



National Maternity Services Plan

2014 – 2015 Annual Report

National Maternity Services Plan: 2014-15 Annual Report

Copyright Statements:

© Commonwealth of Australia 2016

This document was prepared on behalf of the National Maternity Services Inter Jurisdictional Committee under the auspices of the Australian Health Ministers' Advisory Council.

Print material:

© Copyright of Australia 2016

This work is copyright. You may reproduce the whole or part of this work in unaltered form for your own personal use or, if you are part of an organisation, for internal use within your organisation, but only if you or your organisation do not use the reproduction for any commercial purpose and retain this copyright notice and all disclaimer notices as part of that reproduction. Apart from rights to use as permitted by the Copyright Act 1968 or allowed by this copyright notice, all other rights are reserved and you are not allowed to reproduce the whole or any part of this work in any way (electronic or otherwise) without first being given the specific written permission from the Commonwealth to do so. Requests and inquiries concerning reproduction and rights are to be sent to the Communication Branch, Department of Health, GPO Box 9848, Canberra ACT 2601, or via e-mail to copyright@health.gov.au.

Online material:

© Copyright of Australia 2016

This work is copyright. You may download, display, print and reproduce the whole or part of this work in unaltered form for your own personal use or, if you are part of an organisation, for internal use within your organisation, but only if you or your organisation do not use the reproduction for any commercial purpose and retain this copyright notice and all disclaimer notices as part of that reproduction. Apart from rights to use as permitted by the Copyright Act 1968 or allowed by this copyright notice, all other rights are reserved and you are not allowed to reproduce the whole or any part of this work in any way (electronic or otherwise) without first being given the specific written permission from the Commonwealth to do so. Requests and inquiries concerning reproduction and rights are to be sent to the Communication Branch, Department of Health, GPO Box 9848, Canberra ACT 2601, or via e-mail to copyright@health.gov.au.

© Australian Health Ministers' Advisory Council 2016

This report was prepared under the auspices of the Australian Health Ministers' Advisory Council.

Enquiries about the content of the report should be directed to the Maternity Services Inter-jurisdictional Committee Secretariat [msijcsecretariat_WA @health.wa.gov.au](mailto:msijcsecretariat_WA@health.wa.gov.au)

ABBREVIATIONS

AHMAC	Australian Health Ministers' Advisory Council
AHWMC	Australian Health Workforce Ministerial Council
AIHW	Australian Institute of Health and Welfare
ALSO	Advanced Life Support in Obstetrics
AMIC	Aboriginal and Maternal Infant Care
ATSIHP	Aboriginal and Torres Strait Islander Health Practitioner
CATSINaM	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CHSALHN	Country Health South Australia Local Health Network
CCPHPC	Community Care and Population Health Principal Committee
COAG	Council of Australian Governments
DSS	Data Set Specification
FARE	Foundation for Alcohol Research & Education
FGM	Female Genital Mutilation
HWA	Health Workforce Australia
HWPC	Health Workforce Principal Committee
IPTAAS	Isolated Patients Travel and Accommodation Assistance Scheme
MaCCS	Maternity Care Classification System
MBS	Medicare Benefits Schedule
MCP	Maternity Connect Program
MGP	Midwifery Group Practice
MHDAS	Mental Health and Drug and Alcohol Services
MIDUS	Midwifery Upskilling training
MoC DSS	Maternity Models of Care Data Set Specification
MSIJC	Maternity Services Inter Jurisdictional Committee
MSOAP	Medical Services Outreach Assistance Programme
NALHN	Northern Adelaide Local Health Network
NAHSSS	Nursing and Allied Health Scholarship and Support Scheme
NARHLS	Nursing and Allied Health Rural Locum Scheme
NCMI	National Core Maternity Indicators

NHMRC	National Health and Medical Research Council
NMBA	Nursing and Midwifery Board of Australia
NMDDP	National Maternity Data Development Project
NNMEAN	National Nursing and Midwifery Education Advisory Network
NPDI	National Perinatal Depression Initiative
PATS	Patient Assistance Transport Scheme
PBS	Pharmaceutical Benefits Schedule
PHMSS	Puggy Hunter Memorial Scholarship Scheme
PrOMPT	Practical Obstetric Multi Professional Training
PTAS	Patient Travel Assistance Scheme
PTSS	Patient Travel Subsidy Scheme
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RHOF	Rural Health Outreach Fund
ROALS	Rural Obstetric and Anaesthetic Locum Scheme
RPGP	Rural Procedural Grants Program
SIHI	Southern Inland Health initiative
TCEN	Tasmanian Clinical Education Network
VPTAS	Victorian Patient Transport Assistance Scheme
WCHN	Women and Children's Health Network

EXECUTIVE SUMMARY

The National Maternity Services Plan (the Plan) sets out a five year vision for maternity care across Australia. The Plan recognises the importance of maternity services within the health system and provides a strategic national framework to guide ongoing policy and program development from 2010 to 2015. It identifies four priority areas (Access, Service delivery, Workforce and Infrastructure) to improve women's access to maternity services and service delivery.

Annual Reports against the Plan have been published for the 2010-11, 2011-12, and 2012-13 periods. The 2013-14 Annual Report is undergoing endorsement and expected to be published late in 2015. During the period 2014-15, progress has been very positive given the limited resources available to progress items under the Plan. The four key priorities of the Plan have been addressed with a number of significant achievements. These include:

- The national *Pregnancy, Birth and Baby* helpline received over 189,986 calls since it commenced operation on 1 July 2010;
- Three new core maternity indicators were endorsed and are being added to the existing set of 10 national core maternity indicators;
- A national survey examining availability of access to a midwifery carer for postnatal care outside of the hospital setting was undertaken and a report is being finalised;
- 516 maternity and paediatric services were delivered in more than 265 locations nationally under the Rural Health Outreach Fund;
- The *Clinical Practice Guidelines Antenatal Care – Module 2*, covering the second and third trimester of pregnancy were released in February 2015;
- States and Territories continued to provide perinatal mental health screening and referral services;
- The *Women Want To Know* project was launched to encourage health professionals to talk about alcohol consumption with women who are pregnant, planning a pregnancy or breastfeeding and to give the consistent message that no alcohol is the safest option;
- Six scholarships for midwifery were offered under the Puggy Hunter Memorial Scholarship Scheme;
- Stage 2 of the National Maternity Data Development was completed;
- The National Maternity Services Capability Framework continued to inform maternity service planning and risk management improvement in maternity care; and
- Patient travel support schemes continued to operate to provide financial support to women who are required to travel to access maternity and neonatal care.

Whilst the Plan concludes at the end of 2015, the Maternity Services Inter-Jurisdictional Committee (MSIJC) has been extended to 30 June 2016 to continue work on incomplete actions under the Plan. The MSIJC looks forward to making further achievements that will contribute to improving the coordination and delivery of maternity services during 2015-16.

All Australian governments and both government and on-government organisations should be congratulated on the achievements to date. A cooperative and collaborative working relationship between key stakeholders has contributed to the success of the Plan.



Ms Tracy Martin
Chair
Maternity Services Inter-Jurisdictional Committee

BACKGROUND

The Plan was endorsed by the Australian Health Ministers' Conference, comprised of members of state and territory governments and the Australian Government, in November 2010. The Plan recognises the importance of maternity services within the Australian health system and provides a national framework to guide policy and program development over five years from 2010-2015. It aims to improve co-ordination and ensure better access to maternity services across Australia.

The Plan acknowledges that maternity care should be evidence-based and woman-centred. It recognises that comprehensive maternity care requires service planning that is cognisant of and responsive to women's needs and preferences and their ability to access objective, evidence-based information that supports informed choices within a system that emphasises safety and quality.

The Plan identifies four key priority areas:

- Access;
- Service delivery;
- Workforce; and
- Infrastructure.

These priorities were identified through review and consultation, and reflect the high demand for maternity services that are responsive to the needs of all Australian women, and their partners and families. Actions are outlined under each of the four priority areas, and each action is further broken down into action items that cover the initial (2010-11), middle (2012-13), and later years (2014-16).

The Plan recognises that some sectors of the population, including Aboriginal and Torres Strait Islander people and rural and remote communities, experience poorer maternal and perinatal outcomes. Within the four key priority areas, the Plan includes actions that specifically aim to reduce these inequalities.

An annual reporting framework, which includes a report to Health Ministers, was developed by the MSIJC and endorsed by Australian Health Ministers' Advisory Council (AHMAC) in June 2011. It was agreed that Annual Reports would include a brief update on project progress, and highlight any substantial risks or significant barriers to implementation. The reporting framework noted that Annual Reports would be prepared and endorsed by the MSIJC before being provided to the Community Care and Population Health Principal Committee (CCPHPC) and AHMAC for endorsement, and then made publicly available. The MSIJC has prepared the 2014-15 Annual Report which outlines key achievements and progress against action items under the National Maternity Services Plan.

Previous copies of the Annual Reports can be accessed from the maternity publications page on the Australian Government Department of Health website at <http://www.health.gov.au/internet/main/publishing.nsf/Content/maternity-pubs>

ACHIEVEMENTS AND PROGRESS

The Plan's achievements have been supported by the ongoing collaborative efforts of Commonwealth, State and Territory governments and various government and non-government organisations.

Over the 2014-15 period considerable progress has been made against the four key priorities of the Plan as detailed in this report.

PRIORITY 1 – ACCESS

Actions under this priority include increasing access for Australian women and their family members to:

- information that supports their needs for maternity care (Action 1.1);
- local maternity care by expanding the range of models of care (Action 1.2); and
- high quality maternity care in rural and remote Australia (Actions 1.3 and 1.4).

PRIORITY 1 – ACCESS – KEY ACHIEVEMENTS OF 2014-15

- The national *Pregnancy, Birth and Baby* helpline received over 189,986 calls since it commenced operation in 2010. Since being launched in January 2013 to June 2015, the *Pregnancy, Birth and Baby* website has had 1,703,481 visits and 3,151,950 page views.
- Three new core maternity indicators were endorsed and are being added to the existing set of 10 national core maternity indicators.
- A national survey examining availability of access to a midwife for postnatal care outside of the hospital setting was undertaken.
- 516 maternity and paediatric services were delivered in more than 265 locations nationally under the Rural Health Outreach Fund.

PRIORITY 1 - PROGRESS REPORT

Pregnancy, Birth and Baby Helpline (1800 882 436)

Priority 1 of the Plan includes action to increase access for Australian women and their family members to information that supports their needs for maternity care. Work under this action during 2014-15 has included the provision and planning for the expansion of a national evidence-based pregnancy support helpline.

The *Pregnancy, Birth and Baby* helpline (the helpline) replaced the National Pregnancy Support Helpline on 1 July 2010. It offers a more comprehensive service, providing evidence-based information and advice on pregnancy, birthing, postnatal care and the early parenting period. It is a national service that can be accessed 24 hours a day, seven days a week.

Since its inception in 2010, the *Pregnancy, Birth and Baby* helpline has received over 189,986 calls. Since being launched in January 2013 to June 2015, the *Pregnancy, Birth and Baby* website (<http://www.pregnancybirthbaby.org.au/>) has had 1,703,481 visits and 3,151,950 page views.

The Australian Government is planning to expand the Pregnancy, Birth and Baby Helpline late in 2015. This will provide the public with access to evidence-based pregnancy and parenting information (ages 0 to 5 years). Topics will include child development and behavioural information, general pregnancy and parenting information, and tailored content for special interest groups.

Core Maternity Indicators

Work under Priority 1 also continued throughout 2014-15 to develop National Core Maternity Indicators (NCMIs). The Maternity Services Inter-Jurisdictional Committee Expert Working Group proposed a set of 20 core maternity indicators in principle shortly after it assumed responsibility for the project. The first ten NCMIs were developed, and endorsed by AHMAC in December 2011. The National Core Maternity Indicators provide a baseline for monitoring changes in practice and outcomes of maternity services across Australia using nationally agreed clinical indicators. They will assist with improving the quality of maternity services in Australia by establishing baseline data for future monitoring and evaluation of practice change.

The *National core maternity indicators – stage 2 report: 2007-2011* was released by the Australian Institute of Health and Welfare (AIHW) on 17 November 2014. This report describes the development of an additional eight of the original 20 indicators, including scoping and assessing the feasibility of implementing and reporting. In late 2015, the National Health Information Standards and Statistics Committee (NHISSC) approved specifications for two of the eight indicators (NCMI 13 and 15). The status of all of the NCMIs is shown in Table 1. Following endorsement by the National Health Information and Performance Principal Committee (NHIPPC), they will be added to the existing set of 10 national core maternity indicators for reporting using the National Perinatal Data Collection. The indicators will be included in the updated data portal to be released in 2016.

Indicator 18 will be reported in 2018. This new data element captures the main indication for caesarean section and has recently been introduced into the Perinatal Data Set Specification (DSS) 2015-16. A new indicator on skin-to-skin contact after birth, which was not part of the original list, is also undergoing development. Further information is contained in the report which can be accessed from <http://www.aihw.gov.au/publication-detail/?id=60129549627>, and the NCMI data portal <http://www.aihw.gov.au/ncmi/>.

1. In 2015-16, the AIHW anticipates publishing data for NCMIs 13 and 15 for the first time and updating NCMIs 1-10 with data for 2004-2013 where available, bringing the total reported in 2015-16 to 12.
2. NCMIs 12 and 21 are undergoing further development work in 2015-16.
3. NCMI 14 requires further development work which will likely take place in 2017-18.
4. NCMIs 19 and 20 have been referred for further development elsewhere.
5. NCMI 18 will be first reported in 2018-19.
6. With the agreement of MSIJC or the jurisdictions, three indicators are not to be developed or reported at all (NCMIs 11, 16 and 17).

The current NCMI portal will be redeveloped in 2015-16 to improve usability and navigation.

Table 1. NCMI by status

Indicator	Indicator specifications approved by NHISSC	Status
1. Smoking in pregnancy for all women giving birth	Yes	Reported online ^(a)
2. Antenatal care in the first trimester for all women giving birth	Yes	Reported online ^(a)
3. Episiotomy for women having their first baby and giving birth vaginally	Yes	Reported online ^(a)
4. Apgar score of less than 7 at 5 minutes for births at term	Yes	Reported online ^(a)
5. Induction of labour for selected women giving birth for the first time	Yes	Reported online ^(a)
6. Caesarean section for selected women giving birth for the first time	Yes	Reported online ^(a)
7. Non-instrumental vaginal birth for selected women giving birth for the first time	Yes	Reported online ^(a)
8. Instrumental vaginal birth for selected women giving birth for the first time	Yes	Reported online ^(a)
9. General anaesthetic for women giving birth by caesarean section	Yes	Reported online ^(a)
10. Small babies among births at or after 40 weeks gestation	Yes	Reported online ^(a)
11. High risk women undergoing caesarean section who receive appropriate pharmacological thromboprophylaxis	No	Not to be reported ^(b)
12. Babies born ≥ 37 completed weeks gestation admitted to a neonatal intensive care nursery or special care nursery for reasons other than congenital anomaly	No	Further development in 2015-16
13. Third and fourth degree tears for (a) all first births and (b) all births	Yes	First reporting anticipated in 2015-16
14. Blood loss of (i) $>1,000$ mL and $< 1,500$ mL and (ii) $\geq 1,500$ mL during first 24 hours after the birth of the baby (i.e. primary PPH) for (a) vaginal births and (b) caesarean sections	No	Further development required ^(c)
15. Women having their second birth vaginally whose first birth was by caesarean section	Yes	First reporting anticipated in 2015-16
16. Separation of baby from the mother after birth for additional care	No	Not to be reported ^(d)
17. One-to-one care in labour	No	Not to be reported ^(d)
18. Caesarean sections at less than 39 completed weeks gestation (273 days) without obstetric/medical indication	No	First reporting in 2018-19
19. Supporting breastfeeding	No	Referred for further work elsewhere ^(e)
20. Models of care	No	Referred for further work elsewhere ^(f)
21. Skin-to-skin contact after birth	No	Further development in 2015-16

(a) NCMI data portal at <http://www.aihw.gov.au/ncmi/>

(b) The AIHW Expert Commentary Group recommended in 2013 that further development of NCMI 11 not be progressed. All jurisdictions agreed with this recommendation. This related to significant data quality issues.

(c) The data item underlying this indicator began to be reported voluntarily in 2014. National data is anticipated by 2018-19, prior to which indicator specifications will be sent to NHISSC for approval.

(d) MSIJC recommended that further development of this indicator not be progressed for NCMI 16 and 17.

(e) Work on this indicator was referred to the Child Health and Wellbeing Subcommittee.

(f) Work on this indicator will be covered by the National Maternity Data Development Project.

Expanding the range of maternity models of care

Priority 1 of the Plan includes increasing access to local maternity care by expanding the range of models of care available to Australian women and their families. This includes increasing access to midwifery managed and continuity of carer programs. It also involves investigating options for providing publicly funded homebirth and considering the implementation of publicly funded homebirth models.

Midwifery managed and continuity of carer programs

Midwifery managed models of care and continuity of carer programs have continued to increase across Australia. Models have ranged from caseload/team models of midwifery managed care to continuity of carer programs which incorporate antenatal and postnatal care.

Homebirth

Considerable progress has been made in relation to investigating and implementing publicly funded homebirth models since the Plan's inception. Most States and Territories (NSW, VIC, SA, WA, and NT) now offer publicly funded homebirth as an option for low risk women. Subject to government approval, publicly funded homebirth is expected to be available in the ACT in mid-2016. Tasmania is currently exploring options for providing publicly funded homebirth.

Safety and Quality Framework for Midwives

Action under Priority 1 includes endorsing a standard for a safety and quality framework for the provision of private homebirth. Progress has been positive in relation to this action, with the Nursing and Midwifery Board of Australia (NMBA) revising the *Safety and Quality Framework* and releasing the draft *Safety and Quality Guideline for Privately Practising Midwives* for public consultation in April 2014.

The proposed *Safety and Quality Guideline for Midwives* is not restricted to homebirth. It applies to all privately practising midwives, regardless of context of practice. It replaces the *Safety and quality framework for privately practising midwives attending homebirths* and combines the requirements of the registration standards, professional codes and guidelines to incorporate all the legislative and regulatory requirements for safe and professional midwifery practice into one single document. It is intended to ensure the protection of the public, and has been designed to assist privately practising midwives to shape their professional practice so they can provide safe, accountable, woman-centred care.

The NMBA is expecting to release the *Safety and quality framework for privately practising midwives* and the *Registration Standard: Endorsement for scheduled medicines for midwives* early in 2016. These two documents will contribute to improving access to safe and quality maternity care for Australian women and their families, regardless of where they choose to birth.

PROGRESS SNAPSHOT

New South Wales

Twelve of the fifteen Local Health Districts that provide maternity services are providing Midwifery Group Practice as a model of care. Twenty two maternity services are currently providing this as an option of care. An additional Local Health District will be offering Midwifery Group Practice as a model of care option from the 1st July 2015.

Publicly funded homebirth programs continue to be provided in a number of NSW public hospitals.

Victoria

Midwifery managed models continued to operate successfully at a number of health services in metropolitan, regional and rural Victoria, to enhance continuity of care and ensure the sustainability of birthing services. Plans are underway to commence a pilot of continuity of care models through collaborative arrangements with eligible midwives and to expand the publicly funded home birth program.

Queensland

Work has been ongoing to reintroduce birth services in rural areas. Midwifery group practice services continue to be developed and expanded across the State. Additional funding to support a comprehensive postnatal service has been provided to public healthcare service providers.

South Australia

Midwifery led models of care are available at all metropolitan and selected rural public maternity units in SA. Publicly funded homebirth services are available in metropolitan SA.

Western Australia

All Area Health Services providing maternity services in WA have implemented at least one midwifery group practice model. WA also provided publicly funded home birth programs for women living in the Perth metropolitan region, in one major regional centre and with another regional centre currently exploring this option. Work on developing a WA Midwifery Continuity of Carer Tool Kit continued during 2014-15, with consultation and endorsement expected to occur late in 2015.

Northern Territory

The NT Midwifery Group Practice (MGP) models continued to operate successfully in Darwin and Alice Springs. An MGP was also established in Tennant Creek as a satellite service linked to the Alice Springs MGP. This service operates in collaboration with Anyinginyi Health Aboriginal Corporation to provide midwifery led antenatal and postnatal services for women in Tennant Creek and Barkly district. Publicly funded homebirth services are available in Darwin and Alice Springs.

Seven dedicated Remote Area Midwifery positions based in community were funded and Remote Outreach midwifery services continued to support community-based services in all regions.

Australian Capital Territory

The Centenary Hospital for Women and Children provides midwifery led continuity of carer via two programs: the Canberra Midwifery Program and the Continuity at the Canberra Hospital program. These two programs provided care for approximately 1,400 women (30-35% of all births) at The Centenary Hospital for Women and Children in 2014-15. Calvary Health Care Birth Centre commenced in March 2014 providing care to normal risk women. 231 women received care through this program in 2014-15. Plans are underway to introduce publicly funded homebirth in the near future.

Tasmania

Midwifery led models of care continued to expand in Tasmania. All women accessing public maternity care services see a midwife as part of the established models of care operating in Tasmania. Options for providing publicly funded homebirth are being explored.

Clinical Privileges and Collaborative Arrangements for Eligible Midwives

Priority 1 of the Plan recognises the importance of developing consistent approaches to clinical privileges within public maternity services, to enable admitting and practice rights for eligible midwives and medical practitioners. This is critical for women who choose a private midwifery model of care in a public maternity service.

Progress has been made towards developing consistent approaches to the implementation of clinical privileging, credentialing and admitting rights for private midwives to public hospitals in many jurisdictions. However, there continue to be instances where midwives report difficulties establishing collaborative arrangements with obstetric doctors and hospitals. This is despite legislative amendments that took effect on 1 September 2013 to enable collaborative arrangements to be entered into with hospitals and health services, as well as with individual medical practitioners (i.e. obstetricians and GPs with obstetric qualifications).

As at June 2015, an insurance product (outside of the Commonwealth supported product) that covers home birth remains unavailable for privately practicing midwives. The exemption under section 184 of the *Health Practitioner Regulation National Law Act 2009* for privately practicing midwives to hold professional indemnity insurance for planned homebirth was reviewed by COAG Health Council on 17 April 2015. Health Ministers agreed to extend the exemption to 31 December 2016 whilst options for a solution are explored.

PROGRESS SNAPSHOT

New South Wales

A draft document relating to the provision of private midwifery services by eligible midwives in NSW Public Hospitals and an accompanying Access Arrangement has been developed. The Guideline and Access Arrangement are expected to be released late in 2015.

Victoria

Eligible midwives and collaborative arrangements: An implementation framework for Victorian public health services was published in 2013 to assist Victorian public health services to establish collaborative arrangements with eligible midwives.

The framework applies where women are planning to give birth in a public hospital as a private patient of an eligible midwife. It outlines the policy and regulatory environment relating to collaborative arrangements with eligible midwives. It is up to individual public health services to determine whether they implement collaborative arrangements with eligible midwives. Work is underway to establish a pilot program in 2015-16 for women who plan to give birth in a public hospital as the private patient of an eligible midwife.

In 2015-16, a pilot program will be undertaken in selected public health services that will allow women to birth in a public hospital as the private patient of an eligible midwife.

Queensland

Eight of 42 Queensland public hospital maternity units have credentialed eligible private practicing midwives providing continuity of care. More services are preparing to implement the model in the first quarter of 2016. Work is being undertaken, as a matter of priority, to expedite the introduction of collaborative arrangements in to rural and regional areas.

A state-wide, standardised Access and Collaboration Agreement is presently a work in progress. It is anticipated that this body of work will be complete within the second quarter of 2016.

South Australia

The *Clinical Privileging, Admitting and Practice Rights for Privately Practising Eligible Midwives in SA Policy Directive* was released in October 2014. This mandatory policy directive provides a mechanism for women to have a planned private midwifery model of care in a public maternity service in South Australia. Local Health Networks have completed their local procedures to support the process for eligible privately practising midwives applying for clinical privileging, admitting and practice rights. A monitoring framework and reporting structure is being developed.

Western Australia

Credentialed Committees have been established in all area health services with maternity units. CredWA, a state-wide credentialing database, has been established for eligible privately practising midwives to enable information to be submitted online. In June 2015, South Metropolitan Health Service became the first health service in WA to credential eligible privately practising midwives.

Northern Territory

The NT came into line with all other jurisdictions with the enactment of the *Health Practitioner Regulation (National Uniform Legislation) Amendment Act 2014* enabling midwives in the NT to provide intrapartum care in the home under National Law exemption for Professional Indemnity Insurance. Under the NT Medical Services Act, midwives do not have admitting rights to public health facilities and there are no midwives engaged in private practice. A Framework to guide private midwifery practice in the NT is being developed.

Australian Capital Territory

Arrangements for the credentialing process to enable privately practising eligible midwives to admit their own patients to the Centenary Hospital for Women and Children have been established. This includes a Deed of Collaborative Arrangement and Access License. Principles relating to working with eligible midwives are being drafted and midwifery staff are being prepared for this change through education and information sessions. Advertising to invite eligible midwives to apply for credentialing will commence in 2015-16.

Tasmania

Plans are underway to amend the clinical privileging framework to enable eligible privately practising midwives access to public facilities. It is anticipated that this will be achieved in 2015-16.

Access to Public Antenatal and Postnatal Care Services

Some of the actions under Priority 1 include a focus on access to public antenatal care and midwifery post natal care outside hospital settings for at least two weeks after birth. These actions aim to identify availability of access, and consider strategies for increasing access to public antenatal and midwifery based postnatal care in the community where required.

A survey was undertaken in 2012 to assess the level of public access to antenatal services across Australia and investigate factors that cause, or are associated with poor access. The *National Survey of Access to Public Antenatal Care Services 2012* reports on the results of the survey. This document has been endorsed by AHMAC and is expected to be available on the Department of Health's website late in 2015.

A survey was undertaken in 2014 to determine availability of access to a midwife for postnatal care outside the hospital setting for at least two weeks after birth and identify possible mechanisms to support the provision of midwifery postnatal care outside the hospital setting for at least two weeks after birth. The *National Survey of the Availability of Access to a Midwifery Carer for Postnatal Care Outside of the Hospital Setting* reports on the results of the survey. Subject to AHMAC endorsement, this document is expected to be available on the Department of Health's website in 2016.

PROGRESS SNAPSHOT

New South Wales

A number of public hospitals provide antenatal, birthing and postnatal care, with additional facilities providing antenatal and/or postnatal care only. Work with Local Health Districts continued throughout 2014-15 to ensure optimal and evidence-based antenatal care is provided in local settings.

Victoria

Fifty Victorian public hospitals provide antenatal, birthing and postnatal care, with a number of other hospitals also providing antenatal and postnatal care only.

Victoria continues to support programs targeting vulnerable and at risk women and their families during the antenatal and postnatal periods including Healthy Mothers Healthy Babies, the Koori Maternity Service program and Cradle to Kinder program. Programs may include outreach services to increase access for vulnerable women and women with access limitations. The Healthy Mothers Healthy Babies program continued to deliver services in eight local government areas across outer metropolitan Melbourne with high numbers of births, high rates of socioeconomic disadvantage and low service accessibility. In 2014-15 the program was expanded into the Frankston local government area (a total of nine LGAs).

Queensland

The delivery of antenatal and postnatal services in community settings continued in 2014-15 and is expected to expand due to the increasing numbers of services planning to offer midwifery models of care. Additionally, in 2014/2015, there were 1062 telehealth service events with a clinic code of obstetrics midwifery, midwifery-antenatal and midwifery-postnatal assigned. Telehealth numbers continue to improve with increased uptake by Hospital and Health Services.

South Australia

Northern Adelaide Local Health Network opened its fifth community site for women to access antenatal care. The Women and Children's Health Network (WCHN) now has seven community based sites for women to access antenatal community care. The Aboriginal Family Birthing Program at WCHN is reviewing their model of care for Aboriginal and Torres Strait Islander women. The review is occurring in collaboration with consumers to determine the optimal venue and service model.

The hospital based Breast Feeding Support Unit was incorporated into community the midwifery home visiting service to improve access and convenience for women with transfer of care to Child and Family Health Services after two weeks.

Western Australia

Enhancing services for women in rural areas has been a focus. As part of the Southern Inland Health initiative (SIHI) four part time community based midwives were employed across the Wheatbelt region in 2014-15. These community midwives provide antenatal clinics and postnatal care for women within the region via the primary health centre or in their homes. A part time community midwife was also employed to provide antenatal and postnatal care for women living in Katanning and surrounding areas in the Great Southern region.

SIHI is also developing a program to provide antenatal education via videoconferencing. This is expected to be completed in 2015-16, and will enable women in two regions to access antenatal education classes via Scopia from their homes or through the local Telehealth centre in the region.

Each of the Midwifery Group Practice programs established in WA provide postnatal care for at least two weeks following birth including those in regional areas. Additionally many of the Aboriginal Community Controlled Health Services in WA employ midwives who provided postnatal care to Aboriginal women in primary care settings for up to six weeks after birth.

Australian Capital Territory

During 2014-15, Calvary Health Care continued to provide antenatal outreach clinics in the north of Canberra. The Centenary Hospital for Women and Children provides antenatal outreach clinics in both the north and south community health settings of Canberra. Clients of the continuity of midwifery care models at both hospitals also have the option of receiving antenatal care in their home.

Within Calvary Health Care, the Midcall program and the Calvary Continuity of Midwifery Care Services provide postnatal care for up to ten days. Women birthing at the Centenary Hospital for Women and Children are offered domiciliary midwifery care for up to ten days following birth. Once discharged, ACT women are able to access Maternal and Child Health Services in the community.

Tasmania

Each of the four major hospitals provided antenatal care in 2014-15. Postnatal care for up to two weeks after birth in the community was also available. Outreach programs for rural communities are held when resources are available. Women who lived in areas without access to midwives were able to access Child Health Services. There was also an increased focus on providing antenatal and postnatal care to Tasmanian Aboriginal women in 2014-15.

Northern Territory

Community-based midwifery led antenatal care is provided in Darwin and Alice Springs. Alice Springs and Royal Darwin Hospital provide access to a midwife for postnatal care in the home for up to 10 days and the Midwifery Group Practices provide postnatal care for up to 6 weeks. Ultrasound training for Remote Area Midwives and Remote Outreach Midwives was provided to improve antenatal 'point of care' services and enable early dating and pregnancy monitoring in remote communities.

Rural Health Outreach Programs

The Plan includes a number of actions that aim to increase access to maternity services for women in rural and remote Australia. One of these relates to expanding the Medical Services Outreach Assistance Program (MSOAP) to include multidisciplinary maternity care teams. Whilst the MSOAP measure ceased on 30 June 2013, it was consolidated with a number of rural health outreach programs to form the Rural Health Outreach Fund (RHOF) on 1 July 2013. The RHOF aims to improve access to medical specialists, GPs, allied and other health professionals for people living in regional, rural and remote Australia. During 2014-15, maternity and paediatric health continued to be a priority under the RHOF. For the period 1 July 2014 to 30 June 2015, 516 maternity and paediatric services were delivered in more than 265 locations nationally.

PRIORITY 2 – SERVICE DELIVERY

Actions under this priority include:

- ensuring Australian maternity services provide high-quality, evidence-based maternity care (Action 2.1);
- developing and expanding culturally competent maternity care of Aboriginal and Torres Strait Islander people (Action 2.2); and
- developing and expanding appropriate maternity care for women who may be vulnerable due to medical, socioeconomic and other risk factors (Action 2.3).

PRIORITY 2 – SERVICE DELIVERY - KEY ACHIEVEMENTS OF 2014-15

- The *Clinical Practice Guidelines Antenatal Care – Module 2*, covering the second and third trimester of pregnancy, were approved by AHMAC on 20 October 2014 and released in February 2015.
- States and Territories continued to provide perinatal mental health screening and referral services.
- The *Women Want To Know* project was launched to encourage health professionals to talk about alcohol consumption with women who are pregnant, planning a pregnancy or breastfeeding and to give the consistent message that no alcohol is the safest option.

PRIORITY 2 – PROGRESS REPORT

Antenatal Care Guidelines

A key action under Priority 2 of the Plan involves developing and implementing national evidence based antenatal care guidelines. The *Clinical Practice Guidelines Antenatal Care – Module 1*, covering the first trimester of pregnancy were approved by AHMAC on 31 August 2012 and released in March 2013. The *Clinical Practice Guidelines Antenatal Care – Module 2*, covering the second and third trimester of pregnancy were approved by AHMAC on 20 October 2014 and released in February 2015.

Both Modules 1 and 2 of the Guidelines are evidence-based and have been approved by the National Health and Medical Research Council (NHMRC) as meeting the NHMRC standard for clinical practice guidelines. They are implemented at national, jurisdictional and local levels to provide consistency of antenatal care in Australia and improve the experience and outcomes for women and their families. NHMRC approved clinical guidelines are valid for a maximum of five years. It is anticipated that a review of the Module 1 Guidelines will commence in 2015-16.

Culturally Competent Maternity Care

The Plan acknowledges that Aboriginal and Torres Strait Islander women and babies experience poorer maternal and perinatal outcomes compared with their non-Indigenous counterparts. The cultural competence of health services plays a crucial role in helping to ensure that Aboriginal and Torres Strait Islanders access services and are treated in a respectful and safe manner that secures their trust in the capacity of the service to meet their needs.

Actions under Priority 2 of the Plan include identifying the characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander people. A framework was developed to assist health services to maximise their effectiveness in providing maternity services to Aboriginal and Torres Strait Islander women and their families that are culturally sensitive and meet their needs, while ensuring safety and quality are maintained. This was published as the *Characteristics of Culturally Competent Maternity Care for Aboriginal and Torres Strait Islander women* report. It was endorsed by AHMAC in 2013, and published on the Department of Health website in 2014-15.

Funding has been allocated to further progress cultural competency work under Priority 2 in 2015-16. It is anticipated that a tool will be developed to facilitate a nationally consistent approach for monitoring and evaluating the cultural competence of maternity services.

Work at the jurisdictional level has also been undertaken in 2014-15 to develop and expand culturally competent maternity care of Aboriginal and Torres Strait Islander people. States and territories are at various stages of developing policies and implementing or expanding programs that provide culturally competent maternity care for Aboriginal and Torres Strait Islander people.

PROGRESS SNAPSHOT

New South Wales

An Aboriginal Cultural Inclusion Tool for Maternity Services in NSW was piloted in a number of mainstream maternity services in partnership with local Aboriginal Maternal and Infant Health Services (AMIHS) or other Aboriginal Health service providers. Results of the pilots are expected to be available late in 2015 and broader implementation of the tool will then be considered.

Victoria

A culturally sensitive and appropriate care pathway for Aboriginal and Torres Strait Islander women throughout their pregnancy journey was developed and implemented at Barwon Health. This initiative, in partnership with Wathaurong Aboriginal Co-Operative, has focused on the provision of coordinated and integrated antenatal care and culturally sensitive and responsive birthing experience.

The Aboriginal Newborn Identification project continued during 2014-15. This project aims to improve accurate identification of Aboriginal babies born in Victorian hospitals. Preliminary findings at two pilot sites indicate a 50% increase in identification of Aboriginal newborns. Resources developed for the project have been distributed to all Victorian public maternity services - <http://haveyoursay.thewomens.org.au/aboriginal-newborn-identification-project>.

South Australia

A review of the Aboriginal and Maternal Infant Care (AMIC) program was undertaken in 2014-15. As a result WCHN initiated a community based Aboriginal and Torres Strait Islander people clinic for women to access antenatal care. This model of care incorporates an initial cultural assessment by an AMIC Manager. The service will utilise an integrated care team that may include the AMIC Manager, AMIC workers, midwives, social workers, educators and obstetric support. All Aboriginal and Torres Strait Islander women accessing the program will be provided with antenatal care options and offered an AMIC Worker to support them during their childbirth experience.

Northern Adelaide Local Health Network (NALHN) has established a designated maternity clinic for Aboriginal women with high medical risks. This clinic is supported by midwives and AMIC workers. The Aboriginal Birthing Program is at five sites in country.

Western Australia

The WA Health Aboriginal Cultural Learning Framework was endorsed in 2014. This framework identifies opportunities for staff to respond to the needs of Aboriginal communities through strategic partnerships and planning.

The Framework identifies three essential elements to improving health outcomes for Aboriginal people:

- Cultural learning
- Aboriginal leadership
- Aboriginal workforce

WA Health staff are mandated to update and/or complete the Aboriginal Cultural eLearning – “a healthier future” online training within two years from 1 July 2015.

Northern Territory

Aboriginal and Torres Strait Islander Health Practitioners were employed in both Darwin and Alice Springs Maternity services and Midwifery Group Practices. The Darwin Midwifery Group Practice for remote Aboriginal women increased the number of communities able to access the program.

Queensland

Queensland Health is investing in Indigenous child and maternal health through the *Making Tracks Investment Strategy 2015-18*. Approximately 21 maternal and child health initiatives will be rolled out across the State.

Midwife Accreditation Standards

One action under Priority 2 of the Plan entails National Boards considering cultural competence as a component of all training, education and ongoing professional development of the whole maternity workforce. The Australian Nursing & Midwifery Accreditation Council (ANMAC) has reviewed the accreditation standards for midwives.

The *Midwife Accreditation Standards 2014* include a requirement for a discrete subject that specifically addresses Aboriginal and Torres Strait Islander peoples' history, health, wellness and culture. The standard also includes a requirement for midwifery practice issues relevant to Aboriginal and Torres Strait Islander peoples and communities to be embedded in other subjects across the curriculum.

Maternity Care for Vulnerable Women

Developing and expanding appropriate maternity care for women who are vulnerable due to medical, socioeconomic and other risk factors is an action under Priority 2 of the Plan. Women who are vulnerable may include, but are not limited to, culturally and linguistically diverse women, women with pre-existing medical conditions, adolescent mothers, women using drugs, and women experiencing mental illness.

Perinatal Mental Health

Some of the actions under Priority 2 involve providing perinatal mental health screening for women, and ensuring that training, mentoring and supervision of health professionals undertaking perinatal mental health screening is provided. This includes establishing and expanding formal referral pathways for women experiencing depression and mental illness. Commonwealth funding was provided to States and Territories to continue the National Perinatal Depression Initiative (NPDI) in 2014-15. All States and Territories continued to provide perinatal mental health screening and referral services.

In June 2015, State and Territory Health Ministers were advised that Commonwealth funding for the National Perinatal Depression Initiative would cease on 30 June 2015. The one-off funding that the Australian Government allocated to states and territories under the National Perinatal Depression Initiative was provided as an incentive to encourage state and territory governments to implement change in areas such as screening, training and development, and community awareness. Change has now occurred as a result of these incentives and in many places screening practices are now embedded within health services. The Australian Government will continue to provide funding to support women with perinatal depression. In 2015-16 this will include the provision of \$5 million to the Access to Allied Psychological Services (ATAPS) programme to enable women with postnatal depression to obtain services from an appropriate mental health professional. The Australian Government will also continue to work with beyondblue to raise community awareness and ensure that appropriate resources are available for the training of health professionals.

Maternity Care models for at risk women

Under Priority 2 of the Plan, Australian Governments are required to progress investigation of evidence-based maternity care models for at risk women. Work under this Action in 2014-15 continued with the Commonwealth funding the Foundation for Alcohol Research and Education (FARE) to develop the *Women Want To Know* project, which was launched in July 2014. It aims to encourage health professionals to talk about alcohol consumption with women who are pregnant, planning a pregnancy or breastfeeding and to give the consistent message that no alcohol is the safest option. Resources can be found at www.alcohol.gov.au.

Activity also occurred at the State and Territory level in 2014-15 to develop and expand maternity care for vulnerable women.

PROGRESS SNAPSHOT

New South Wales

Mental Health and Drug and Alcohol Services (MHDAS) for Aboriginal pregnant women, their families and communities continued to operate across nine local health districts. NSW Health continued to support Drugs in Pregnancy Services through the recent review and re-release of Clinical Guidelines for the *Management of Substance Use During Pregnancy, Birth and the Postnatal Period*.

An education resource was developed to support clinicians antenatally in their conversations with women affected by Female Genital Mutilation/Cutting (FGM/C) and their families. The resource incorporates woman friendly language with illustrations that can be shared with women and their partners. The resource aligns with the *Guideline for Pregnancy and Birthing Care of Women affected by FGM/C* released in

September 2014. The guideline is designed to assist health professionals to provide sensitive and culturally appropriate, evidence-based care to women affected by FGM/C.

Maternity services continued to screen pregnant women for domestic violence.

South Australia

Perinatal depression screening pathways and escalation processes have been developed and implemented to ensure a sustainable pathway following completion of funding for the NPDI. Antenatal clinics have been increased in metropolitan community sites targeting areas with vulnerable populations to increase access.

Western Australia

The Refugee and Migrant Women Working Group was re-established in January 2015, subsequently facilitating consumer focus groups to inform the development of a toolkit of resources for maternity care providers.

The Perinatal Palliative Care Model of Care was endorsed in September 2014 and is available on the WA Cancer and Palliative Care Network site

<http://www.healthnetworks.health.wa.gov.au/cancer/palliative/index.cfm>.

With the opening of a new level 5 maternity service at Fiona Stanley Hospital in October 2014, services to women with pregnancy complications such as diabetes have been enhanced in the southern catchment areas. This health service also includes an eight bed Mother Baby Unit for women with perinatal mental health conditions requiring inpatient care.

NT

The Diabetes in Pregnancy Partnership Project (PANDORA Study) continued. This study aims to improve care and outcomes for pregnant women with diabetes continued. A Diabetes in Pregnancy Clinical Register has been developed. The Register aims to assist clinicians in the management of women with diabetes and their babies and to provide information for epidemiological and quality assurance purposes. Work is continuing to refine models of care.

Tasmania

Guidelines relating to the care of pregnant bariatric women were updated in 2014-15. Risk assessment continues to be guided by local policies and guidelines, and referral pathways were used to refer clients to specialised services. Specialised multi-disciplinary clinics were available for young pregnant women, bariatric women, Aboriginal women, women with high risks or complex needs, and women with alcohol and drug problems.

Victoria

The Victorian Department of Health and Human Services, in conjunction with Monash University, offer the online learning tool to enable midwives to access training in perinatal mental health. A total of 719 midwives have accessed the learning tool since the launch in June 2013. The learning tool is available online at

<http://www.perinatal.med.monash.edu.au>

Queensland

Evidence based state-wide clinical guidelines on obesity in pregnancy and gestational diabetes mellitus have been developed. These documents support clinicians to deliver safe, quality healthcare that improves patient experience and outcomes.

PRIORITY 3 – WORKFORCE

Actions under this priority include:

- planning and resourcing to provide an appropriately trained and qualified maternity care workforce that provides clinically safe woman-centred maternity care within a wellness paradigm (Action 3.1);
- developing and supporting an Aboriginal and Torres Strait Islander maternity workforce (Action 3.2);
- developing and supporting a rural and remote maternity workforce (Action 3.3); and
- facilitating a culture of interdisciplinary collaboration in maternity care (Action 3.4).

PRIORITY 3 – WORKFORCE - KEY ACHIEVEMENTS OF 2014-15

- At June 2015 there were 182 midwives with an endorsement for scheduled medicines and 125 eligible midwives (notation only).
- The Nursing and Midwifery Board of Australia completed the review of the *Eligible Midwife Registration Standard* and the Registration standard endorsement for *Scheduled Medicines for Midwives*.
- Six scholarships for midwifery were offered under the Puggy Hunter Memorial Scholarship Scheme in 2014.

PRIORITY 3 – PROGRESS REPORT

A number of actions under Priority 3 of the Plan were originally the responsibility of Health Workforce Australia (HWA). In the 2014 Budget, the Australian Government announced the closure of HWA. The closure took effect on 7 August 2014 and all HWA functions transferred to the Commonwealth Department of Health.

National Nursing and Midwifery Education and Advisory Network

Work under Priority 3 includes investigating drivers of productivity, performance and retention of the maternity workforce. Work has continued on this Action during 2014-15 with the publication of the *Nursing Sustainability, Improving Nurse Retention and Productivity Report* and *Australia's Future Health Workforce – Nurses* in December 2014. Recommendations from the reports included establishing a National Nursing and Midwifery Education and Advisory Network (NNMEAN).

The COAG Health Council is currently considering the draft Terms of Reference for establishment of the NNMEAN. The role of the NNMEAN will be to provide high level strategic advice to Health Ministers on an evidence based approach to the planning and coordination of education, employment and immigration for nurses and midwives in Australia. Once established the NNMEAN will develop a work plan identifying priority activities, timeframes and expected outcomes in consultation with the Health Workforce Principal Committee (HWPC), and will report to AHMAC through the HWPC. The development of the Australia's Future Health Workforce report for Midwives is expected to be a key outcome of the inaugural NNMEAN workplan.

Eligible Midwives

Professional requirements for the recognition of eligible midwives have been in place since 1 July 2010. During 2014-15, the NMBA continued to apply the registration and endorsement standards to all applicants. At June 2015 there were 182 midwives with an endorsement for scheduled medicines and 125 eligible midwives (notation only).

Review of Eligible Midwife Registration Standard and the Endorsement for Scheduled Medicines for Midwives

The NMBA undertook a review of the *Eligible Midwife Registration Standard* and the Registration standard endorsement for *Scheduled Medicines for Midwives*. These two registration standards were developed in 2010 to enable midwives to access the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Schedule (PBS).

At the time the registration standards were developed there were no courses available to midwives to meet the requirement of the standard for completion of a National Board approved program of study to develop midwives knowledge and skills in prescribing. To facilitate access to the MBS for midwives the NMBA agreed to develop the two standards and allow midwives 18 months to complete a course in prescribing, creating a two-step process for midwives to have access to MBS and PBS.

There are now four midwifery medication courses approved by the NMBA therefore removing the need to continue with the two-step approach. The NMBA proposal combines the two registration standards into one standard 'endorsement for scheduled medicines for eligible midwives'. Public consultation was held from 24 October 2014 to 19 December 2014, and the registration standard has been submitted to the Australian Health Workforce Ministerial Council (AHWMC) for approval.

Nursing and Allied Health Scholarship and Support Scheme

The Commonwealth continued to offer nursing and midwifery scholarships (under graduate, post graduate, continuing professional development and midwifery prescribing course scholarships) under the Nursing and Allied Health Scholarship and Support Scheme (NAHSSS) in 2014-15. The NAHSSS provides a maximum of \$10,000 per year for under graduate studies, \$15,000 for post graduate scholarships and up to \$7,500 for midwifery prescribing course scholarships.

Aboriginal and Torres Strait Islander Maternity Workforce

Priority 3 recognises the importance of developing and supporting an Aboriginal and Torres Strait Islander maternity workforce. A range of activities occurred in 2014-15 at both the Commonwealth and State and Territory level to progress this action.

The Australian Government continued to provide new scholarships under the Puggy Hunter Memorial Scholarship Scheme (PHMSS) in 2014-15. This scheme provides financial support to assist Aboriginal and Torres Strait Islander people who are undertaking study in a health related discipline at undergraduate or TAFE (Certificate IV and above) level. Scholarships are available for both full time and part time studies. Six scholarships for midwifery were offered under the PHMSS in 2014.

In addition to the PHMSS, the Australian Government provided funding to the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINam) to mentor and support the Aboriginal and Torres Strait Islander nursing and midwifery workforce, and nursing and midwifery students.

Activity also occurred at the State and Territory level to support and strengthen the Aboriginal and Torres Strait Islander maternity workforce.

PROGRESS SNAPSHOT

New South Wales

Eight nursing and midwifery undergraduates were identified for support via the NSW Aboriginal Nursing & Midwifery Strategy Cadetship and will commence working with their linked hospital during the university semester break in December-February 2014-15. At June 2015, five Bachelor of Midwifery cadets were being supported.

Ethics approval for the evaluation of the rural postgraduate midwifery student scholarship by the SAX Institute is in its final stages. Rural postgraduate midwifery scholarships are provided to small rural maternity facilities to support the employment of a postgraduate midwifery student. On completion of their postgraduate studies the recipient will be offered ongoing employment as a registered midwife once registration and employment criteria are met. The SAX evaluation is planned to conclude by May 2015.

South Australia

Rural scholarships continued to be offered in SA. The Aboriginal cadetship program was available at the Lyell McEwin Hospital for Indigenous people studying nursing or midwifery. AMIC workers are in both metropolitan and rural large maternity services.

Victoria

In 2013, the Victorian Department of Health and Human Services, through *Koolin Balit: The Victorian Government strategic directions for Aboriginal health 2012 – 2022*, developed two complementary programs. The Aboriginal Nursing, Midwifery and Allied Health Cadetship Program provides supported induction into employment at health services and the Aboriginal Nursing and Midwifery Graduate Program supports graduates in the transition from student to professional.

The programs have been implemented at three hospitals in Melbourne; Monash Health, the Women's and St Vincent's Hospital Melbourne and three regional hospitals: Bendigo Health, Echuca Health and Latrobe Regional Hospital. In 2014/15, seventeen Aboriginal cadets have participated in the cadetship program, including one midwifery student and one nurse/midwife student. Nine Aboriginal graduates, including two midwives and one nurse/midwife, have continued to be employed in health.

NT

During 2014-15, Midwifery Group Practices for Remote Aboriginal women continued to retain Indigenous staff in Indigenous Liaison Officer and Aboriginal Health practitioner roles. Cadetships were offered to support tertiary education and the Back on Track Project was launched by the Minister for Health in 2014. The project aims to increase the number of Aboriginal and Torres Strait Islander Health Practitioners (ATSIHP) in the workforce by an additional 10 percent per year with a focus on key areas such as entry pathways, training and education, recruitment and a clearly articulated career structure. The NT Strategic plan for Nursing and Midwifery 2015-2018 includes the development of a workforce strategy to increase participation of Aboriginal people in nursing and midwifery.

Queensland

Queensland is undertaking an investigation into new career pathways that will support the growth and retention of Aboriginal and Torres Strait Islander midwives.

Rural and Remote Maternity Workforce

Access to maternity care in rural and remote Australia is influenced by maternity workforce shortages. Priority 3 acknowledges the need to develop and support a rural and remote maternity workforce. A range of measures, at both Commonwealth and State and Territory level, were implemented in 2014-15 to work towards this objective. These include the provision of locum support, scholarships, and education and training options for the rural and remote maternity workforce.

Maternity Rural Workforce Locum Support

During 2014-15, the Australian Government continued to provide locum support to the rural maternity services workforce through:

- the Rural Obstetric and Anaesthetic Locum Scheme (ROALS), managed by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG); and
- the Nursing and Allied Health Rural Locum Scheme (NARHLS), managed by Aspen Medical.

Both of these programmes aim to improve rural workforce retention, and assist with continuity of services for obstetricians, nurses and midwives (among others).

At 30 April 2015, a total of 124 placements were completed under ROALS, consisting of 98 Specialist Obstetrician and 26 GP Obstetrician placements. In 2014/15 a total of 851 placements were completed under NARHLS, consisting of 750 nursing/midwifery and 101 allied health placements.

Education and Training for Rural and Remote Maternity Workforce

The Australian Government continued to support the Rural Procedural Grants Program (RPGP). This program, which was introduced in 2004, provides grants to GP proceduralists to reimburse relevant training, up-skilling and skills maintenance activities. RPGP has two components offering a grant for the cost of up to \$20,000 for 10 days training per year for procedural GPs practising surgery, anaesthetics and/or obstetrics; and up to \$6,000 for three days training in emergency medicine.

States and territories also had various measures in place during 2014-15 to support capacity building of rural maternity services.

PROGRESS SNAPSHOT

Victoria

Victoria continued to support the rural and remote maternity workforce through the Maternity Connect Program (MCP). The MCP was developed to help rural health services to deliver quality maternity services in their local communities. Through the MCP, rural health services can arrange for their midwives to work for a planned period of time in another health service to ensure their workforce has the skills required. Sixty nine placements were completed in 2014/15. A total of 180 participants from five Victorian rural regions have completed placements since the program's inception in 2012.

South Australia

The SA Health Perinatal Emergency Education Project (standardised education program for managing perinatal emergencies) was rolled out across SA. It provides a coordinated and strategic approach to education and training in perinatal emergency care, and ensures standardised training is provided to deliver positive perinatal outcomes. All staff working in perinatal services are required to complete mandatory training. Perinatal networks have been formed in the rural regions of Country Health South Australia Local Health Network (CHSALH) to identify and address training needs of the rural workforce.

Western Australia

Obstetric Workshops continued to be provided by Rural Health West across rural WA in 2014-15. In May 2015 the WA Government announced an additional medical school (Curtin University) would offer a five-year undergraduate, direct-entry medical program from 2019. This program will select and train students to work in areas of need around Western Australia especially rural and remote locations. The Commonwealth will fund new medical Commonwealth supported places for the school from 2019-20. When the school reaches full capacity in 2022 it will provide 110 new places per year.

Northern Territory

The NT supported a team of 30 multidisciplinary clinicians from Royal Darwin Hospital, Gove District Hospital, Katherine Hospital and Alice Springs Hospital maternity services to attend train-the-trainer Practical Obstetric Multi Professional Training (PrOMPT) provided by RANZCOG in 2014-15. The training has been implemented in the hospitals as a result.

Twenty midwives from all NT regions were supported to attend a pilot education program Certificate in Allied Health Performed Ultrasound for Midwives provided in collaboration with the Australian Society for Ultrasound in Medicine (ASUM). This included associate membership to ASUM to enable credentialing. A further 22 Midwives (Top End and Central Australia) received support to attend Midwifery Upskilling (MIDUS) training through CRANA plus education courses. Support was also provided to 25 midwives and doctors to attend Advanced Life Support in Obstetrics (ALSO).

The NT Department of Health provides support through the Australian Government funded Indigenous Cadetship program for Indigenous students who are currently enrolled in courses of study including Medicine, Nursing, Midwifery, Psychology, Social Work, Pharmacy, Physiotherapy, Speech Pathology, Dietetics and Nutrition, Exercise and Sport Science, Environmental Health and Health Science.

The Nursing and Midwifery Office continues to offer studies assistance grants to support midwives professional development activities. In 2014-2015 a number of midwives were recipients of this grant.

Tasmania

The Tasmanian Clinical Education Network (TCEN) continued to support all health professionals with education in 2014-15. TCEN caters for health professionals in rural and remote area via videoconferencing. In some cases professional development is delivered locally through partnership arrangements with a larger facility. Significant

investment has been made in technology that supports the professional development of health professionals working away from mainstream services. On-line learning resources are accessible to all staff within public hospitals.

New South Wales

NSW Health Nursing and Midwifery Office have provided scholarships since 2011 for postgraduate midwifery students in small rural maternity units with a total of 30 awarded to date. Another 10 scholarships will be awarded for 2015. This initiative is currently in the process of being evaluated by the SAX Institute with completion due in mid-2015.

Queensland

Birth services have been established and in some cases re-introduced in specific rural and remote areas throughout Queensland, for example; Beaudesert and Cooktown.

PRIORITY 4 – INFRASTRUCTURE

Actions under this priority include:

- ensuring all maternity care is provided within a safety and quality system (Action 4.1); and
- ensuring maternity service planning, design and implementation is woman-centred (Action 4.2).

PRIORITY 4 – INFRASTRUCTURE - KEY ACHIEVEMENTS OF 2014-15

- Stage 2 of the National Maternity Data Development was completed.
- National perinatal data were released via a web-based platform for the first time.
- Patient travel support schemes continued to provide financial support to women who were required to travel to access maternity and neonatal care.

PRIORITY 4 – PROGRESS REPORT

National Maternity Data Development Project

Under Priority 4 of the Plan, the Australian Government has a commitment to facilitate standardised nationally consistent maternal and perinatal data collections and publish a report on maternal and perinatal outcomes. The National Maternity Data Development Project (NMDDP) has been undertaken by the AIHW to fulfil this commitment. The NMDDP aims to develop a nationally consistent and comprehensive maternal and perinatal mortality and morbidity data collection in Australia. The project is guided by an Advisory group consisting of experts in the fields of obstetrics and midwifery, and statistics.

Stage 1 of the NMDDP commenced in May 2011 and concluded in June 2013. Stage 2 commenced in July 2013 and concluded in June 2015. This stage focused on continuing the development of priority data items and of the Maternity Care Classification System (MaCCS), extending maternal mortality reporting work, developing methods to better capture and report on national perinatal mortality, and providing greater access to maternal and perinatal data through web-based data visualisation tools.

Key achievements of the NMDDP in 2014-15 included:

- the Maternity Models of Care Data Set Specification (MoC DSS) was finalised and endorsed as a national health data standard by the National Health Information Performance Principal Committee (NHIPPC) on 14 May 2015;
- *Maternal deaths in Australia 2008-2012* was released on 10 June 2015;
- national perinatal data were released via a web-based platform for the first time. The first module on maternal demographics was released on 16 December 2014. A second module was released on 17 June 2015. This second module included aspects of antenatal care such as duration of pregnancy at first antenatal visit and maternal characteristics such as smoking and body mass index. The perinatal portal (available from <http://www.aihw.gov.au/perinatal-data/>) receives an average of 209 web visits per month;
- work continued on developing national standards for three clinical data items (head circumference, peripartum hysterectomy and related conditions contributing to peripartum hysterectomy);

- work commenced on developing psychosocial data items (e.g. screening for domestic violence, mental health, alcohol, and substance use); for the Perinatal DSS;
- consultation for this project work continued under the overarching national governance established during Stage 1, with the committees having met several times during the year:
 - the NMDDP Advisory Group met face to face in October 2014
 - the Clinical and Data Reference group met 3 times (August 2014, March 2015 and June 2015);
 - the National Perinatal Mortality Reporting Advisory Group met twice (August 2014 and December 2014);
 - the Maternity Care Classification System (MaCCS) working party met twice (October 2014 and March 2015),
 - the National Maternal Mortality Advisory Committee met once (October 2014), and
 - the Screening for Domestic Violence working party met once (September 2014).
 - Members of these committees also provided expert advice and assistance out of session.

Stage 3 of the NMDDP commenced in July 2015 to continue work commenced in Stages 1 and 2 of the project.

Use of Innovative Technology

Priority 4 of the Plan recognises the potential to use innovative technology solutions to provide specialist consultation and care to women in rural and remote locations. Australian Governments are responsible for exploring options and facilitating the use of innovative technology solutions to enable increased numbers of women in rural and remote locations to access appropriate specialist maternity consultation and care.

Australia is committed to the promotion and appropriate sharing of clinical knowledge and information to support better health and wellbeing for all Australians. In 2012 the Personally Controlled Electronic Health Record (PCEHR) system was launched, placing the individual at the centre of Australia's health system. The PCEHR system allows the individual to choose to share their health information with their doctor, hospitals and other healthcare providers to enable provision of the best possible care. Currently the system is an "opt in" system, and individuals who choose to register have their health information available to them online. There are currently over 2.4 million PCEHR records, which accounts for roughly 10% of the population. 57% of registered individuals are women. The broader electronic Health eco-system includes a Child eHealth record app, which is a mobile app which allows parents to record important health, growth and development information as their child grows.

In its 2015-16 Budget, the Australian Government announced funding of \$485.1 million over four years for strengthened eHealth governance arrangements and trials of participation arrangements, including opt-out. It also includes three years funding for continued operation and redevelopment of the PCEHR system. System enhancements will include improvements to the usability of the system and more clinical content to increase participation in, and use of, the system by individuals and healthcare providers.

PROGRESS SNAPSHOT

Queensland

The Telehealth Support Unit in collaborative arrangements with Health & Hospital Service (HHS) based Telehealth Coordinators continued to promote the use of Telehealth as a viable modality for the delivery of specialist services to women living in rural and remote areas. In 2014/2015, there were 1062 telehealth service events with a clinical code of obstetrics midwifery, midwifery-antenatal and midwifery-postnatal assigned. Telehealth numbers continue to improve with increased uptake by Hospital and Health Services. Including those with rural and remote/very remote populations. The Telehealth Support Unit continues to explore innovative methods of Telehealth enabled specialist service delivery to ensure equity of access for women living in rural and remote areas.

South Australia

SA Telehealth was used as required in 2014-15. SA Health revised the *Standards for the Management of the Obese Obstetric Women* will now include a guide to remote assessment of the obese pregnant woman to be undertaken in co-ordination with a metropolitan based Specialist Anaesthetist, reducing the need for rural women to travel for assessment. This is expected to be published in early 2016.

Northern Territory

NT Telehealth facilities were available in remote clinics during 2014-15. Uptake of the use of these facilities is increasing. Development of the electronic shared pregnancy care plan continues with implementation anticipated in 2015-16.

The National Maternity Services Capability Framework

Priority 4 of the Plan recognises the importance of planning, designing and implementing woman-centred maternity services. Factors that require consideration include birth rates within communities, geographic factors, socioeconomic factors, resourcing and service capability, and linkages with medical specialists and other health professionals and services.

The *National Maternity Services Capability Framework* (the Capability Framework) was endorsed by AHMAC in 2010 and published in 2013. It provides a rigorous methodology to support maternity service planning and risk management improvement in maternity care. It has also been designed to assist women and their maternity care professionals to make informed decisions about the most appropriate place for the woman to give birth based on the complexity of the pregnancy.

During 2014-15, States and Territories continued to use the Framework to inform the review and development of individual jurisdictionally based documents that address additional specific nuances of local maternity services, and help assist clinicians and the woman and her family to make an informed decision about the most appropriate place to undertake her confinement.

PROGRESS SNAPSHOT

New South Wales

During 2014-15, face-to-face-consultations were undertaken across NSW with Local Health Districts regarding the draft NSW Maternity and Neonatal Service Capability Framework. Feedback has been incorporated and it is expected that the document will be released in the coming year.

South Australia

The *Directive: Standards for Maternity and Neonatal Services in South Australia* was revised in 2015 having been first published in 2010. The standards were developed in accordance with contemporary professional quality and safety standards and establish the minimum standards for the provision of maternity and neonatal services in South Australia. The standards incorporate recommendations made by the South Australian Maternal, Perinatal and Infant Mortality Committee, and align with the *National Maternity Services Capability Framework*.

ACT

A draft Capability Framework was prepared during 2014-15. This was informed by the *National Maternity Services Capability Framework*. ACT is working with NSW to ensure their Capability Framework aligns with that of NSW.

Northern Territory

The Northern Territory transitioned to a New Services Framework for Health with two new entities, Top End Health Service and Central Australia Health Service operated by Statutory Management Boards that will oversee service delivery. The framework endorsed by Cabinet in 2013 includes improved service integration is a Key Performance Indicator for the Boards.

Planning for the new Palmerston Regional Hospital is being informed by the NT and National Maternity Services Capability Frameworks.

The Central Australia Health Service undertook a review of the Coordination of Midwifery Services and recommendations for implementation address better integration of maternity services and enhancement of the woman's journey.

Tasmania

Tasmania has developed a role delineation framework as part of its significant reform of health. The framework has been widely consulted and the implementation plan is being finalised.

Patient Travel Support Schemes

Priority 4 recognises that many women are not able to locally access the maternity and neonatal care they require. In such instances it is important that women have access to support for accommodation and transport to enable them to obtain safe and evidence-based high quality care. All jurisdictions (with the exception of the ACT) continued to provide patient travel support schemes in 2014-15.

PROGRESS SNAPSHOT

New South Wales

The Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) continued to provide travel and accommodation subsidies for patients who were required to travel at least 100km one-way to access specialist medical treatment. Eligible Aboriginal and Torres Strait Islander women can access IPTAAS subsidies if they are at risk of antenatal complications and need to remain near the location of the treating specialist in the antenatal period.

Victoria

The Victorian Patient Transport Assistance Scheme (VPTAS) continued to provide financial assistance to patients living in rural and regional Victoria who were required to travel long distances to access medical specialist services. This included financial support for both transport and accommodation for eligible patients.

Queensland

Queensland Government continued to support patients who needed to travel, to access specialist medical services through the Patient Travel Subsidy Scheme (PTSS). The scheme provides financial assistance to eligible patients (and approved escorts) who are required to travel more than 50 kilometres from their local public hospital to access specialist medical services. Assistance may be provided towards travel and accommodation costs. Travel subsidies are provided for the most clinically appropriate and cost-effective mode of transport (air, rail or bus travel or travel by private motor vehicle).

South Australia

The Patient Assistance Transport Scheme (PATS) continued to operate in SA during 2014-15. The PATS is a subsidy program that funds some travel, escort and accommodation costs when rural and remote South Australians travel over 100 kilometres each way to see a specialist.

Western Australia

The Patient Assisted Travel Scheme (PATS) continued to provide support to Western Australians during 2014-15. The PATS provides a subsidy towards the cost of travel and accommodation for eligible permanent country residents, and their approved escorts, who are required to travel a long distance to access certain categories of specialist medical services (including Telehealth).

Following a Parliamentary Inquiry into the PATS in 2014, a number of recommendations relating to maternity care were considered. The provisions for an accommodation subsidy for women from remote areas were increased and funding assistance for an escort for all women was endorsed.

Northern Territory

The Patient Assistance Travel Scheme (PATS) continued to provide financial assistance to Territorians who were referred by an approved practitioner to the nearest approved specialist medical service. The scheme covers fares for travel and provides a subsidy for accommodation and some financial assistance for ground transport e.g. taxis or buses. It also provides a subsidy for fuel if patients drive to an appointment. A review in 2013 revealed many instances of long distance travel for short appointments and led to a project aimed at increasing the number of appointments and specialist services available via telehealth.

Tasmania

The Patient Travel Assistance Scheme (PTAS) provided financial help with travel and/or accommodation costs to eligible Tasmanian residents who needed to travel to access the nearest appropriate specialist medical service. Community midwifery services specifically for Aboriginal women were available, which decreased the need to always access the hospital for care.

Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Schedule (PBS) Subsidies

Introduction of Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) subsidies for antenatal, intra-partum (excluding homebirth) and postnatal care provided by eligible midwives is a key action under Priority 4.

Since 1 September 2010, midwives endorsed to prescribe under state or territory legislation have been able to apply for approval as PBS prescribers (authorised midwives). All States and Territories amended their respective drugs and poisons legislation if required to allow eligible midwives access to prescribing rights.

Since 1 November 2010, Medicare benefits have been payable for antenatal, intra-partum and postnatal services (up to 6 weeks post birth), provided by eligible privately practising midwives working in collaboration with a specified medical practitioner.

In 2014-15, participating midwives provided 65,789 MBS-rebateable antenatal, intra-partum (not including homebirth) and postnatal services, at a cost of \$4,912,259 in MBS rebates. Over the same period, midwives also provided 2,881 MBS-rebateable obstetrics and telehealth services, which cost \$331,892 in MBS rebates.

SUMMARY

During 2014-15, governments have been working independently and with stakeholders at a jurisdictional and national level to implement the Plan. Considerable work remains to be done but significant progress has been made under each of the four key priority areas of the Plan. The achievements noted for 2014-15 have contributed to improvements in the co-ordination of maternity services and access to maternity services in Australia. Much of the work undertaken has been built upon the existing evidence base and will continue to ensure that woman-centred maternity care is provided within a safe and quality system across Australia. As the Plan progresses into its final years, this work will continue to inform and improve the planning and delivery of maternity services in Australia.