentation

Shared and reciprocal documentation, including some form of woman-held record, will ensure that all members of the collaboration are aware of essential information throughout the episode of care. Several jurisdictions in Australia regularly use woman-held records, such as New South Wales, Victoria, Queensland, South Australia, and the Australian Capital Territory.

Electronic or triplicate records allow sharing of accurate documentation and also reduce duplication of effort, enabling more streamlined care for women.

Electronic records in the form of web-based or e-health records, or a USB stick, may be other possibilities for storing and transporting records, although it must be saved in a generic format so it can be accessed without needing specific software programs.

3.2.3 Transfer plans

Transfer plans identify who the collaborating partners are and what the plan is, if or when a woman's care needs to be relocated or escalated. They include agreement on consultation and referral guidelines, transport plans, and methods for documenting any consultation and transfer.

3.2.4 Care pathways

There should be documented pathways of primary, secondary and tertiary clinical care. Plans should identify and address any potential barriers to continuity of care.

3.2.5 Access to hospitals

Midwives, particularly private practice midwives, will need access to all hospitals at which they intend to practice for prenatal, intrapartum and postnatal care of women. Services and hospitals will need processes to allow access for midwives in line with the principles of collaborative maternity care.

MOUs are a possible mechanism for services to negotiate hospital access with midwives. These could operate in a similar way to hospital clinical privileging processes where midwives are able to practise at the hospital within defined parameters.



A good hospital access process should include:

- establishment of visiting rights
- clarification of the scope of practice
- clarification of access to allied health services
- adherence to policy and procedures
- auditing and peer review
- professional development.

Standardised mechanisms for hospital access and clinical privileging should be established within as broad a jurisdiction as possible (i.e. statewide, within-area health services or districts). This can enable better access for midwives, and facilitate women's access and continuity of carer.

3.2.6 Credentialing

In the midwifery profession, credentialing is generally understood to be a process undertaken through a professional organisation by an individual to ensure they meet competency standards, or in some cases, advanced practice. Generally, credentialing has not been used in relation to hospital access as it is for the medical profession. However, in some jurisdictions it may be one way to establish midwives' access to hospitals.

For example, in 2005 the New South Wales Department of Health established a formal process through its Credentialing Framework to verify and evaluate the qualifications and experience of midwives. This framework is designed for employed midwives working in midwifery services, such as Ryde Midwifery Group Practice. In New South Wales, this framework is administered by the NSW Branch of the ACM. Whatever the context of the credentialing, the process is aimed at ensuring a high standard of practice and safe care. As part of the department's scheduled policy directive review, the framework is being re-evaluated in the context of current midwifery and maternity services in New South Wales.

3.2.7 Hospital bookings

All women should be advised to book into a hospital, regardless of their birthing plan. There should be no implication that this will be a required step; however, booking ensures continuity of care and facilitates transfer and escalation processes, when required.

3.2.8 Admission status

The admission status of the woman (as a private or public patient) should be clarified with the service (and insurer if appropriate) at the time of booking.

3.2.9 Postnatal care

There should be clear opportunities for communication with, and transfer to, the woman or her family's local health and wellbeing service community, including GPs, maternal, family and child health nurses, and early childhood and community services. Unfortunately, birth often creates a disconnection between services, service providers, records and facilities, particularly in rural and remote areas (PMSEIC 2008).

3.2.10 Competition

There may be real or perceived competition between maternity health professionals (Reiger 2006). Even a perception of competition has the potential to damage trust or influence professionals who are part of the credentialing process to refuse access to hospitals for others (ACOG 2007a; NHMRC consultations 2009). It is important that all professionals prioritise woman-centred care, and recognise the importance of working together respectfully to support a woman's choices. Appropriate

mechanisms for addressing this risk must be considered by both the professions and the jurisdictions.

3.2.11 Dealing with conflict

Due to many of the issues previously discussed in this Guidance, collaboration can be a challenge. Due to the complex interaction of morals, ethics, laws, policies, cultures, as well as the ways they can be interpreted by each individual, there are many areas where conflicting opinions may lead to disagreements (Brown et al 1999, Weaver et al 2005). In turn this could potentially result in a breakdown of collaboration, poorer outcomes for women and their babies, and create tension in the working environment for maternity care professionals (Farmer et al 2003, Brooten et al 2005, Reiger 2006). Acknowledgment that these hurdles may be faced is the first step towards overcoming them:

... Dysfunctional collaborative practice is characterised by inconsistent philosophical and organisational structures for behaviour (Brown et al 1999).

Other sections of the Guidance discuss issues such as providing comprehensive information to inform care choices and respecting women's decisions, documenting histories and care plans, interprofessional education, mutual trust and respect, and other strategies that, when properly implemented, may reduce the chance of encountering these difficulties. This section discusses what can be done if this doesn't work.

One personal conflict many carers face is what they should do when their own moral, ethical and cultural beliefs do not align with the woman's wishes (FPA Health and Read 2006). Religious or moral objection or refusal to treat needs to be used responsibly and with careful consideration of a woman's right not to be abandoned, so as not to put her in danger, constitute discrimination or perpetuate inequalities (Harris 2000, NHMRC 2006, ACOG 2007ab, Tonti-Filippini 2008). In this situation, care should always be transferred to another professional or it could have serious consequences for the woman and baby's health, increase costs, decrease access to services and be a significant barrier to a good outcome (NHMRC 2006; NHMRC consultations 2010):

... virtues such as prudence, fairness and trustworthiness enable clinicians to apply ethical principles sensitively and wisely in situations of conflict. [In] women's health care there must be particular sensitivity to the needs of women (ACOG 2007a:3).

As the refusal to treat may also have an effect on professional relationships, this potential impact should also be considered (ACOG 2007a). While formal dispute mechanisms are a well known way to record grievances or complaints, communication can often avoid the need to use them. Any objection and the reasoning for it should be discussed with members of the collaboration, so that they can improve understanding of each other's perspectives and gain insight into why one person in a collaborative team may choose to stay with a woman who does not follow their advice, and why another may refuse care. This communication offers the opportunity to build these considerations into practice, recognising and clarifying expectations, and reducing the risk of misunderstandings or misinterpretations of written plans in the future (Dunlop and Holosko 2004, Weaver et al 2005, Medves et al 2006, Reiger 2008). Services should also evaluate their policies to reduce the chance that they put practitioners in difficult situations so they may feel the need to refuse treatment (ACOG 2007b):

Refusals that unduly burden the most vulnerable in our society violate the core commitment to justice in the distribution of resources (ACOG 2007b:4).

Women want carers who provide them with consistent information, who respect their autonomy, show concern for their comfort and wellbeing and are nonjudgemental (Becker et al 2009). The best outcomes can be achieved by communicating why a recommendation is made, doing so in an appropriate empathetic manner, and allowing women appropriate time to make informed decisions (Brooten 2005, ACOG 2007a, Faunce 2008, Becker et al 2009). Woman-centred care using this approach has also been shown to reduce complaints and litigation (Baird 2008).



Box 3.4 An example of conflict in the workplace

As the Nambour Selangor Private Hospital Maternity Unit (Queensland) grew, difficulties arose in trying to maintain a coherent model of care. Some issues included:

- orientation problems for new staff
- challenges regarding governance based on individual personality differences
- several professionals wanting to practice using a non-evidence based approach
- disagreement between different team members about when collaboration should take place.

The unit established effective governance and leadership, encouraging a willingness to compromise, and regular audit processes. These have been critical in ensuring better outcomes and good staff morale.

Box 3.5 Example of collaboration influencing cultural change in maternity care

The Canadian Multidisciplinary Collaborative Primary Maternity Care Project (MCP² Project) detected positive changes in attitudes towards liability and collaborative care over time. At the start of the project, participants identified liability as a barrier to collaboration; however, several participants interviewed at the end of the project said liability would be less of a concern with collaborative teams because of better communication within the team. Teams need to understand how the team will function and that includes discussions of structure that may be uncomfortable for professionals who have worked in hierarchical structure and are used to being in charge.

Source: Multidisciplinary Collaborative Primary Maternity Care Project, Canada (NPMCC 2006).

3.3 Considering collaborative care in different settings

In addition to the issues described in Section 3.2, a range of issues need to be considered for specific service settings. This section describes issues that are specific for the major settings where maternity care collaborations are likely to occur.

3.3.1 Issues for midwives working privately

Roles and responsibilities

Private practice midwives are contracted by individual women for their maternity care. Depending on the woman's needs, there may be many different opportunities for the midwife to collaborate with other practitioners, services and hospitals. This will require clarifying roles and responsibilities in relation to the woman and the midwife's expectations and all collaborating partners.

Shared documentation

Some private practice midwives develop their own women's notes or maternity records, while others use existing state or territory services' maternity records. Some jurisdictions have developed a set of midwifery notes specifically for clients of private practice midwives. For example, Queensland Health has developed a record that contains duplicate copies of all the woman's notes. To maximise safe care it is essential that everyone involved in the woman's collaborative care have an up-to-date record of the woman's history, relevant issues and care to date.

Access to hospitals

Under new legislation for eligible midwives, more private practice midwives will have the opportunity to care for women in hospitals. Currently, most private midwives are not able to continue as the woman's primary carer in the event of transfer during labour. One mechanism to enable this could be through an MOU (see Box 3.3).



Hospital bookings

As in any setting, all women who are clients of private practice midwives should be encouraged to book into a hospital to ensure smooth processes in the event of transfer in labour or if consultation or referral during the pregnancy is needed.

Postnatal care

Private practice midwives generally provide very comprehensive postnatal care in the community. Productive collaboration with the woman's usual GP and women, family and children's community services will ensure a smooth transition for the woman to these services once she is discharged by the midwife.

Box 3.6 Example of private midwives collaborating with a public hospital

To ensure the safest care for clients of private practice midwives, Toowoomba hospital staff and the midwives are currently developing an MOU. It covers a number of aspects related to consultation and referral, exchange of information (e.g. around the midwife obtaining client test results) and the woman's booking in arrangements. This information sharing is always done with the woman's consent. The MOU will foster positive relationships between hospital staff and the private practice midwives by enhancing communication opportunities such as private practice midwives attending hospital skill update sessions and regular case review meetings.

3.3.2 Issues for nongovernment organisations or Aboriginal medical services

Roles and responsibilities

Aboriginal health workers providing antenatal and postnatal services have a key clinical and educative role and work in collaboration with other maternity health professionals. This needs to be recognised when collaborating with larger hospitals and may mean clarifying roles and responsibilities between all care providers, including those of a selected position rather than a named individual.

A transfer plan

For some women, particularly Aboriginal or Torres Strait Islander women, there may be significant issues involved in transferring care to another location in terms of culture, language, separation from community and feeling unsafe in unfamiliar surroundings. These issues should be discussed with the woman or her community early in the pregnancy.

Access to hospitals

Consideration should be given, particularly in rural or remote areas, as to how ambulance services or other transport can be accessed and how transport may affect hospital access if any part of labour occurs in a woman's home.

Care across regions

Often services are linked to particular communities that may cross state or territory borders. This can create issues around different jurisdictional regulations. Funding for nongovernment services can also be structured differently to funding for other services within the same jurisdictions and needs to be considered to ensure clients are not disadvantaged.

3.3.3 Rural and remote areas

One-third of Australian mothers live outside major metropolitan areas. Providing maternity care for women living in rural and remote areas is an important issue for maternity services (ACRRM et al 2008:2) and there is very little choice of care for women in these areas. Birthing 'on country' (i.e. when women are able to stay in their communities) is a big issue for many women and their care providers.



Maternity service provision in more rural and remote settings rely on linkages with other providers such as community health centres and maternity hospitals. While some centres may have access to community midwives and/or an Aboriginal Medical Service, many women in more remote locations have to access services by plane, long drive (or both), and in unfamiliar surrounding with limited family, cultural and social support. Figures indicate that approximately 23% of Aboriginal and Torres Strait Islander mothers were transferred for birth compared to 3% of non-Indigenous mothers (QLD Health (2007) Perinatal Statistics 2005, cited in the PMSEIC report). See Barbara's story in Appendix 2 for a first-hand example of this situation.

Care providers may find that their recommendations are not followed if the woman makes an informed choice to stay in the community. Often these choices are based on other risks that are important to the woman around cultural needs or requirements for the safety of other children. Care must continue to be provided for these women and the primary care provider may need additional support from her collaborating partners. When a woman must leave her community, it can create many social and cultural problems that have to be addressed in addition to clinical needs (Nel and Pashen 2003; NHMRC consultations 2009).

The *National Consensus Framework for Rural Maternity Services* (ACRRM et al 2008) sets out the principles for policy and planning to support quality maternity services in rural Australia. The framework was established by consensus among core professional organisations providing maternity care.

A rural context highlights the importance of flexibility in collaborative care models. The framework does not endorse a single approach to rural maternity services, but encourages flexible approaches that recognise the realities of rural settings. In a rural or remote area, it may be particularly important to clarify the service and skills mix of the available team members. Rural maternity settings also need to have reliable information and communication technologies to facilitate specialist advice and support.

The framework also emphasises that rural and remote maternity care must be based on models and evidence that is appropriate to rural and remote settings, rather than imposing models that may be successful in urban settings. Particular service issues in rural and remote areas include coordinating emergency retrieval services and transportation, and ensuring that women have access to safe maternity care, consistent with their assessed level of risk, as close as possible to where they live. Even if birthing services are not available in the community, antenatal and postnatal services should be accessible.

These considerations have implications for a range of collaboration issues:

Local context

It is important that local health care arrangements and limitations are taken into account, particularly for rural and remote areas (e.g. blood bank, secondary and tertiary arrangements). Consideration should also be given as to how ease of access to ambulance or other transport may affect hospital access if any part of labour occurs in a woman's home. Distance and travel time should be taken into account for any transfer processes, and arrangements planned well in advance.

Roles and responsibilities

The roles and responsibilities of each collaborating partner should be clearly defined, and the maternal care coordinator identified. Due to workforce shortages and high turnover, especially in rural and remote areas, it may be more practical to establish the collaboration with a selected position (e.g. 'consultant on duty'), rather than a named individual clinician. Members of the collaboration might include doulas, Aboriginal health workers or strong women workers, as well as midwives, obstetricians, hospital personnel and district medical officers.



Transfer plans

Any collaboration will need to reflect the reality of practice in rural and remote care. Transfer of care may look different in these settings as care will often remain with the midwife or nurse in close communication with specialists or GP obstetricians.

Shared documentation

Records may be harder to share if there are significant travelling distances involved. This is where a woman-held record is particularly useful for ensuring that communication reaches all collaborating professionals.

Care pathways

Documented pathways of primary, secondary and tertiary clinical care should include escalation processes, referral guidelines and transfer plans (e.g. the Perinatal Emergency Referral Service in Victoria). These plans are crucial in rural and remote areas. They should identify and address any potential barriers to continuity of care.

Access to hospitals

Midwives in private practice may need access to hospital(s) for prenatal and postnatal care, and for intrapartum care. Midwives need to have visiting rights within all hospitals at which they intend to practice. Particularly in the case of rural and remote areas, midwives may work across a number of regions containing a number of hospitals. It may be worthwhile for hospitals and services within a region to make mutual arrangements and joint policy to ensure consistency and ease of access for midwives and their clients.

Hospital bookings

All women should be advised to book into a hospital, regardless of their birthing plan, as early booking ensures clear transfer or escalation processes, if they are required. In rural or remote areas, there may need to be a booking pathway system, where hospitals that are unable to provide maternity services on a particular day are succeeded by the next hospital in the region. Details of availability or closures of maternity services should be readily available both to women and maternity care professionals.

Advice

Rural and remote health care personnel need to have access to timely, relevant and useful advice from peers working in larger or more metropolitan areas. Good telephone and telemedicine protocols and linkages should be established with professionals who are able to provide advice and who are aware of local circumstances.

Shared information

It is important that women and maternity care professionals have access to information about local hospital arrangements and care, particularly if a hospital or maternity unit will be closed at any particular time.

Workforce issues

A workforce must be maintained. Remote areas are particularly fragile in regard to workforce changes, as leave, relocation or retirement of personnel can have a large impact on a small workforce. It is important that local hospitals and clinics recognise this and put into place systems to address potential shortages, such as subsidised locum services. Having a position (e.g. 'consultant on duty') listed for collaboration is more practical than a named individual in a situation where there is high staff turnover. There is a greater role for GPs and district medical officers in these settings.



Postnatal care

There should be communication and transfer links to local postnatal caregivers, including GPs, and early childhood and community services. As these may be rarer in rural and remote areas, clear links to support the woman and her baby to transition back into the community should be established early, to ensure that they receive the best quality of care.

Professional development

Midwives and other maternity personnel in remote areas may find it difficult to access professional development. They will need to ensure that appropriate continuing education is obtained. Opportunities for training and development could be pursued with other members of a collaborating network (e.g. interdisciplinary training sessions) or within the hospitals that the care providers are credentialed with.

3.3.4 Metropolitan public hospitals

The size of the larger metropolitan services can have the advantage of providing greater options of clinicians and services for women. However, there is also a greater risk of fragmented or discontinuous care, which has implications for a range of collaboration issues:

Roles and responsibilities

The roles and responsibilities of each member of a team should be clearly defined, and the maternity care coordinator should be identified. In larger hospitals, this may involve clarifying roles and responsibilities of a named position (e.g. 'consultant on duty') as opposed to a named individual.

Shared documentation

Although a benefit of larger public hospitals is that they usually have a greater availability of maternity care staff and services, this can actually result in the woman experiencing more fragmentation and discontinuity of carers. A shared, woman-held or electronic record reduces the possibility of duplication, and ensures reciprocal communication amongst all collaborating professionals.

Communication

While there may be more options and pathways of care available in metropolitan areas, it is important that the maternity care coordinator ensures that this does not result in fragmented, discontinuous care. There should be the opportunity for weekly access to an obstetric clinic where the midwife may bring her client for a three-way discussion, as well as regular team meetings and case reviews. The degree and depth of collaboration with obstetricians should be clearly documented, to support the midwife to follow the woman's care plan. In these circumstances, it is especially important that the woman's informed choice or consent decisions are recorded and respected.

Access to hospitals

Midwives may need access to hospital(s) for antenatal and postnatal care of the woman, and for intrapartum care. Access may be problematic at metropolitan hospitals, as they may not see any incentive for providing access for a private midwife's practice. Funding incentives or system changes could help overcome this barrier. Women in this setting have the advantage of a greater choice of 'place of birth'. Although the choices vary greatly across locations, many facilities offer birth at hospital, birth centres (either attached to the hospital or freestanding), and in some areas there is also the option of publicly funded homebirths.

Credentialing

Most public hospitals already have an established system of credentialing for medical practitioners, along with audit, governance and case review. Refer to Section 3.2.6 for further information on credentialing for midwives.

**Admission status**

The admission status of the woman (as a private or public patient) should be clarified with the service (and insurer if appropriate) at the time of booking. There may be more flexibility in the options for admission status and insurance arrangements in larger hospitals.

Professional development

Auditing and peer review, and ongoing interdisciplinary training (possibly as part of maintaining regular credentialing) should be easier to access and facilitate in the environment of larger public hospitals.

3.3.5 Private hospitals**Roles and responsibilities**

The roles and responsibilities of each member of a team should be clearly defined, and the maternity care coordinator should be identified. Private hospitals may have defined models of employment and involvement of midwives.

Shared documentation

Shared and reciprocal documentation, including some form of woman-held record, will ensure that all members of the team are aware of essential information throughout the woman's care.

Competition

There may be competition between obstetricians and midwives, with the potential for specialist or GP obstetricians who are part of the credentialing process to refuse access to midwives. Financial disincentives could be perceived or experienced by obstetric staff, such as providing advice and time in collaboration without remuneration where they are not salaried employees. It is important that all professionals prioritise woman-centred care and recognise the importance of working together to support a woman's choices. Strategies to manage these risks may need to be examined by the professional bodies.

Employment

Private hospitals and private specialists have their own model of employment of midwives and this would determine the collaboration requirements and activities. In some cases, midwives may be employed by the private hospital and, as such, they would follow their employment duty statement. In others, the midwife may be an employee of the specialist who has visiting rights to the hospital, and, again, they would collaborate according to the requirements of the obstetric practice. As a third model, a private obstetrician may collaborate with a private practice midwife (independent or solo practitioner) under mutually understood and previously negotiated protocols.

4 Clinical resources for collaboration

This chapter describes the Australian and international clinical practice guidelines that are currently available to health care professionals, outlines the steps to consider when establishing protocols to guide clinical practice, and suggests some resources that could be developed in the future.

4.1 Current Australian guidelines

Consultation revealed strong consensus on the benefits of user-friendly guidelines that promote consistency of practice and contribute to effective clinical reasoning. Currently, Australia has a number of guidelines that provide specific guidance for consultation and referral, based on clinical indicators. Two such documents are:

- *National Midwifery Guidelines for Consultation and Referral* (ACM 2008)
- *RANZCOG Guideline: Suitability Criteria for Models of Care and Indications for Referral within and between Models of Care* (RANZCOG 2009a).

Other guiding resources are also available, including detailed clinical practice guidelines prepared by the National Institute for Health and Clinical Excellence in the United Kingdom (see Section 4.2).

The RANZCOG college statement, released in March 2009, aims to assist medical professionals to deliver best-practice evidence-based maternity care across multiple models of care (RANZCOG 2009a). The statement includes guidance on the clinician referral appropriate for specific complications and indications, with referral to specialities such as specialist anaesthetists, specialist paediatricians, specialist obstetricians and maternal–fetal medicine subspecialists or senior obstetricians at a specialised facility.

The ACM guidelines are targeted more at midwives, but comments from the consultations suggested that the guidelines are widely used by clinicians in many practices and hospitals across jurisdictions, and in May 2010 the New South Wales Department of Health issued a policy directive to ensure that all midwives providing antenatal care in New South Wales services use the ACM guidelines. The guidelines contain tables listing specific conditions or circumstances that a woman or her baby may present with, and recommends whether the midwife should discuss the situation with a colleague (level A), consult with a medical or other health care provider (level B), or refer the woman or her infant to secondary or tertiary care (level C).

Table 4.1 shows the primary responsibilities for care at each level in the ACM guidelines. Figure 4.1 provides an overview of the integrated care pathway recommended by the ACM guidelines.

4.2 Clinical practice guidelines

National evidence-based clinical practice guidelines (CPGs) for consultation and referral within maternity care have not yet been developed in Australia. Antenatal guidelines are currently being developed by the NHMRC, funded by DoHA.



Table 4.1 Summary of codes for care from the Australian College of Midwives guidelines

Level	Responsibility	Care provider
A Discuss	The responsibility for maternity care in this situation is with the midwife	Midwife
B Consult	Evaluation involving both primary and secondary care needs: the individual situation of the woman is evaluated and agreements made about the responsibility for maternity care	Medical or health care practitioner and/or midwife depending on agreements
C Refer	This is a situation requiring medical care at a secondary or tertiary level, for as long as the situation exists	Medical practitioner (where appropriate the midwife continues to provide midwifery care)

The National Institute for Health and Clinical Excellence (NICE), based in the United Kingdom, has endorsed the following CPGs:

- *Clinical Guidelines and Evidence Review for Post Natal Care: Routine Post Natal Care of Recently Delivered Women and their Babies* (Demott et al 2006)
- *Intrapartum Care—Care of Healthy Women and their Babies During Childbirth* (NCCWCH 2007)
- *Antenatal care—Routine Care for the Healthy Pregnant Woman* (NCCWCH 2008).

NICE has an international reputation for the development of high-quality CPGs based on systematic literature reviews, critical appraisal of included studies and grading of evidence.

4.3 Establishing protocols to guide clinical practice

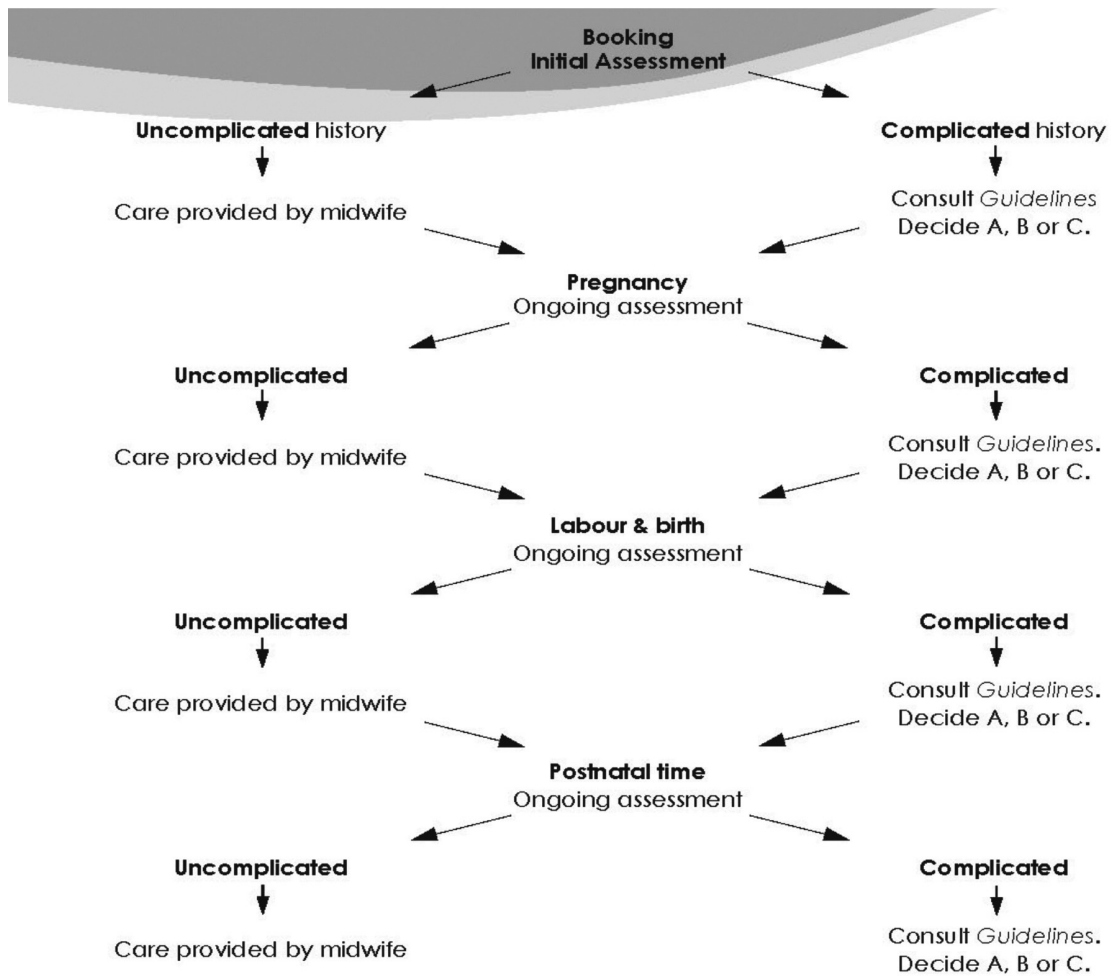
Guidelines are important for promoting consistency of practice, but consistent facility or team policies and standards are also important. Pathways and protocols should also be flexible enough to be adapted to each specific setting; systems that are too regimented may reduce communication with women and individualisation of care.

The NHMRC literature review (NHMRC 2009) indicated several pathways and protocols that contribute to a collaborative approach to maternity care. Some of these are currently used in maternity services; others have been developed for other health care services, but could be adapted to maternity services. The following subsections describe some issues to consider when developing protocols and policies for collaborative maternity care.

4.3.1 Consumer involvement

Involving women in all decisions related to their care is an essential component of high-quality maternity care. Health care professionals should provide their clients with appropriate, consistent information (McWilliam et al 2003). This can be achieved by discussing issues with the woman, consulting with her on decisions, providing her with education sessions or supplying her with written information that is readily accessible to all women (Jones et al 1999, Ouwens et al 2005, WA Department of Health 2007). Woman-held records are a possible strategy to assist with documenting care and with involving women as partners in their own care. Such records also ensure that the focus of the record remains on the woman, her baby and her family, and that the language used is appropriate (Dyas and Burr 2003).

Figure 4.1 Decision diagram for use by midwives



- A Discuss with midwife/medical practitioner and care provided by midwife
- B Consultation with medical practitioner and care continues with midwife or is transferred to medical practitioner
- C Refer care to medical practitioner

When there is any doubt, consultation is recommended

Sources adapted from: Obstetrical Manual. Final Report of the Obstetric Working Group of the National Health Insurance Board of the Netherlands, 2000; College of Midwives of Ontario, 2000. *Indications for Mandatory Discussion, Consultation and Transfer of Care*, 2000; NZ Ministry of Health Maternity Services. *Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000*, July 2002.

Source: ACM (2008)



4.3.2 Identifying risk

As described in Chapter 1, the aim of maternity care is to provide a service that is woman-focused, equitable and based on the best evidence for safety and quality. Risk is a dynamic concept—a woman's identified risk factors can change throughout the pregnancy, birth and postnatal period, and different clinicians and women can interpret risk differently.

A risk-management approach ensures that everyone involved in maternity care can identify levels of risk at all stages of pregnancy, birth and postnatal care, and can take appropriate steps to transfer care from one level (e.g. midwife or GP in primary care) to another (e.g. specialist obstetrician) when needed (Farmer et al 2003, Harris and Saxell 2003, Jackson et al 2003).

Thus, all maternity service providers need clear guidance for identifying and categorising risk and for the roles and responsibilities of primary, secondary and tertiary service providers with respect to specific risk factors (Amelink-Verburg et al 2009). Clear guidance is especially important in collaboration, as different professional groups may have different concepts and interpretations of risk (WA Department of Health 2007).

Although risk management provides for a logical and well-mapped approach to safe maternity care, focusing on the risks of pregnancy and birth can place an unduly negative emphasis on maternity care and contribute to a misplaced fear of things going wrong. It is extremely important for both the woman and the clinician to be aware of possible risks and to implement preventive and mitigating strategies, but how these risks are discussed with the woman is also important. Baird (2008) put it this way:

Unfortunately, there has been a rise in defensive medicine and too much intervention in the forlorn hope of eliminating all risk.

Importantly, women will have their own interpretation of risk, which should be considered, taking into account each woman's individual needs and situation (e.g. travelling away from their local community for consultations can be more difficult for Aboriginal and Torres Strait Islander women due to concerns regarding leaving country and family, language barriers, financial barriers involved in the travel itself, cultural differences and other factors). For some women, hospitals can be perceived as a source of great risk, as they handle birth with a greater focus on medical risk and less consideration for cultural and spiritual beliefs (Kildea 2006). Having services available locally in rural and remote areas, and communicating in ways that are respectful of a woman's needs improves the likelihood that women will follow care recommendations, attend consultations, and tell their carers about their personal and medical history, all of which greatly reduces risk (Nel and Pashen 2003, Becker et al 2009).

If risk changes during a pregnancy, then this should be discussed with the woman and, with her agreement, appropriate collaborating professionals should be consulted.

Regardless of risk, the woman is the ultimate decision-maker, and should be offered information, even in an emergency situation (NHMRC 2006).

For competent adults, the power to consent to treatment also includes the right to refuse treatment [or] withdraw consent ... for any reason (or no reason at all) even where that situation may lead to their death (FPA Health and Read 2006:46).



4.3.3 Integrated care pathways

Integrated care pathways (ICPs) are used by many facilities to help standardise and streamline patient care and the documentation of care (McLachlan et al 2008). ICPs have a documented sequence of clinical interventions measured by timeframe, with common goals or desired outcomes (Buxton et al 2004, Hunter and Segrott 2008). A number of terms are used to describe ICPs: clinical pathways, critical paths, care maps, collaborative plans of care, multidisciplinary action plans, care paths and anticipated recovery paths. By specifying who should do what, when and where, ICPs improve care planning (Atwal and Caldwell 2002). They also eliminate problems that may occur when professional role boundaries or role definitions are blurred (Huby and Rees 2005, Lockhart 2006). Care plans or guidelines, however, should not be seen as a substitute for clinical judgement (Atwal and Caldwell 2002, Docherty et al 2003; NHMRC consultations 2009).

Knowing exactly when each health care professional will be required to be part of a woman's care can reduce waiting times (Hunter and Segrott 2008), and help eliminate any elements of care from being repeated unnecessarily or overlooked (West and Sacramento 2004). Such planning can also assist in creating staff rosters and best use the skills of the whole team (McWilliam et al 2003). An example of guidelines based on ICPs are the ACM guidelines (ACM 2008).

4.3.4 Communication: meetings and documentation

Many studies have noted that practitioners may have concerns about accountability in an environment where several health professionals contribute to patient care. Collaborative arrangements require communication to build trust and mutual respect; this trust and respect can also help relieve concerns about accountability and perceptions of risk (Crozier 2003, Cross-Sudworth 2007).

Protocols to help improve communication and relieve concerns about accountability include: regular team meetings, interprofessional education or training activities, and clearly documented patient records that include signatures or initials of care providers on the patient notes when an entry is made (Docherty et al 2003, Hadjistavropoulos et al 2003). As mentioned previously, woman-held records can also improve continuity of care (Dyas and Burr 2003). This is discussed further in Section 4.4.

Documentation should include clear and consistent records of:

- information provided to women and indications that the messages have been understood
- informed consent
- responsibility and accountability for decisions
- the woman's understanding of risk and her responsibility for her own choices and decisions about care, especially if these decisions are in conflict with professional advice (in such circumstances it must be clearly documented that the woman has accepted a certain level of risk).

The importance of improving communication flows between clinicians and those involved in a woman and baby's community care after the birth (e.g. GPs, community services, allied health) should not be forgotten (Byrne 2002, Lombardo and Golding 2003). Many services have the opportunity to improve communication around discharge and postnatal care.

4.3.5 Other tools

Other tools that can assist in a collaborative approach to maternity care are computerised databases (e.g. ObstetriX)¹¹ or e-health records, which facilitate patient information and history sharing for health professionals (Yates et al 2007; NHMRC consultations 2009).

¹¹ See NSW Department of Health website, www.health.nsw.gov.au/pubs/2007/pdf/dom_voil_snap_28-40.pdf (Accessed 17 February 2010).



4.4 Potential clinical resources

The NHMRC consultations found that there were three types of resources that participants felt would improve collaborative care: a woman-held record system, universal guidelines and evidence-based information for women.

As previously discussed, a woman-held record system would facilitate communication and provide accountability for the advice given to the woman by different health professionals. A single, universal hand-held record system, or an electronic health record that could be accessed by GPs and midwives, would be useful. Woman-held records can help improve continuity of care by the consistent tracking of conversations and decisions during a woman's maternity care, and facilitate transparency and accountability. Currently, several Australian states and territories have implemented woman-held records, including New South Wales, Victoria, Queensland, South Australia, and the Australian Capital Territory.

Participants in the NHMRC consultation forum acknowledged that the existing college guidelines serve differing purposes: the ACM guidelines were developed for midwives, while the RANZCOG college statement was developed for obstetricians. Forum participants agreed that it would be beneficial for the colleges to develop common guidelines for collaborative maternity care.

Many practices or college groups have information for women, but the NHMRC consultations found that it would be useful to have universal, evidence-based information for women that acknowledges multidisciplinary perspectives on risk. Such information would assist with concerns about the difficulties and the politics of communicating risk, given the cultural and social elements of birth that are not present in many other medical decisions. Another suggestion was that a national website for women and professionals could be a useful information resource to provide access to policies, guidelines and statistics.

5 Monitoring and evaluation

To ensure women have access to high-quality, safe and collaborative maternity care, it is vital that collaboration is monitored, evaluated and reviewed. Such reviews can be linked to clinical outcomes, and to process and relationship outcomes (UK Department of Health 2005, WHO 2006).

This chapter provides an outline of key issues that will need to be considered when developing national programs for monitoring, evaluation and review of collaborations. Also of importance is review and reflection of practice by individual clinicians.

5.1 Individual professional development and review of practice

If individual practitioners continually reflect on their practice, this process informs their clinical practice and how they approach aspects of practice. Reflection can be undertaken in a solo setting, a (work) group setting or a professional setting, such as during clinical supervision. Opportunities to reflect on one's own and others' practice are essential to integrate experiences and knowledge (Reiger and Lane 2009).

There are numerous ways to be involved in ongoing professional development—many health and medical associations and services provide opportunities for clinicians to continue their professional education. For example, the ACM has a comprehensive continuing professional development program (Midplus) and supports a formal three-year cycle program called Midwifery Practice Review (MPR). MPR, in particular, looks at relationships of collaboration and support within midwives' practice. RANZCOG has a mandatory program of continuing education across four aspects of practice and recertification in a three-year cycle (Haller et al 2008, Main and Bingham 2008; NHMRC consultations 2009).

5.2 Peer and case review

Peer review is often linked with professional development schemes. The United Kingdom has a system of midwifery supervision that provides substantial and comprehensive support for its midwives. Such a system of 'supervisors of midwives' was strongly supported by the Australian midwives that this project consulted as a way of providing valuable support and mentoring of practising midwives (Saxell et al 2009; NHMRC consultations 2009).

Participants in the NHMRC consultations indicated that there is scope to augment current peer-review activities. Improving collaborative maternity care may provide opportunities to participate in multidisciplinary peer review, where collaborating partners contribute to each other's practice and collaboration activities (NHMRC consultations 2009; Box 5.1).

Box 5.1 Audit and review in the collaborative setting

Nambour Selangor Private Hospital Maternity Unit (Queensland) has a three-tiered audit process involving all professions. Activities include:

- weekly chart review of all births
- development of an Adverse Patient Outcome program
- regular review of good and bad outcomes, with cases selected by the Maternity Unit Manager
- combined perinatal morbidity and mortality review with the local public hospital (which has more than 2300 births per year)
- review of adverse events and root cause analysis as required.



5.3 Audit processes

Having auditable measures in place makes it easier to assess service provision (such as staffing levels), and to assess and discuss as a group any problems that arise during client care. Case meetings provide an opportunity for teams to talk about issues in detail, resolve problems, seek advice from others and share learning from experiences, and remain up to date with patient information (Shannon 2002).

Data collection also creates an evidence base to support protocols or to suggest how they may be changed or developed.

Audit processes may also include:

- informal case review for cases with both good and adverse outcomes
- processes that identify, as much as possible, 'near misses' occurring in care provided, so there is recognition of the possible implications these incidents have for becoming serious adverse outcomes
- morbidity and mortality review that is multidisciplinary, preferably represented or led by all staff involved
- analysis of more serious adverse outcomes via tools such as root cause analysis.
- assessment of the impact on collaboration of 'core maternity indicators'; for example, breastfeeding rates, or smoking cessation advice and decreased smoking rates in pregnancy.

Audit processes should also highlight good outcomes, particularly situations of 'unusual normal' (where a situation had an unexpectedly good outcome). These processes congratulate providers who may otherwise feel undervalued, as audits are often more punitive and focused on negative outcomes (NHMRC consultations 2009).

Services and clinicians involved in maternity care currently use a range of protocols to review clinical and management processes. Consultations have indicated that collaborative maternity care must include opportunities for multidisciplinary review and audit of both the collaboration itself and the clinical outcomes resulting from improved collaboration (Lockhart 2006; NHMRC consultations 2009).

Opportunities to improve collaboration could also facilitate the review of the collaboration itself; that is, building review into integrated care pathways or making the review of the collaboration a standing item in any clinical meeting or conference. Box 5.2 shows some possible steps for evaluating collaboration.

Evaluation of multidisciplinary shared care models and models that provide Aboriginal and Torres Strait Islander women with a range of birthing options was identified as a 'gap in knowledge' in the 2008 PMSEIC report focused on maternal, fetal and postnatal health.

Box 5.2 Steps to consider when evaluating collaboration**Develop an evaluation framework**

- What do you intend to achieve?
- Do you want to evaluate both the process and the clinical outcomes?
- What activities will be required? Especially early in a collaborative relationship, be very clear about processes around collaboration. Ensure that there are both formal and informal aspects within the process.
- Consider the documentation around discussions or consultations of client care to ensure clear accountability by all involved.
- It may be useful to have written referral documents that make it clear to women who is providing their care, and also clearly spells out the 'pathway' of care or further referral between clinicians for both staff and women.
- What are the constraints?
- What existing evaluation or monitoring frameworks do you need to consider (e.g. Perinatal Society of Australia and New Zealand guidelines and reporting)?

Develop indicators to measure the outcomes

- What will you measure; for example, morbidity and mortality outcomes, client and staff satisfaction, improved service access, efficiency, cost, short-term and long-term outcomes?
- How will you measure outcomes—by data collection, interview, survey? And how many or much measurement do you require—for how long and how often?
- Who will examine the results—will they be publicly available or just for those directly involved?
- Do your indicators show which changes had direct causality where improvements were made or problems arose? How valid are your outcomes?

Evaluate outcomes

- Did the model achieve what it set out to achieve?
- To what extent was it achieved?
- Were there unexpected changes or outcomes?
- Do the outcomes represent meaningful benefits or changes for women and their families and members of the collaboration?
- Are these outcomes sustainable?

Source: Adapted from the Multidisciplinary Collaborative Primary Maternity Care Project, Canada, Module 6 (NPMCC 2006).

5.4 Clinical practice guidelines for perinatal mortality

Inadequate investigation of perinatal deaths limits the information available to health care providers and parents. Such information can assist with understanding the reasons for deaths and in planning future pregnancies.

The *Clinical Practice Guidelines for Perinatal Mortality* (PSANZ 2009) were developed by the Perinatal Mortality Group of the Perinatal Society of Australia and New Zealand (PSANZ) to assist clinicians when investigating and evaluating causes of perinatal deaths. The guidelines provide a systematic approach to support audit and research activities that aim to reduce perinatal deaths.

Based on literature review and consensus of the PSANZ working party, the guidelines list core investigations recommended for all stillbirths and neonatal deaths, and define perinatal and neonatal death classifications. The guidelines recommend that a standardised dataset should be collected for all perinatal deaths; this dataset should include significant family, medical and obstetric history, all major pregnancy complications (including whether the pregnancy was terminated) and investigations undertaken around the time of death, including placental histopathology and autopsy.



In addition to the guidelines for investigations, PSANZ have included psychological and social aspects of perinatal bereavement in the guidelines, to ensure that parents are appropriately supported through their grieving process. This support is especially important when obtaining consent for perinatal autopsies. Other important steps in improving audits include improving public awareness of the value of perinatal autopsy and improving standards for perinatal postmortems and postmortem reporting.

PSANZ recommend that guidelines should be implemented by all institutions where births occur; implementation includes establishing a multidisciplinary perinatal mortality review committee. The working group is currently revising the Perinatal Mortality Audit Package, which includes checklists and data collection forms, to improve the quality of information available for audit and research activities (PSANZ 2009).

■ Appendix I

Guidance development process

Membership of the Maternity Collaboration Project Reference Group

Professor Chris Baggoley (Chair)	Australian Commission on Safety Quality in Health Care
Ms Elizabeth Chatham	Women and Children's Hospital Australasia
Professor Hannah Dahlen	Australian College of Midwives
Professor Sue Kildea	CRAN <i>Aplus</i>
Ms Kelley Lennon	Belmont Birthing Service, New South Wales
Dr Morton Rawlin	Royal Australian College of General Practitioners
Ms Debbie Slater	Childbirth Australia
Associate Professor Ruth Stewart	Australian College of Rural and Remote Medicine
Mr Bruce Teakle	Maternity Coalition
Professor Sally Tracy	Australian College of Midwives
Dr Ted Weaver	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Professor Alec Welsh	Royal Australian and New Zealand College of Obstetricians and Gynaecologists University of New South Wales
Ms Elizabeth Wilkes	Australian Private Midwives Association
NHMRC	
Ms Cathy Mitchell	NHMRC
Ms Gill Hall	NHMRC
Ms Indiana Holley	NHMRC
Ms Sarah Blackledge	NHMRC
Observers	
Ms Marion Berry	Australian Government Department of Health and Ageing
Ms Judi Sutton	Australian Government Department of Health and Ageing
Ms Heather Kirk	Australian Government Department of Health and Ageing
Ms Rosemary Bryant	Australian Government Department of Health and Ageing
Technical writers	
Dr Janet Salisbury, Ms Ruth Pitt, Ms Kylie Evans, Dr Carolyn Weiller	Biotext, Canberra



Guidance development

Reference Group appointment and meetings

In September 2009, the National Health and Medical Research Council (NHMRC) appointed a multidisciplinary reference group, the Maternity Collaboration Project Reference Group (the Reference Group), to oversee development of the Guidance. The Reference Group members represented a diverse range of clinicians involved in maternity services, as well as the women and families who use these services. The chair was Professor Chris Baggoley of the Australian Commission on Safety and Quality in Health Care. The Reference Group was advised by the NHMRC Health Care Committee and the Australian Government Department of Health and Ageing (DoHA) Maternity Services Advisory Group.

The Reference Group met twice before the publication of the draft Guidance for public consultation and once after the consultation to finalise the Guidance for NHMRC approval (see below). Members of the Reference Group also attended and contributed to the national stakeholder forum on 10 December 2009 (see below).

Literature review

To inform the development of the Guidance, the NHMRC reviewed the Australian and international literature about maternity care collaboration. The purpose of the review was to examine the evidence base for collaborative working relationships and how they could best be used in the Australian maternity health care context.

The NHMRC literature review team consulted with DoHA to develop questions and keywords for the literature search for evidence. The questions initially developed were:

- What is the evidence base supporting a collaborative maternity or health care model?
- What collaborative care models exist within Australia and overseas?
- What are the essential elements of a collaborative care model?
- What are the barriers to implementing a collaborative care model within the Australian health care context, and within the delivery of maternity services within Australia?

The literature was searched in September 2009 using the following terms derived from the above questions:

obstetrics; nurse midwives; midwifery; birthing centres; maternal-child health centres; obstetric care; maternal care; maternal health services; prenatal care; postnatal care; cooperative behaviour; cooperation; inter-professional relations; collaboration; continuity of patient care; referrals and consultation; communication; patient care team.

The search was conducted through the DoHA Library, using the following databases:

- Medline (health and medicine)
- Embase (health and medicine)
- Australasian Medical Index
- Google Scholar
- Cochrane Library
- general web search for online documents and websites.

Search results were limited to documents published in English from January 2002; 103 articles were retrieved for further review.

After reading through the abstracts of these documents, the NHMRC team discussed the findings and decided to conduct a second search to gain more information about collaborative teams in other fields of health care. A fifth key question was determined as:

- What pathways and protocols currently exist to assist the multidisciplinary delivery of health services, including maternity services?

Search terms derived from this question were:

practice guidelines as topic; critical pathways; implementation; protocol; delivery of health care, integrated; cooperative behaviour; inter-professional relations (expanded); patient care team; multidisciplinary.

This second search was conducted using Medline, Embase, Australasian Medical Index and Google Scholar, with search results limited by English language and publication from 2001 to September 2009. Fifty-seven articles were retrieved for further review. The abstracts of these documents were read by NHMRC staff, and then cross-checked and discussed to determine their value and or relevance to this project. NHMRC staff also checked the reference lists of the retrieved articles and obtained relevant articles to add to the review.

Further documents were submitted by individual stakeholders and organisations, and documents recommended from the members of the Reference Group. Other key documents that are currently being used widely by maternity professionals in Australia, such as existing clinical consultation and referral guidelines produced by Australian key stakeholder organisations (e.g. RANZCOG, ACM), were also included.

Information relevant to the key questions listed above was extracted into spreadsheets, which were presented to the Reference Group for inclusion in a discussion paper to present to stakeholders and for development of the Guidance. The literature suggested evidence that collaborative care models are effective in streamlining patient care and can contribute to improving outcomes. The Reference Group requested that the five key questions used previously should be refined to the following for application to the development of the Guidance:

- What are the current Australian collaborative models?
- What are the current overseas collaborative models?
- What are the essential elements and/or critical facilitators of a collaborative care model?
- What pathways and protocols already exist to allow a collaborative approach to maternity care?

The final report of the literature review included analysis of the included papers against these questions, which were then used for the development of the Guidance document.

Stakeholder consultations

To ensure the involvement of a range of professions in developing the Guidance, the NHMRC consulted with a wide range of stakeholders. The consultations aimed to:

- seek information on the issues of collaboration, consultation and referral and current clinical guidelines
- capture the roles and needs of clinicians in all maternity settings
- seek advice on what the National Guidance for Maternity Care should look like.

An overview of the consultations is shown in Table A1.1.



Table AI.1 Stakeholder consultations

Group	Consultation activities
Australian College of Midwives	Meetings with Executive Officer and state branch members in New South Wales/Australian Capital Territory, Queensland and South Australia
Royal Australian and New Zealand College of Obstetricians and Gynaecologists	Meetings with National President and regional committees in New South Wales, Australian Capital Territory, Queensland, Western Australia and Tasmania
Royal Australian College of General Practitioners	Meeting with college representative
Australian Private Midwives Association	Meetings with member representatives in New South Wales, Queensland, South Australia, Western Australia and Tasmania
Rural and Rural Services	Teleconference and a meeting with the national president and National Broad CRANApus. Teleconference with Australia College of Rural and Remote Medicine
Queensland Centre for Mothers and Babies Association	Meeting with Associate Professor Sue Kruske
Consumers	Consumer focus groups in Queensland, South Australia and teleconferences with Western Australia, Rural New South Wales and Victoria.
Hospital services	Mater Mothers Hospital and Mater Private Hospital, Brisbane Royal Brisbane Hospital
Government committees	Presentation to Maternity Services Advisory Group Teleconference with Maternity Services Interjurisdictional Committee Presentation to the National Maternity Services Council
Various other individuals and organisations	Various

Workshop on Collaborative Maternity Care

On 23 October 2009, nine maternity care professionals working in collaborative models of care were invited to participate in a workshop where successful collaborative strategies and enabling factors were discussed. The workshop developed lists of enablers and barriers to maternity care collaboration, which were used to inform the development of the Guidance.

National stakeholder forum

On 10 December 2009, 62 participants attended the NHMRC Stakeholder Forum on Developing National Guidance for Collaborative Maternity Care, in Canberra. The forum participants included health professionals and other stakeholders from across the country, including midwives, GP obstetricians and obstetricians from private, public, metropolitan, regional and remote sectors across Australia, as well as neonatologists, allied health professionals, researchers and jurisdictional representatives involved in maternity care to inform the Guidance. The Forum was facilitated by Dr Norman Swan.

Before the forum, the NHMRC prepared a discussion document for participants based on a proposed outline of the draft Guidance document. The discussion paper addressed the following issues:

- defining collaborative care
- principles for collaborative maternity care
- key elements of collaboration
- establishing collaborations
- current clinical resources (guidelines)
- monitoring, evaluation and review.

At the forum, participants developed a definition and key principles of maternity care, and discussed key elements and issues to consider when establishing a collaboration.

Preparation of the draft Guidance

Based on the discussion paper developed for the national forum (see above) and the outcomes of the forum, a draft Guidance document was prepared by the NHMRC in consultation with the Reference Group.

Public consultation

In March 2010, the draft Guidance was released for public and targeted consultation until 27 April 2010. Public consultation was advertised in *The Australian* on 27 April 2010, *NHMRC Tracker* and on the NHMRC website with an invitation to comment. In addition, the Consumers Health Forum was notified of the release, and advertisements were placed in the March 2010 issues of the following professional publications: *Australian Nursing Journal*, *Midwifery News* and *O&G Magazine*, and also the consumer group Maternity Coalition's *Birth Matters* magazine.

A total of 71 submissions were received and forwarded to all members of the Reference Group for review. The NHMRC project team prepared a summary of the issues raised in the submissions for further consideration by the reference group and final changes were agreed to by the Reference Group and incorporated into a final draft of the Guidance. Nonconfidential submissions were received by the following organisations and individuals (in alphabetical order):

- Alison Chandra: midwife, ACT
- Alison Gaffney: consumer, QLD
- Ana Biffin: prospective consumer, rural NSW
- Andrea Juszczak-Albertini: private practice midwife
- Dr Andrew Child: Director of Women's Health and Neonatology, Sydney South West Area Health Service
- Dr Andrew Foote: obstetrician and gynaecologist, ACT
- Associate Professor Kereen Reiger: Deakin University, and Dr Karen Lane: LaTrobe University, VIC
- Australian and New Zealand College of Anaesthetists
- Australian College of Mental Health Nurses
- Australian College of Midwives, ACT Branch
- Australian College of Midwives, National Office
- Australian College of Midwives, Queensland Branch
- Australian Medical Association
- Australian Nursing Federation
- Australian Private Midwives Association
- Beverly Walker: mother, grandmother, semiretired lactation consultant lobbyist and activist

- Bonny Marsh: President, Friends of the Birth Centre, Brisbane QLD
- CARES, SA
- Carina Brown: midwife
- Catholic Health Australia
- Centre for Midwifery, Child and Family Health in the Faculty of Nursing, Midwifery and Child, Youth and Women's Health Program, ACT Health
- Dierdre Turner: consumer
- Dieticians Association of Australia
- Eleanor Marney: Castlemaine Birth Choices
- Emma Fox: consumer
- Faculty of Nursing, Midwifery and Health, University of Technology Sydney
- Hayley Quach: rural consumer, VIC
- Homebirth Access Sydney, NSW
- Jane Wolff: consumer, SA
- Kathleen Plumb: consumer
- Kim Thomson: consumer, NSW
- Kirsten Paisley: rural consumer, VIC
- Professor Lesley Barclay: Director, Department of Rural Health, Northern Rivers University; School of Medicine, University of Sydney
- Liza Kennedy: Conscious Conception and Birth Centre
- Maree Nolan: mother of three; Treasurer, Friends of the Mackay Birth Centre; Regional President, Maternity Coalition QLD; Consumer Representative, Northern Maternity and Neonatal Clinical Network
- Margaret McGuire: midwife
- Maryann Long: CNM, MPH, midwife, QLD
- Maternity Coalition
- Melissa Maimann: Essential Birth Consulting, private midwife, NSW
- Melody Bourne: midwife in private practice, Brunswick VIC
- Mercy Health and Aged Care, Central Queensland
- Professor Michael Chapman, Head of School, School of Women's and Children's Health, University of New South Wales
- National Association of Specialist Obstetricians and Gynaecologists
- National Rural Women's Coalition
- Nicole Kennedy: consumer, QLD
- Nina Peheim: rural consumer, VIC
- Paula Bruckard: consumer, SA
- Pauline Costins: midwife, WA
- Primary and Population Health, Children Youth and Women's Health Service South Australia
- Rebecca Jenkinson: consumer, QLD
- Roberta Murphy: midwife, WA
- Dr Rod St Hill: Dean, School of Business, Christian Heritage College, QLD
- Roslyn Donnellan-Fernandez: community midwife SA; Women and Children's Hospital Foundation Midwifery Fellow
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists, National Office
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists, SA/NT Chapter
- Royal Australian College of General Practitioners

- Royal College of Nursing
- Royal Hobart Hospital, TAS
- Rymer Tabulo: Mackay, QLD
- Samantha Bryan: consumer, QLD
- Service Manager/Director of Midwifery and Nursing, Maternity and Gynaecology, Birra-Li Aboriginal Birthing, John Hunter Hospital and the Belmont Birthing Service
- Statewide Obstetric Support Unit, WA Health
- Tania Robinson: midwife and consumer, Perth WA
- Vanessa Shribman: consumer; founding member of Birth Matters South Australia
- Virginia Maddock: herbalist, nutritionist and doula, NSW
- Women's and Newborns' Health Network, Health Networks Branch, WA Health
- Women's Health Victoria

Approval by the CEO of the NHMRC

The final Guidance was submitted to the NHMRC Council at the 182nd Session in July 2010 for recommendation to the Chief Executive Officer (CEO) for release to DoHA. The Guidance was published to assist eligible midwives in advance of the planned 1 November 2010 commencement date for the new Medicare Benefits Schedule and Pharmaceutical Benefits Scheme arrangements.

Submission to the Department of Health and Ageing

After approval by the NHMRC CEO, the NHMRC completed design and publication of the Guidance and submitted the final publications to DoHA with a detailed communication strategy to assist DoHA in its implementation of the Guidance.

■ Appendix 2

Case studies of existing collaborative models

This appendix includes personal and clinical stories that display the range of collaboration that currently exists in Australia's maternity settings. They have been provided by clinicians and women during the National Health and Medical Research Council (NHMRC) consultations, and through a literature review. There are literally hundreds of different maternity experiences occurring across Australia every day to pregnant women, new mothers, families and maternity care professionals, just to name a few. This small selection is included not as a complete package of collaborative maternity care as described in the Guidance, but to show the varied elements in practice. Some of the case studies show effective collaborative practice, others show some elements of collaboration, while others highlight some practices that do not reflect good collaboration.

Women's stories

Susan's story

Susan would like to have her third baby at home, in the care of Kate, an independent midwife. Susan's second experience of labour was traumatic and she is determined not to return to hospital for her third labour.

Kate and Susan discuss booking Susan into a hospital, in case transfer of care is required. Susan consents to make the booking, but refuses to attend the hospital in person. Kate agrees to liaise with the antenatal clinic at the hospital and, with Susan's permission, provide them with medical records. Kate also liaises with Susan's GP.

Susan feels that the baby is in the breech position and, at their next meeting, Kate confirms that this is the case. Kate explains Susan's options, including the possibility that the baby will turn on its own. Susan is concerned about having the baby in the hospital, especially the possibility of having a caesarean. Kate has a regular case meeting with John, an obstetrician at the hospital, so she obtains Susan's consent to discuss her care.

John and Kate discuss Susan's history and pregnancy, and agree to arrange a meeting with Susan and her husband. At the collaborative consultation, John explains Susan's options and the associated risks. After taking some time to think about the options, Susan and her husband decide on an external cephalic version (ECV), which is successful. Susan continues with her plan to birth at home, although she discusses how the hospital can make her feel more comfortable if transfer becomes necessary, including having Kate present at the birth.

Source: A role play of this hypothetical scenario, based on the experiences of a midwife and obstetrician, was presented at the NHMRC Forum on Developing National Guidance for Collaborative Maternity Care, December 2009 (see Appendix 1).

Barbara's story

Maternity services in remote Australia

Over the last 40 years in remote Australia, women have increasingly been relocated from their homes to birth in regional centres. Typically, they will leave their homes at 36–38 weeks gestation to await birth, usually alone, in the regional setting. These policies are driven by a belief that birth in remote areas is too 'risky'. Many remote areas no longer have the infrastructure, staff or insurance cover to support on-site birthing. However, women state they do not like to be away from their families for weeks at a time, as worrying about the children left behind and other family members causes immense stress. Important contributors to a positive experience of maternity care are often lacking in this model, namely: continuity of care, choice of care, place of birth and the right to maintain control. It is clear that the model of care is not socially or culturally acceptable to women and their families, nor is it satisfying for the health care providers.

Midwives working in these areas are frequently the only skilled maternity service provider in the community for Aboriginal women. Ideally, to increase their effectiveness in the community, they will work side by side with Aboriginal health workers, though there is a current shortage of these professionals also.

The midwives are often faced with ethical challenges for which there are no clear guidelines, and in many instances, no easy answer. Often, the women do not want to leave their communities for birth, yet they do what is advised, believing it is best for their baby. Others will avoid antenatal care so as not to be sent away from their families for birth. Some women will tell you early in their pregnancy that they are staying in the community for birth, no matter what. Others will be sent out late in pregnancy but return and then present to the health centre in labour, too late to be transferred back to town.

Barbara is an Aboriginal woman who lives on a small outstation, two hour's drive from a remote community in the north of Australia, which is one hour's flight to the regional centre. The traditional culture and land ownership values of the people in this region remain strong. Many in the community speak English as their third or fourth language and some do not understand English at all.

The remote nurse midwife usually worked in the 'women's room' providing antenatal and postnatal care (for around 35 women at any one time), as well as performing routine and emergency 'women's business' care. Approximately 10 women a year would choose to have their babies in the community.

Barbara presented for a 'checkup' and it was clear she was pregnant. Barbara was very shy and did not understand English. One of the Aboriginal health workers (AHWs) spoke her language and agreed that she would be appropriate to work with the midwife to provide Barbara's care. *(There are times when AHWs are not appropriate to assist, depending on their relationship with the person involved. These avoidance rules are an important part of the kinship system).* Barbara had a previous pregnancy, eight years earlier, with one antenatal visit at her outstation where it was noted she had some complications related to her blood pressure. She had birthed her baby on her 'land' with her family in attendance (no health care providers) and her medical records stated she had 'a big bleed' following the birth.

Barbara's blood pressure was again high. The midwife called the district medical officer (DMO), to discuss the situation and Barbara was advised to go to town for a checkup to assess both her and the baby's wellbeing. Barbara did not want to go as she was frightened and had never been away from the community before, let alone travelled on a plane. The last time she had a baby she did not have any complications and felt safer at home surrounded by family. Additionally, she planned to birth at her outstation, on 'her own land'. If her baby was not born there the correct ceremonies will not be performed and the family believed the baby could have problems establishing a connection to the land.

The midwife was concerned Barbara may develop serious complications that could risk the lives of the mother and baby. There were no on-site doctors and very little equipment for emergencies. Additionally, the midwife could get 'blamed' by other community members or her employers (clearly Barbara needed referral) if she 'allowed' Barbara to stay, especially if something went wrong. Together, with the AHW, they explained to Barbara why it was important to go to Darwin.

Initially, the DMO refused to authorise an escort to accompany her and act as an interpreter, stating 'we have an interpreter service and this is not her first baby'. (*The patient-assisted travel scheme (PATS) states that women are only allowed an escort if they are having their first baby and if they are under 16. The PATS budget was overspent and DMO's were told to be very strict with who is allowed to come in*). Advocating on Barbara's behalf led to a compromise where Barbara agreed to go to the regional centre with an escort, for review only, and on the understanding that she could return to await the birth at home (even if this was against medical advice). When she did return she had been started on blood pressure medication and stated she would not be going back to the regional centre for the birth, as she had been too frightened there. Her medical referral had recommended that she return at 34 weeks to await the birth and over the following weeks there was a lot of pressure from the visiting doctor for her to do so.

Further negotiation with Barbara led to an agreement that she would come in from her outstation and stay with relatives as she neared her due date. She also agreed to tell the midwife when she was in labour. The midwife was called to the birth minutes after the baby was born and found Barbara with her baby sitting by the campfire surrounded by aunties and sisters. All were well and very happy. Barbara returned to her outstation two days later.

Though the outcome is not always positive when women choose to avoid the care offered, it is the carer's job to work with them and within a system that may not be meeting the woman's needs to provide safe, high-quality care where possible.

Source: Adapted with the kind permission of the story's author Professor S Kildea, from Homer, Brodie and Leap (Chapter 10), in Homer, Brodie and Leap. Eds (2008).

Nichola's story

We were a little apprehensive as this was our first experience of the maternity care system in Australia. Our first two girls were born in the United Kingdom. I visited Kaleeya¹² for the first time as an antenatal patient about six months before my due date. I was thoroughly impressed at the Kaleeya open day by the staff, tour, presentation and the quality of the facilities. All of my questions were answered. Due to the apparent high standards of the maternity team, I was certain that I wanted to have my third child at Kaleeya. My appointments with the GP obstetricians and midwives were pleasant and well managed.

I always felt that I received the appropriate level of care. The Kaleeya staff were always accommodating, professional and flexible when arranging my appointments.

Things moved very quickly on the night of my baby's birth, and the ward team gave me excellent advice and reassurance—not to mention encouragement. My family and I were made to feel very welcome from arrival. We enjoyed a very private birthing experience with the amazing support of two fantastic midwives! Our son was born a healthy 3.8 kg with no complications and his two big sisters were welcomed onto the ward within the hour to meet their new little brother! When recovering I was given time and support to establish breastfeeding and no one ever made me feel that they were too busy to help. I found sharing a room to be a positive experience and enjoyed the opportunity to receive and give mutual support and also meet another new mum.

12 Kaleeya is a public hospital located in Fremantle, Western Australia.



My follow-up care after discharge was exceptional. I had free and ready access to visiting midwives and a lactation consultant who helped me through some difficult and emotional times. My first birthing experience in Australia was extremely positive and I thoroughly recommend Kaleeya. I am very grateful to the whole maternity team for providing me with such a high standard of care.

Source: WA Department of Health (2007).

Gemma's story

For my first pregnancy I was cared for by community midwives attached to a hospital. The model of care was to have one primary midwife. I had most appointments with her, and in the final weeks these were in my home. I had three or four appointments with a backup midwife.

When I was in labour my primary midwife came to my house. After a second vaginal examination (VE) the midwife said I was not progressing, so we had to transfer to hospital. To be honest I was feeling overwhelmed, unsupported, scared and embarrassed, and was happy to go by then. I assumed I would get an epidural and give birth in the labour ward. I asked for an epidural right away, the pain had got so much worse, and the hospital anaesthetist gave me this; syntocinon was also started.

I was pleased to get another community midwife who could stay with me through the next few hours of labour (if you can call it that when you're pain free under epidural), and for the rest of the birth and recovery.

It was about 16 hours into the labour that caesarean was first suggested. The baby's heartbeat had been strong and steady the whole time, and there was never any sign of distress so, as we planned a large family, the doctor agreed I should try labouring for a while longer, as a caesarean could make future births more difficult. I had not read the chapter on caesarean birth in *What to Expect When You're Expecting* (yes sadly, that was the type of book I was reading) and I still thought that my nice oils and yoga positions would help me.

We signed the consent form through tears—I knew I didn't want my baby born this way, but we were all (my husband and I, and my mum too) so tired and the hospital staff had told me that I hadn't progressed since being on the syntocinon so I would probably never progress. My son was born at 1pm after about 23 hours of labour.

As the midwife had read my birth plan, she helped to make things happen that were important to me, like skin-to-skin contact immediately after birth (she took the most precious photo of this!), breastfeeding in recovery and keeping the placenta.

Later, when I got my notes I found that after having been 5 cm dilated for hours and hours, my final VE in the operating room was 8 cm. These VE findings were not discussed with me and I wondered why. To characterise my first birth as a hospital-interfered-with, failure-to-wait (aka failure to progress) disaster is unfair on the hospital staff, but it is difficult for me to remember to be grateful for what they could do, given that they were so restricted in what they could have offered.

For my second pregnancy, I booked into the same hospital and I wanted to try to have a vaginal birth after caesarean (VBAC), so I also hired a private midwife for extra support. I also saw an obstetrician, where I could ask any questions about how VBAC would be handled, because I was high risk. I asked her so many questions she told me it was worse than sitting her final exams. Most of the answers were as I expected and were quite specific around how long I could labour and push, no use of syntocinon, no induction and not going too overdue.

My midwife suggested a blood test to check iron levels because I was still breastfeeding my older son, so I went to a local GP. He refused to request the test and he didn't want to get involved because I said I was considering a homebirth. I had to go into the hospital for this test, and the

doctor there booked me in for a 19-week ultrasound. She was already appalled I had refused the early scan and didn't want this one. I was 8 or 9 weeks pregnant already and knew my dates, and had told them there was nothing they could tell me about my baby that would make me consider abortion, but she booked the appointment anyway.

Again I laboured at home. This time I knew my midwife would be with me for as long as it took. After she had been at my house for a number of hours (I might have called her a little too early!) she suggested having another midwife attend. The second midwife was already known to me and I agreed. The second midwife had new suggestions, and more strength for me to call upon. She was also able to help keep my husband involved and focused. Later, when transfer to hospital became a possibility, she was able to help discuss pros and cons, but I decided not to go. The midwife didn't abandon me, despite not following her recommendation to transfer, and was very helpful.

The way in which the second midwife was invited into the birth space, our home, was respectful and professional. My primary midwife explained why she thought it was a good idea to get another midwife to attend, and I was asked my permission first. The second midwife moved respectfully and quietly into my home, didn't make any sudden changes or even any comments, she watched what was unfolding and then spoke quietly and helpfully to me. I did not feel that her presence was a sign that things were progressing too slowly or that there was any danger. The atmosphere was kept calm and so I was calm. I was able to move past the fear I was carrying from my own birth, and that of my first son, and to birth a baby all by myself. Of course I didn't do it by myself, but that was how the experience felt. Thanks to my midwives working so hard, and so quietly, I felt like I had achieved something amazing. The early days of being a mother of two were so much easier to live through compared to the days and weeks of first becoming a mother where I felt I had failed already because I couldn't even give birth properly.

The way the unexpected collaboration occurred was perfect. I was consulted, I agreed, the new care provider was respectful and quiet until she was sure of the situation, and the two midwives worked together to make it look like they were doing nothing at all. Later I learned they had had different opinions on some things but that had never been an issue for me. They discussed the situation away from me, and presented me with my options in a calm way. The effect of this positive birth experience is astounding to me still, two years later.

Source: NHMRC consultations (2010).

Anne Maree's story

Anne Maree's story highlights how collaboration can work in practice to provide high-quality woman-centred care. In this case, collaboration was based on mutual respect between health professionals and was tailored to the needs of the individual woman.

Anne Maree has two children; her first baby presented as transverse (lying across in the uterus) and she needed to have a caesarean section. Anne Maree had the constant support of a private midwife throughout the pregnancy and birth, who assisted Anne Maree in planning for a positive caesarean. They arranged to have a number of personal touches such as Anne Maree's choice of music playing in the operating theatre. She was never separated from her baby. Afterwards one of the theatre nurses came to see Anne Maree and told her it was the best caesarean they had ever seen at the hospital and that all caesareans should be like that. Anne Maree attributes this wonderful experience to the thoughtful consultation and collaboration of her midwife with the medical and theatre team, including the obstetrician and anaesthetist.

Six years later Anne Maree was pregnant again. Early in the pregnancy she had concluded from careful research that it was very possible to have a vaginal birth after caesarean. Anne Maree wanted a consistent, ongoing relationship with her primary caregiver and chose a private midwife



as she felt that this would maximise her chances of having a natural birth if it was possible. Her private midwife encouraged Anne Maree to meet with an experienced obstetrician in a nearby regional city just in case she needed his particular expertise. The midwife accompanied Anne Maree and her husband to the appointment. As the pregnancy progressed the baby presented as breech and Anne Maree continued to see the obstetrician and her midwife.

Anne Maree found the contribution of her private midwife to be invaluable as she considered the possibility of having a natural breech birth in a public hospital with the support of the obstetrician. After discussion and careful questioning, the obstetrician agreed to all of Anne Maree's requests related to her labour care, for example positions for birth. The obstetrician was experienced in breech births and respected the experience of Anne Maree's midwife. Anne Maree respected the judgment of the obstetrician and told him that they would follow his advice in labour if at any stage he felt surgery was needed. Anne Maree laboured at home in the care of her midwife until she transferred to hospital where approximately five hours later her daughter was born breech in a gentle natural birth with all of their requests respected.

Source: NHMRC consultations (2010).

Stacie and Don's story

We live rurally about two hours east of Perth and our hospital can no longer deliver babies there. I wasn't very keen to undergo another caesarean for my birth due to the recovery time of my past experience and I now also had two toddlers to care for, in a relatively remote location. We were unsure as to the support we would receive in attempting a vaginal birth after caesarean (VBAC), given our most recent birth experience and our distance from Perth.

Fortunately, we were able to find a doctor who was very supportive of our choice and we planned the birth approach that best suited us and the doctor's safety parameters.

As my pregnancy progressed to the last weeks, I became very apprehensive and fearful for the safety of our baby's arrival. We visited the doctor at 39 weeks. At this time we ended up choosing an elective caesarean. The process was explained to us, and with a date set we went home to pack and prepare (and still kind of hoping I would go into labour naturally!).

I felt rather sad leading up to the birth, feeling that by planning the whole process in this way it would detract from the natural phenomena that birth should be and had previously been for me. Scarlett's birth had been overwhelming, but her safe arrival was paramount and while we wanted this new baby to be safe too, it was still hard to believe it was right for me to be making the choice to have him surgically.

So we thought through what we would have wanted, had we had the VBAC we were planning. It was suggested that we have some music we liked (my 16-year old put together a CD with everything from the Muppets to Counting Crows on it!). On the day, we asked if the baby could be delivered straight onto my chest (skin to skin) and that the cord be emptied of blood before being cut by my husband. All our requests were received and accepted, which sort of surprised us. The midwives that would be with us were also excited about our birth!

And it was wonderful! Our beautiful little 9 lb 15 oz boy was born and delivered straight onto my chest. I was able to hold, kiss and just look at him for the first 20 minutes or so of his life before they took him to be checked over, and having that time with him was so special; he was so calm and watchful. The atmosphere in the operating theatre was one of complete support.

There was so much kindness surrounding us (with touches of humour), which continued out into the recovery area and up onto the ward. The staff were extraordinary; everyone that we had any involvement with, from the antenatal clinic to the theatre staff, to the lovely women who tidied our room or delivered our meals, to the beautiful souls that helped us through the first few days of Harrison's arrival into this world. It was absolutely the right place for us to have our baby and we thank everyone who was a part of our birth experience.

Source: WA Department of Health (2007).

Obstetrician's experience

A woman was in labour at home with a private midwife for a planned homebirth. She laboured slowly and was then at full dilation for a prolonged time. She was finally brought in to the local public hospital, exhausted and in obstructed labour.

There was no existing collaborative relationship between the private midwife and the hospital staff. The midwife did not stay with the woman in the hospital. It took the hospital midwives and obstetrician several hours to negotiate a caesarean section for her (she had a malpresentation), as the woman did not consent to the procedure.

Next time around, she saw a private obstetrician for her antenatal care, and had a planned caesarean section at term. She was very pleased with the outcome.

Source: Private obstetrician's personal account, ACT.

Services/programs

Queensland Health/Toowoomba Hospital and midwives in private practice developing a memorandum of understanding (MOU)

This document is being developed by midwives in private practice (MIPPs) in Toowoomba and the Director of Nursing and staff at Toowoomba Public Hospital.

To ensure the safest care for clients of the MIPPs, the midwives approached Toowoomba Hospital to negotiate a positive way for clients of MIPPs to access the services of Toowoomba Hospital. From these discussions the idea of a MOU developed. Both the midwives and the hospital staff wanted to ensure seamless care for the woman should a consultation, referral or transfer into hospital of mother and/or baby become necessary. The need for exchange of information between the woman's midwife and the health care facility was also considered extremely important. An example of this would be when the midwife follows up on a woman's test results or the woman is booking into the hospital. It is understood that a woman and her family would always need to give their consent for information about her to be given by her midwife to others.

As part of the MOU the MIPPs have developed comprehensive pregnancy referral and booking guidelines and they also use the ACM *National Midwifery Guidelines for Consultation and Referral* in their practice (ACM 2008). Hospital staff and all other stakeholders are developing joint workplace instructions to ensure there is shared understanding and agreement around a woman's care while in hospital. These discussions included such issues as the midwife contacting the on call consultant for clinical guidance during a woman's labour, providing notes from the labour in the event of transfer to hospital and also obtaining the women's informed consent and any possible declining of advice or care.

At this stage the arrangements currently give the MIPP no clinical governance in the hospital. The expectation is that decision making is based on a team approach involving the woman and her partner, their midwife and the hospital medical and midwifery staff.



The MIPPs guidelines also outline the woman's postnatal care and provide information back to the woman's GP and community family health services.

The hospital is also keen to foster positive working relationships between its staff and the MIPPs, and the MIPPs are now able to attend the various education seminars and skill update sessions the hospital holds. In addition, in the event of a client transferring to hospital from home during labour, the midwife providing her care will attend the hospital multidisciplinary meetings where care is reviewed. This allows the midwife to give accurate information about the woman's clinical situation and the care provided before coming to hospital.

Source: Acting Nursing Director, Women's & Children's Health, Toowoomba Hospital and Toowoomba private practice midwife.

Royal Hospital for Women, Sydney, Midwifery Group Practice

The midwives in the Royal Hospital for Women Midwifery Group Practice (MGP) are employed on annual salaries, allowing their workload to be arranged according to the needs of the women in their care. Each midwife has a caseload of around 40 women per year. The MGP currently cares for 1250 women per year. All women are eligible for MGP care, regardless of their identified risk factors. Referral and consultation for medical advice or referral is based on the ACM national midwifery guidelines (ACM 2008). The midwives work in group practices of four full-time equivalent midwives per group practice and have an identified obstetrician for each group practice, with whom they consult in the first instance about any concerns with medical management or to review blood test results.

In the MGP, the collaborative relationship between MGP midwives and obstetricians is similar to the relationship between obstetricians and other obstetric staff. The MGP model fosters increased continuity of care (and of carer), and a continuing relationship with the midwives enables the obstetrician to develop trust in their ability to screen for problems.

Part of the program at the Royal Hospital for Women is being conducted as a randomised controlled (multicentre) trial. Early results suggest that the MGP model has reduced rates of caesarean section, length of hospital stay and admission to the neonatal intensive care unit; improved work practices; reduced numbers of overtime staff employed in the delivery suite; and has contributed to a ready supply of midwives with their names on the waiting list to be employed at the hospital. Many of the obstetricians enjoy working with the midwives and most visiting medical officers have been happy to participate, possibly because they are aware that the program is being evaluated carefully.

The women in the program carry their antenatal card (a brief summary of their pregnancy and medical history) and the hospital staff can access shared records. If conflict occurs during decision making, a standard escalation policy is used to identify the conflict and bring in the next-senior level of decision making. All area health service policy and guidelines are adhered to.

The program highlights how midwives can offer continuity of carer to all women, regardless of identified risk factors. It also demonstrates how obstetricians can have a role in low-risk care. It shows how pathways for consultation can be made clear, and how obstetricians and midwives working together can develop trust and respect. The trial has not yet evaluated the impact on teaching and training. The MGP model may have advantages for registrars and all midwifery and medical students rotating through the service in providing opportunities for continuity of care with women, opportunities to experience peer review and opportunities to learn how to work collaboratively together in a multidisciplinary team.

Source: Information presented at the NHMRC Forum on Developing National Guidance for Collaborative Maternity Care, December 2009 (see Appendix 3)

Peel Maternity and Family Practice: caring for mothers and babies

The Peel Maternity and Family Practice is a general practice that provides care for women through their antenatal and intrapartum period, and for women and their babies in the immediate postpartum period. The practice aims to provide a coordinated and holistic team approach, with a small family atmosphere. The practice provides comprehensive management from conception through the antenatal periods, delivery and postnatal checkups.

The practice also provides contraceptive advice and management (including Implanon and intrauterine device insertion and removal), Pap smears, screening for sexually transmitted infections and other minor gynaecological procedures and advice. The practice consists of GP obstetricians and midwives. The GP obstetricians attend the delivery at the local hospital and provide care in hospital after delivery along with the hospital-employed midwives. The midwives at the practice also work part time on the maternity unit, so are at times able to care for the women in labour too. Other doctors may assist with sessions from time to time and a dietician is available for private appointments.

The midwives provide much of the day-to-day care, with the doctors in a more supervisory role, becoming more involved if problems develop.

Source: NHMRC Workshop on Collaborative Maternity Care, October 2009 (see Appendix 1); WA Department of Health (2007).

South Coastal Women's Health Services

The South Coastal Women's Health Services provides antenatal and postnatal services that are culturally focused and delivered through clinics or by home visits as per the client's choice. The locations of these clinics, ease of access and the need for transport assistance has been given much consideration. This service works in partnership with other services and agencies, adding capacity and enhancing services, and offers a more comprehensive model of care. It ensures personalised continuity of care for the client that is delivered in a relaxed and informal environment. The service operates an open appointment system that is not rushed. It has a fully equipped crèche staffed by child care workers, and this area is also used as the waiting room and for the provision of parent education. Care is provided by Aboriginal health workers, midwives, female GPs, mothercraft nurses, and Aboriginal counsellors and educators.

I was very surprised by the support given to me at the clinic; they helped me to adjust to my pregnancy, they were very supportive and organised. The clinic is in a very convenient place and having transport available was a great help. Another good thing is that you are seen quicker than if you were in a doctor's surgery and having Aboriginal health workers is good because often places don't have any Aboriginal staff. (Quote from a woman who used the South Coastal Women's Health Service)

Source: WA Department of Health (2007).

Anangu Bibi Family Birthing Program, Port Augusta and Whyalla, South Australia

I think non-Aboriginal people and Aboriginal people working together is a good way. Non-Aboriginal people can't offer the service without us, but we can't do it without them either. (Aboriginal Maternity and Infant Care Worker)

This quote captures the benefits of collaboration and how well it works to benefit the women using the services of the Regional and Family Birthing and Anangu Bibi Birthing Program.

This program was established in 2004 in two regional South Australian towns with the aim of improving primary and hospital care. It offers culturally appropriate care and support to Aboriginal women of all ages from Port Augusta and Whyalla and non-Aboriginal teenage women in the Whyalla area.

The project includes the following key principles:

- the service is led by Aboriginal Maternal and Infant Care (AMIC) workers
- skills are exchanged between midwives and AMIC workers
- the service offers primary health care with continuity of care givers.

However, although the service was set up to be led by AMIC workers, the relationship that has developed is much more of a two-way partnership model.

A key part of the program was the establishment of the Aboriginal Women's Advocacy Group. This group is made up of respected women and elders from several language groups in and around the area. This is an important component of collaboration within the project, as the group has a strong ongoing role in increasing understanding between both groups of workers.

The Port Augusta service provides care across pregnancy, labour, and birth and postnatal care, and employs three AMIC workers and four midwives. The Whyalla service provides antenatal and postnatal care with only one AMIC worker and one midwife.

All the women using the service have described the AMIC worker's role as a highlight of the program. Interviews with the AMIC workers showed the importance of the trust that has been built between the women, the AMIC workers and the midwives in getting to know each other. As the women see the AMIC workers working alongside the midwives, they feel more comfortable to raise health issues with the midwives. The AMIC workers, through their connections to the community and understanding of culture, assist the midwives and hospital staff in the best way to approach women regarding aspects of their care, or provide a communication link between the women and the midwives. Having care with the same midwives also helps the women to develop trust in the service. This has been particularly helpful within the hospital setting as women's past experience of mainstream services are not always positive.

An evaluation of the program found that skill sharing and two-way learning engenders mutual respect between the midwives and the Aboriginal workers. Clear benefits of the care model have been highlighted by both the AMIC workers and midwives, and cultural safety has been maintained for Aboriginal women and their families.

The good working relationships between the program midwives and the AMIC workers have also helped to increase understanding from staff in mainstream services about the challenges facing Aboriginal women.

Source: Stamp et al (2008).

St George Outreach Maternity Program, St George Hospital, Sydney

With the aim of improving the satisfaction of Australian women relating to their maternal care in public hospitals, the St George Hospital of Sydney's St George Outreach Maternity Project (STOMP) was designed to give women high-value continuity of care during pregnancy, birth and the postnatal period. Initially introduced in 1997 as a two-year randomised controlled trial, it is now a well-established part of mainstream maternity services, highly valued by the local communities it serves in southeastern Sydney. St George Hospital is one of the first public hospitals in Australia to offer a range of options for pregnant women on a permanent basis.

Since it commenced in 1997, the STOMP program has successfully evolved to its current structure, which began in August 2009. The most recent changes have moved from team midwifery to a midwifery group practice model of care. There are two groups of six full-time midwives who work in three sets of pairs, which provides good support for the midwives while maximising that care will occur with the women's main midwife and the backup midwife (the pair). Each full-time midwife cares for 40 women per year but they also meet the 40 clients of their backup midwife. The two groups run clinics in Hurstville, Rockdale and Riverwood suburbs in premises such as early childhood centres.

In the original project, St George Hospital moved the public hospital antenatal services into two community-based clinics run by a small team of midwives and an obstetrician or registrar. A high level of interdisciplinary collaboration and negotiation was required in order to achieve the transfer of the regular clinics into the community. This involved midwives, obstetricians, community health staff, hospital managers, staff from nongovernment agencies, researchers, bilingual health workers and others. The outcome has been the successful relocation to a community-based setting of what, in urban Australia, is traditionally a hospital-focused service. What has emerged is a model of care with the capacity to improve perinatal health outcomes, increase the use of midwives' skills, promote effective collaboration and facilitate access.

The program continues to offer care to women with pre-existing clinical risk factors or who develop risk factors during their pregnancy, through collaboration with obstetricians who also work at the centre. In addition to midwives, obstetric staff and auxiliaries, the department is supported by a dedicated team of anaesthetists who can provide 24-hour cover for obstetric emergencies and epidurals for pain relief where appropriate. The program has a regular weekly case review meeting with a consistent obstetric doctor (a registrar) in addition to linking into hospital clinics run by a consultant obstetrician for women planning their next birth after caesarean (NBAC, the term increasingly replacing vaginal birth after caesarean, VBAC). The case review meetings are a strong aspect of the collaborative relationship between staff and have developed into a valuable learning and teaching opportunity.

As mentioned, pregnancy care mostly occurs at the community clinics. The women birth at the St George Hospital Birth Centre or main Delivery Suite, and generally go home within 48 hours after the birth. The STOMP midwives usually visit the women while they are in the hospital postnatal ward and then provide, on average, three to four postnatal visits for follow-up care once women go home. The hospital sends discharge information to the woman's regular GP and the STOMP midwives also collaborate with GPs and other community women and children's services to maximise the smooth transition for the family back into the community.

Studies have shown that STOMP has been perceived by women to be beneficial. With more than 6000 babies born since the start of STOMP in 1997, the benefits have been far-reaching. The model is associated with a lower caesarean section rate and more positive experiences for women. It provides effective, cost-effective and satisfying maternity care, and shows that new models of maternity care can be implemented with existing resources when organisations have a strong commitment to change.

The permanent establishment of STOMP has been followed by the introduction of a number of different programs of care; for example, Risk Associated Pregnancy (RAP), which caters for pregnant women with more complex health problems. Similar to STOMP, it involves women in small groups being assigned to the same midwives, the same obstetrician, and the same physician during pregnancy and for their intrapartum care.

Source: STOMP program staff St George Hospital June 2010, South Eastern Sydney Illawarra Health 2007, Homer et al (2002), Sarzin (2001).



Belmont Birthing Services, John Hunter Hospital, Newcastle

The midwives in the Belmont Birthing Services (BBS) are employed on annual salaries, allowing their workload to be arranged according to the needs of the women in their care. Each midwife has a caseload of around 40 women per year. The BBS midwives currently care for 280 women per year; these women have low to medium levels of risk (as per the ACM guidelines). The midwives work in teams of four and each team works alongside an obstetrician, consulting with the obstetrician about any concerns or to assess blood test results.

BBS is currently expanding to accommodate 720 women per year, with 18 full-time equivalent midwives working within the group. The environment in which the woman chooses to have her care, including antenatal, intrapartum, birth and postnatal, will be decided by the woman and her family, in consultation with her midwife working within an interdisciplinary team. This environment can be within the community (her home), the birth centre or the hospital.

The services at Belmont and Ryde hospitals are currently being evaluated through a three-year (2009–11) prospective cohort study of primary level maternity units in Australia and New Zealand funded by the NHMRC.

Source: NHMRC consultations (2010).

Nambour Selangor Private Hospital Maternity Unit, Sunshine Coast

Nambour Selangor Private Hospital Maternity Unit (Selangor) is located in Nambour, on the Sunshine Coast in Queensland. It began in 1997, after two years of planning. The unit started with a collaborative model of care. The reasons for this were many, but primarily the obstetricians and midwives were united in the view that the best care for women came from different health professionals bringing different skills to the mix of woman-centred care.

How did it begin?

The hospital owners listened to a considered argument based on current and future needs for a different sort of maternity service, and the decision to base the unit around a collaborative model of care was made to attract quality staff and avoid the ‘turf wars’ between different maternity professionals that obstetricians were sick of. The first maternity unit manager had a broad background of hospital midwifery education and homebirth practice.

The maternity unit protocols and policies were developed collaboratively from current evidence, with input from all working in the unit and other interested parties. There were many disagreements in this process, but working together provided a good opportunity for professionals to learn and understand each other’s points of view. As the unit evolved, the policies have been regularly reviewed, maintaining an evidence base to provide the best service possible.

Although it is a private obstetric setting, there is a midwives’ clinic, which was initially set up by the hospital to provide more free consulting time for obstetricians. Women can be seen as often as they wish by midwives, in collaboration with obstetricians. It is a good way of demystifying the unit and allowing women to build rapport with midwives. Other benefits include links with antenatal education, (such as the ‘Know your midwife’ program) as many women were cared for in labour by a familiar midwife, allowing good continuity of carers. For staff, it provides an opportunity to develop a breadth of skills, and mentoring. Overall, it works well with only a few problems, and the feedback received has been that mothers like and value the service.

A waterbirth policy has been developed in response to requests from women and midwives. None of the obstetricians had any experience in waterbirths, but after a literature review, discussions, and visits to units practicing waterbirths, Selangor developed their own waterbirth policy, which was audited as part of the regular unit audits. The use of water during both labour and birth became a popular choice for women.

Other add-on clinics include a postnatal depression service run by a mental health nurse, who had developed close professional links to a consultant psychiatrist with an interest in antenatal and postnatal depression, a 'well baby' clinic and new parent classes. All these different clinics are multidisciplinary and were set up as a collaborative care model.

Unit audit

Three tiers of audit were developed, although at times there has been poor staff attendance at audit meetings. Audit activities include:

- weekly chart review of all births and the Adverse Patient Outcome program
- regular review of good and bad outcomes, with cases selected by the maternity unit manager
- combined perinatal morbidity and mortality review with the local public hospital, which has more than 2300 births per year
- 'catastrophe' review and root cause analysis as required.

Results

The results of implementing a collaborative model of care have been excellent, with good outcomes and stable intervention rates. Breastfeeding rates are more than 85% at six months, and mothers' feedback has been overwhelmingly positive.

Problems encountered

As the unit grew and staff changed (to five obstetricians and more than 80 midwives), it became more challenging to maintain a coherent model of care. At times there were some orientation problems for new staff, and governance issues due to personality differences between staff.

On occasions different professionals chose to work from a non-evidence-based approach, and there has been some disagreement between different team members about when collaboration should take place. In particular, obstetricians felt at times midwives had allowed labour to progress for too long without any intervention.

Conclusion

Collaborative care has taken a while to get right, but it can lead to improved care for women, a better work environment and more job satisfaction for all. It needs good governance and leadership, and a willingness to compromise, but now people want to work in the unit, which is good for morale.

A stable, core group of senior midwives have effectively led the midwives, and as obstetrician numbers have grown from two to five, it has allowed for 'succession' planning and development of special interests.

Having a regular audit process with *all* disciplines has helped to promote better outcomes as the risk management improved.

The hospital is currently expanding, with new programs being developed to meet demand, and a range of services available to better suit the needs of women and their families.

Source: Information provided by Dr E Weaver, Specialist Obstetrician, Nambour Selangor Private Hospital Maternity Unit.

Private obstetric and midwifery collaborative practice

Three midwives work part time in the specialists practice, from Monday to Friday. Two of these midwives also work at the private hospital in the birth suite where most of the practice clients birth their babies. This provides some continuity of care and a strong connection between the hospital and the practice.



As midwives we have autonomy within our scope of practice to make decisions about women's care, and arrange pathology, radiology and ultrasound on behalf of the obstetrician when she is away from the practice at one of the hospitals. For example, if a woman phones with particular symptoms, the midwife is able to arrange a scan and provide advice to her, or we liaise with the hospital to arrange for the woman to be reviewed.

We review the client's history when they first book into the practice, obtaining as much information as possible and prioritise more urgent cases to be seen in a timely fashion by the obstetrician. As this practice is for high-risk obstetric clients we have guidelines to assist decision making.

The midwives run a separate appointment book for both obstetric and gynaecological care. They see a range of women for antenatal and postnatal checks, wound care, breastfeeding issues, mastitis care and postnatal depression support. As many women have medical issues such as high blood pressure in pregnancy, we see them between regular visits with the doctor as required, and discuss with the obstetrician blood pressure readings and if there is the need to adjust medications. We assist women with booking in to hospital, and begin education for labour, birth and early parenting as well as doing preventive screening for postnatal depression. We aim to address any other concerns the women have about their pregnancy.

Connecting women to allied health professionals such as physiotherapists, dieticians, psychologists, community parenting and postnatal support services assists in maintaining a holistic approach to care for women during and after their pregnancies.

The clerical staff refer to us for clinical support for client's enquiries, and in turn we are able to refer to our specialist for medical advice whenever necessary. Assisting with minor surgical procedures in the rooms is an important role, as we can be a support person for the women and providing such services in the practice enables the women to avoid hospital admission for such procedures.

Having the midwives working in the practice has benefits for all stakeholders. We all work as a team and support each other, and this contributes to the efficient and effective running of the practice overall. Being able to work with a degree of independence as midwives is rewarding and takes a lot of time pressure off our specialist enabling her to concentrate on the care for women with more complex medical issues and her gynaecology practice.

Source: Practice midwives personal account, private obstetrics and gynaecology practice Canberra, ACT.

Appendix 3

Summary pamphlet for women

To help women understand how collaborative care arrangements can help them, the National Health and Medical Research Council has produced an A4 tri-fold pamphlet of information for women about collaborative maternity care. A copy of the pamphlet is provided below.

Who does what?

Midwives


Provide care to women during pregnancy—from conception until early parenting in collaboration with other health care providers. Midwives can provide most aspects of “low risk” pregnancy, labour and birth, and postnatal care to women. They may need to refer you to, or talk with, a doctor or other services if you or your baby have or develop any problems.

Obstetricians & GP

Provide specialised care for mothers and babies in collaboration with other health care providers. They can look after women with “routine” and “complicated” pregnancies and births, and provide labour and birth care in hospitals.

Your health professionals working together with you and your baby

Collaborative Maternity Care Information



Family doctors (GPs)

Also provide primary care to women during pregnancy in collaboration with other health care providers. Most family doctors do not assist with labour and birth in hospital. They can provide shared care with hospitals, midwives and/or obstetricians in pregnancy, and care to the new family after birth.

Australian Government
National Health and Medical Research Council
Department of Health and Ageing

www.nhmrc.gov.au

Woman-centred Collaborative Care

- You and your health care providers working together to help you receive safe, quality care throughout pregnancy, birth and after your baby is born.
- Women-centred care means that you are the focus of your health care, and that health professionals will work together with you and your family to make sure you get the best care. Giving you all the information you need about your care is important for you to make decisions. You should receive full information from all your health carers which should be suited to you, and have the chance to ask questions about your choices, what you want and what you're not sure of. When you are included in discussions and decisions this gives you—and other women—the best quality, safe care. Women-centred collaborative care allows for:
- Respect for your goals and values.
 - Better services because it is centred on you and your family.
 - Supportive relationships with care providers.
 - Up-to-date information from all carers, based on the best research to enable you to make the best and safest choices and decisions for you and baby.
 - Respect for your right to make decisions about your care, or refuse advice from clinicians.
 - Regular and respectful communication between caregivers.

Questions you may want to think about

Hospitals, GPs, Obstetricians, midwives and other services and carers all have skills and options that are a bit different. With so many it's helpful to ask what these are and how they fit with what you want and need.

The questions below can help you get the care you want during your pregnancy, birth and early parenting time.

Pregnancy

Have you thought about what kind of pregnancy, labour and birth care you would like? Is the type of care you would like available in your area?

Have you discussed who your main maternity carer will be?

Have you spoken to them about their role and responsibilities and what type of care they can and can't provide? Are there other members in your care provider's team?

You should be supported in your choices and have access to safe, good quality care. Sometimes your main care provider may wish to talk with or refer you to other health professionals to do this.

Have you given as much information as possible to your care provider and team about your health and what you need, want and expect during your pregnancy, birth and after your birth?

Have you been happy with the information you have received? Was it in a language you understood? Were you given enough time to ask questions and make decisions?

Do you have a partner or other support people? Have you talked about how they will be involved?

Are you aware of your rights and responsibilities?

Your care provider should give you information on the pros and cons of any options, tests etc. Feel free to ask for more information and evidence for these recommendations. A useful acronym to remember is BRAN (what are the Benefits, Risks, and Alternatives and what happens if you do Nothing).

At any time you can ask for a second opinion and you have the right to decide what care you receive. This includes not following advice or treatment (including tests) if you choose.

Labour and Birth

Do you have things you want for the labour and birth, or things you are worried about?

- Have you discussed them with your care provider?
- Does your care provider understand and agree with your choices?
- Have you planned with your carer how to make this happen?

What happens if things do not go to plan?

Labour and birth can be very intense and not always what you expect. By planning what might happen and what to do, where to go and who will you see if your situation changes you can be more in control and calm.

- Have you discussed what will happen if you need to transfer care to another health care provider either in your pregnancy or during your labour?
- Do you know who else works with your care provider?

Postnatal

Do you know who your care providers will be after your baby is born, and what role they have? Do you know how long you will receive care and where you will receive it?

Have you talked about what postnatal care you want and what services or support are available for you, your family and your baby?

Have you been given information about early childhood and parenting help in your community? Most areas have carers to help with breastfeeding and other needs after your baby is born.

Have you been given a copy of your medical records if you want one? If you have a regular GP and want them to have a copy, you should ask your carer to send it to them.

Do you feel comfortable with the way your records have been managed?

Are you happy with the way your care has been provided? Have you provided any feedback to your carer? Health professionals are people too- by talking about what was great and what you weren't happy with in your care you can help them help you. If this doesn't work- you have a right to complain about your care. Do you know how to do this?



■ Glossary

Clinical privileging is the process by which a health care professional is granted permission by a health service (e.g. a hospital) to provide care services within defined limits. These limits are based on an individual's qualifications, experience and registration status.

Collaborating partners are maternity care professionals who are actively collaborating (i.e. not in an employee–employer relationship). Collaborating partners refer women to each other as the need arises.

Collaboration is a process where two or more independent professionals work together with the woman to achieve common goals by sharing knowledge, learning and building consensus.

Collaborative agreement or arrangement describes an informal or formal recognition of the terms of a collaboration.

Collaborative practice refers to a group of maternity care professionals who collaborate with each other and with women in the planning and delivery of their maternity care (see also Section 1.1).

Continuity of care describes a situation where a woman is cared for by a group of professionals who share common ways of working and a common philosophy.

Continuity of carer means care provided, or supervised, over time by the same trusted carer (usually including backup arrangements).

Coordinator of care is the person nominated by a woman to coordinate her maternity care.

Doula is a nonclinical professional support person who assists the woman and her family to prepare for birth and parenting through emotional and physical support.

Family is used in this document to mean the woman's spouse, husband, defacto, partner, sibling, kin, parent, guardian or community.

Informed choice occurs when a woman has the autonomy and control to make decisions about her care after a process of information exchange that involves providing her with sufficient, evidence-based information about all options for her care, in the absence of coercion by any party and without withholding information about any options.

Informed consent is when a woman consents to a recommendation about her care after a process of information exchange that involves providing her with sufficient, evidence-based information about all the options for her care so that she can make a decision, in the absence of coercion by any party, that reflects self-determination, autonomy and control.

Informed refusal is when a woman refuses a recommendation about her care after a process of information exchange that involves providing the woman with sufficient, evidence-based information so that she can make a decision that reflects self-determination, autonomy and control.

Maternity care professionals are registered clinicians who provide care for women during antenatal, intrapartum or postnatal stages of maternity care (e.g. midwives, GP obstetricians, obstetricians and GPs).

Strong women workers are women who have specialised cultural knowledge related to their local community who work with Aboriginal and Torres Strait Islander health workers and other professionals in their communities in projects generally related to improving the health of pregnant women, new mothers and their babies.

Woman-centred care is focused on the woman's individual, unique needs, expectations and aspirations, rather than the needs of institutions or maternity service professionals. This type of care recognises the woman's right to self-determination in terms of choice, control, and continuity of care.

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