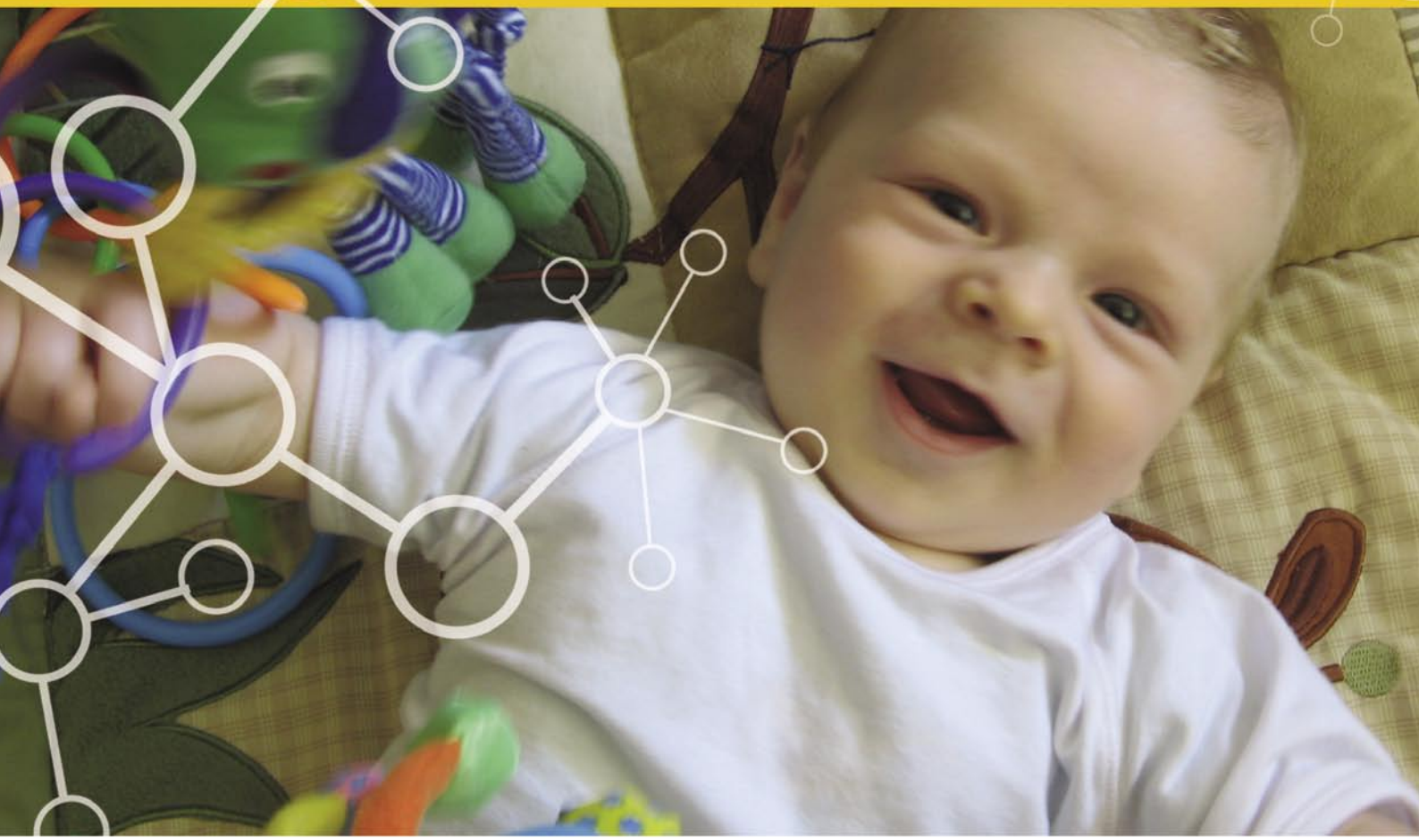
National Consensus Framework for **Rural Maternity Services**



rural health workforce australia

National Rural Faculty
The Royal Australian College of General Practitioners

RURAL DOCTORS ASSOCIATION OF AUSTRALIA
Caring for the Country

AUSTRALIAN COLLEGE OF MIDWIVES INCORPORATED

acrm
Australian College of Rural & Remote Medicine

Preface

This Framework has been developed to fill a growing need to guide policy and planning for sustainable rural maternity services across Australia. The need for such a Framework is demonstrated by community and professional concern about the ongoing closure of rural birthing services. However, until now, there was no set of agreed principles that communities, service providers, decision makers and funders could use to work together to ensure safe, evidence based maternity care for the third of Australian mothers who live outside major cities.

The proposal for a National Consensus Framework for Rural Maternity Services grew out of a Symposium on Birthing Services in Small Rural Hospitals: Sustaining Rural and Remote Communities held in Alice Springs, 2005. The symposium was organised by the Rural Doctors Association of Australia (RDAA) and the Australian College of Rural and Remote Medicine (ACRRM) with funding from the Commonwealth Department of Health and Ageing.

RDAA subsequently secured funding from the Department to develop a Framework in collaboration with the Australian College of Midwives, ACRRM, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the National Rural Faculty of the Royal Australian College of General Practitioners and Rural Health Workforce Australia. A Management Group consisting of representatives from all six organisations directed this challenging work.

The purpose of the project was the codification of a set of principles to provide a Framework for policy and planning to support quality maternity services in rural Australia. The Framework was established by consensus among the professional organisations representing the core disciplines that provide maternity care. The principles of the Framework have been formally endorsed by the Boards of each of the participating organisations.

A wider Advisory Committee consisting of representatives from professional and consumer organisations provided valuable input and guidance throughout the project.

In order to achieve consensus, the project team used a modified Delphi technique to collate and analyse the input received from individuals and organisations across Australia.

The consensus process provided an avenue for the participating organisations to communicate, enhance working relationships and collaborate effectively throughout the development of the Framework. The consultation process provided a rare opportunity for consumers and health professionals alike to discuss and share perspectives of rural maternity services.

Although the contract stipulated only the development of a set of principles, the methodology used resulted in a rich body of data that included good exemplars of practical implementation strategies. It was decided to include these with the Framework, although the exemplars listed are by no means comprehensive or exhaustive; nor are they endorsed by all participants. It is anticipated that stakeholders at all levels will wish to develop their own strategies for the flexible implementation of the Framework in the diverse environments of non-metropolitan Australia.

The consultation process confirmed that a multi-disciplinary approach to the delivery of maternity care for rural women is integral to sustaining rural services and providing high quality care. Rural health professionals are keenly aware of the vital role a collaborative approach and effective teamwork plays in providing quality care.

Flexibility emerged as a strong theme throughout the development of the Framework. It is important to note that the Framework does not endorse one single approach to rural maternity service delivery but rather flexible approaches that recognise the realities of rural settings.

The disparity between birth outcomes for Aboriginal and Torres Strait Islander women and other mothers in Australia must be addressed in any national approach to maternity service delivery. While the principles of the Framework are applicable to all non-metropolitan maternity care, it is more appropriate for Aboriginal and Torres Strait Islander women and their service providers to

lead the development of specific strategies to implement these principles. However, some relevant strategies that were proposed in our consultations have been included in the exemplars.

The Framework was primarily developed as a tool for the six participating organisations to use in participating in policy and planning for safe and sustainable rural maternity services. However, we hope other organisations and jurisdictional authorities will also use this evidence based document which has been compiled with very wide stakeholder input.

We believe this Framework provides the basis for sustainable quality rural maternity services and will make a significant contribution to the work of the National Health and Hospitals Reform Commission and the development of a National Maternity Services Plan.

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April 2008

Photo credit: Patrick Daley

National Consensus Framework Principles

Principle 1 - Quality and Safety

1.1 Rural maternity services should be underpinned by an evidence-based continuous quality improvement culture that acknowledges the realities of rural settings

1.2 Rural women have the right to make informed choices about their care and health care professionals have the responsibility to provide the information to enable them to do this

1.3 All rural maternity care facilities should be accredited according to rurally relevant national standards

1.4 Seamless referral networks and systems must be based on mutual understanding and respect for the roles and responsibilities of all members of the rural maternity care team

1.5 Risk management strategies should be in place in all systems of care affecting women from preconception through antenatal, intrapartum and postnatal care

Principle 2 - Access

2.1 Women should have access to safe maternity care consistent with their assessed level of risk as close as possible to where they live

2.2 Rural women must be able to access antenatal, postnatal and support services in their own communities even if birthing services are not available

2.3 Rural women should be able to make an informed choice consistent with their assessed level of risk to receive their maternity care in community environments that have ongoing and timely access to larger centres

2.4 Emergency retrieval services with coordinated transportation must underpin rural women's access to appropriate care as required

2.5 Decisions about the development, sustainability, downgrading or closure of rural maternity services must be evidence-based, transparent, subject to independent impact assessment and taken in consultation with the local community

Principle 3 - Models of Care

3.1 Rural maternity care should be based on models, innovation and evidence appropriate to the rural environment, rather than the imposition of models that may be successful in urban settings

3.2 Team-based models of care should utilise the skills of all members of the team efficiently by involving them at the appropriate level of service delivery. They should be appropriate to the size and diversity of the community and the mix of skills and services available locally.

3.3 While recognising the need for involving all members of the maternity care team, rural maternity services should promote continuity of care and carer

Principle 4 - Infrastructure

4.1 All facilities within an integrated rural maternity service network should be equipped to provide safe maternity care and at least one facility should provide the full range of equipment and trained personnel to undertake more complex maternity and neonatal care

4.2 Formally networked referral and transfer systems must be in place at all rural maternity units to ensure the safe and timely transfer of women and/or their babies who require specialised care

4.3 All rural maternity services must have reliable information/communication technology, including computer systems, video/teleconference services and phone networks to facilitate specialist advice and support for the local maternity care team

4.4 Rural hospitals without maternity services must have equipment, training and reliable communication systems to enable them to deal with unplanned births

Principle 5 - Workforce

5.1 The maternity care workforce in Australia must be sustained and enhanced by targeted, coordinated strategies that support collaborative care by doctors and midwives

5.2 There must be targeted recruitment strategies for all members of the maternity care workforce

5.3 All maternity care team members must have access to regular continuing professional development, including training in maternity emergency care, and the use of equipment that supports their current scope of practice

5.4 Terms and conditions for rural maternity service providers should recognise the additional responsibilities and on-call requirements of those providers

Principle 6 - Funding

6.1 Incentive funding should support rural models of maternity care

6.2 Quarantined funding must be available for teaching, training and continuing professional development of the rural and remote maternity care workforce

6.3 Health authorities must acknowledge and assess the impact of cost-shifting to communities and families when considering the price of maintaining or abolishing local birthing services

6.4 Remuneration should acknowledge and reward qualifications that certify competence in the provision of rural maternity care and reflect the skills, complexity and responsibility of the rural maternity care team

Photo credit: Vicky Mitsios

Examples of Practical Implementation Strategies

Principle 1 - Quality and Safety

Principle 1.1 & 1.2

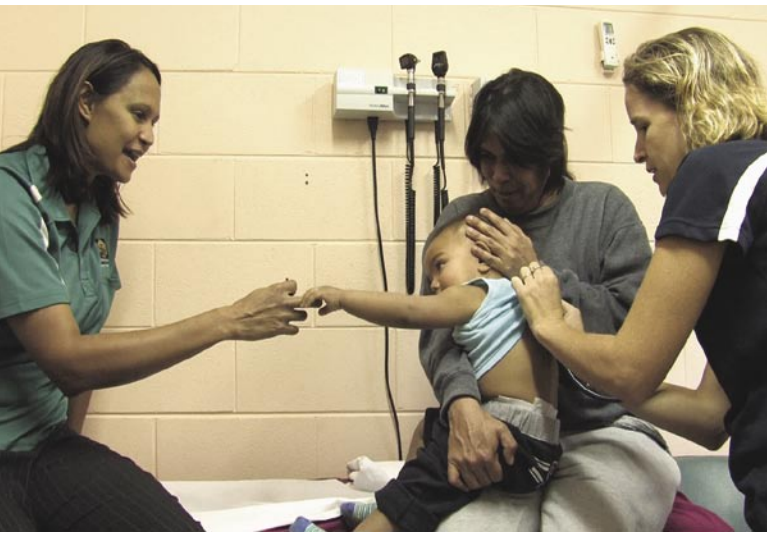
Rural maternity services should be underpinned by an evidence-based continuous quality improvement culture that acknowledges the realities of rural settings

Rural women have the right to make informed choices about their care and health care professionals have the responsibility to provide the information to enable them to do this

Strategies

- *Rural maternity services should engage in routine quality improvement cycles based on peer review, evidence-based guidelines, national benchmarks and local audit data that includes client and community satisfaction*
- *Rural maternity services should be resourced to administer robust and consistent systems to collect and disseminate data that enable monitoring of clinical processes and birth outcomes, and womens' satisfaction with the service*
- *Consumers and community representatives must be invited to participate in formal assessment of the quality and safety of rural maternity services*
- *Services within an integrated service network must be resourced to engage in regular joint clinical review of all women who are transferred between units*

Photo courtesy: Rural Health Workforce Australia



Principle 1.3

All rural maternity care facilities should be accredited according to rurally relevant national standards

Strategies

- *Rural maternity services must be subject to regular review processes which refer to both national evidence-based standards and local client input*
- *All rural facilities providing maternity services must be supported to collect and report data for a national core set of indicators which inform local service delivery*
- *All health professionals should be credentialled according to relevant national professional standards or processes*

Principle 1.4

Seamless referral networks and systems must be based on mutual understanding and respect for the roles and responsibilities of all members of the rural maternity care team

Strategies

- *Consistent and collaboratively developed guidelines and protocols should be used by all the professions providing maternity care and across jurisdictional boundaries*
- *Coordinated systems must be established to facilitate integrated service networks and transfers across jurisdictional boundaries*
- *A system should be established to monitor and evaluate the transfer processes, clinical outcomes and consumer satisfaction*

Principle 1.5

Risk management strategies should be in place in all systems of care affecting women from preconception through antenatal, intrapartum and postnatal care

Strategy

- *Local maternity service plans must incorporate specific consensus and evidence-based risk assessment and clinical guidelines and communication protocols as well as infrastructure, human resources and equipment for emergency transfer. These plans must be developed and implemented in collaboration with local communities and their health care professionals.*

This section contains examples of some strategies for the practical implementation of the Framework's principles. The list is not comprehensive; it represents ideas that came forward during the consultation which indicate ways in which the principles might be applied.

We anticipate the principles of the Framework will provide a basis for stakeholders at all levels to develop their own strategies for flexible implementation in rural communities across Australia.

Principle 2 - Access

Principle 2.1

Women should have access to safe maternity care consistent with their assessed level of risk as close as possible to where they live

Strategies

- *Aboriginal and Torres Strait Islander women must have access to maternity services which are culturally safe, provide continuity of care and give access to the best possible expertise through collaborative models involving Aboriginal Health Workers, GPs, GP obstetricians, midwives and specialist obstetricians*
- *Low risk women in rural areas should have access to maternity care provided by midwifery models of care operating within an integrated service network*

Principle 2.2

Rural women must be able to access antenatal, postnatal and support services in their own communities even if birthing services are not available

Strategy

- *Women in rural and remote areas where no local birthing services are available should have access to outreach antenatal and postnatal care provided by appropriately qualified health professionals*

Principle 2.3

Rural women should be able to make an informed choice consistent with their assessed level of risk to receive their maternity care in community environments that have ongoing and timely access to larger centres

Strategy

- *Women and communities must be given clear information about the maternity care options available to them and the associated limitations and implications*

Principle 2.4

Emergency retrieval services with coordinated transportation must underpin rural women's access to appropriate care as required

Strategies

- *Ambulance officers and volunteers, midwives and others who provide transport for maternity care should be provided with appropriate training*
- *Quality improvement systems should generate data that enables routine monitoring and audit of retrieval systems, equipment and resources*
- *Systems must be established for the routine interchange of information between referring and receiving hospitals*

Principle 2.5

Decisions about the development, sustainability, downgrading or closure of rural maternity services must be evidence-based, transparent, subject to independent impact assessment and taken in consultation with the local community

Strategies

- *Communities should be supported to participate in determining the maternity services they require and designing models of care that are locally applicable*
- *Independent impact assessment of proposed closures of rural maternity units which investigate cost shifting, health outcomes and broad community issues should be a contractual condition of the Australian Health Care Agreements*

Examples of Practical Implementation Strategies

Principle 3 - Models of Care

Principle 3.1

Rural maternity care should be based on models, innovation and evidence appropriate to the rural environment, rather than the imposition of models that may be successful in urban settings

Strategies

• Health authorities and maternity care providers should develop integrated service networks (including rural hub and spoke and cluster models) which involve midwives, Aboriginal Health Workers, GPs and specialists in locally based care and transfer and retrieval services

• Communities and their health care professionals should be supported to develop criteria and design services appropriate to their specific environment

• Information about good working models of rural maternity care should be collected and widely disseminated

Photo courtesy: Assoc. Prof. Alan Bruce Chater

Principle 3.2

Team-based models of care should utilise the skills of all members of the team efficiently by involving them at the appropriate level of service delivery. They should be appropriate to the size and diversity of the community and the mix of skills and services available locally.

Strategies

• All models of maternity care must be underpinned by evidence-based risk management protocols, and supported by midwives, GP obstetricians and specialist obstetricians, administration, adequate funding and flexible on-call systems

• Strategies, training and funding systems should support GPs, midwives and specialists to work collaboratively in flexible locally designed team models of care that utilise the skills and competence of all of the team efficiently and incorporate rural and regional specialists

Principle 3.3

While recognising the need for involving all members of the maternity care team, rural maternity services should promote continuity of care and carer

Strategies

• Care should be provided in broad team based models which allow primary maternity care to be performed by a midwife, GP obstetrician or specialist obstetrician depending on the woman's choice and risk stratification

• Inter-professional communication and networks should be developed to ensure continuity of care and carer

• Services designed for Aboriginal or Torres Strait Islander women should be integrated with local maternity services and offer continuity of care provided collaboratively by midwives, GPs and Aboriginal Health Workers

Principle 4 - Infrastructure

Principle 4.1

All facilities within an integrated rural maternity service network should be equipped to provide safe maternity care and at least one facility should provide the full range of equipment and trained personnel to undertake more complex maternity and neonatal care

Strategy

• *Decisions about the equipment and personnel needs of each integrated geographical service network should be made in consultation with the local community*

Principle 4.2

Formally networked referral and transfer systems must be in place at all rural maternity units to ensure the safe and timely transfer of women and/or their babies who require specialised care

Strategies

• *Obstetric advisory and retrieval services should be centrally coordinated with a single point of contact*

• *Retrieval services must be funded to a level that enables adequate equipment maintenance and replacement*

• *Each referral centre within an integrated service network should be funded to provide consultation, referral and retrieval support to staff in other units in the same network*

Principle 4.3

All rural maternity services must have reliable information/ communication technology, including computer systems, video/teleconference services and phone networks to facilitate specialist advice and support for the local maternity care team

Strategy

• *Integrated networks should provide a multidisciplinary range of personnel for emergency contact and expert advice through 24 hour telephone access*

Principle 4.4

Rural hospitals without maternity services must have equipment, training and reliable communication systems to enable them to deal with unplanned births

Strategy

• *Training, including on site programs to handle obstetric emergencies, should be provided annually to all members of the rural health care team and other relevant health professionals*

Photo courtesy: Rural Health Workforce Australia

Examples of Practical Implementation Strategies

Principle 5 - Workforce

Principle 5.1

The maternity care workforce in Australia must be sustained and enhanced by targeted, coordinated strategies that support collaborative care by doctors and midwives

Strategies

- *Local maternity care teams should be supported to identify their own specific requirements for training and professional support needed in their own setting for the model/s of care in their own setting*
- *Multi-disciplinary maternity care team training should be provided on site for all clinicians involved in maternity care*
- *Training for re-entry into the rural maternity care workforce should focus on individual needs to meet the requirements of the local community and standards set by professional colleges and jurisdictions*
- *Rural midwives, procedural generalists and specialist obstetricians require specific incentives to retain and extend their skills*
- *Systems should enable midwives to work across their whole scope of practice in collaborative models in the private or public sector*

Principle 5.2

There must be targeted recruitment strategies for all members of the maternity care workforce

Strategies

- *Adequate orientation and ongoing professional and family support should be provided for all professionals willing to contribute to the rural maternity care team*
- *Scholarships and incentives should be available to encourage students of rural and remote origin to return to work in rural and remote maternity services*
- *Family support incentives and networks should be developed and delivered through funded infrastructure*
- *More rural clinical placements must be made available for all midwifery, general practice obstetricians and specialist obstetrics trainees*
- *Rural maternity services should provide financial incentives and flexible working conditions to attract and retain members of the rural maternity care team*
- *A national scholarship and re-entry scheme for rural midwifery should be established as a matter of urgency*

Principle 5.3

All maternity care team members must have access to regular continuing professional development, including training in maternity emergency care, and the use of equipment that supports their current scope of practice

Strategies

- *Subsidised locum relief should be provided to backfill for all clinicians undertaking continuing professional development*
- *Regular up-skilling through simulation and training in regional centres should be funded to facilitate GPs, midwives, obstetricians, paediatricians and other specialists working together*

Principle 5.4

Terms and conditions for rural maternity service providers should recognise the additional responsibilities and on-call requirements of those providers

Strategies

- *Indemnity issues and medico-legal factors affecting rural maternity care must be addressed for all those who provide it*
- *Insurance demands upon maternity care professionals should be continuously monitored to ensure premiums do not become a disincentive to the provision of rural maternity services*
- *Systems and structures should rationalise medical on-call arrangements to facilitate improved working conditions and sustainable rosters*
- *Subsidised locum relief should be available for all providers of maternity services*
- *Flexible on-call arrangements for midwives should be supported where there is interest in implementing caseload midwifery models of care*
- *Adequate remuneration for on-call must be provided for all members of the maternity care team*

Principle 6 - Funding

Principle 6.1

Incentive funding should support rural models of maternity care

Strategies

- *The Australian Health Care Agreements and other Commonwealth funding mechanisms should include incentives to sustain existing services and establish new maternity services in small rural communities and penalties where a maternity service is withdrawn without sufficient consultation and evidence*
- *Quarantined funding should be provided for the development and maintenance of innovative service models appropriate to rural communities*
- *National funding mechanisms should be used to utilise, establish, sustain and extend appropriate midwifery services within the rural maternity care team*
- *Funding for rural maternity services should cover local risk identification and management and provide for collaboration and service coordination that follows the woman's pathway through maternity care*

Principle 6.2

Quarantined funding must be available for teaching, training and continuing professional development of the rural and remote maternity care workforce

Strategies

- *Incentives for teaching, particularly in the team context, should be made available*
- *Incentive schemes should reward quality improvement activity in the rural maternity care team*
- *The Australian Health Care Agreements and other Commonwealth mechanisms should fund training places for all members of the rural maternity care team*

Principle 6.3

Health authorities must acknowledge and assess the impact of cost-shifting to communities and families when considering the price of maintaining or abolishing local birthing services

Strategies

- *Research into the cost effectiveness of maternity services in rural areas should be funded and published*
- *Incentives should reward upgraded rural maternity services*
- *Where antenatal, postnatal and birthing services cannot be provided locally, adequate financial assistance must be provided to women who have to access maternity services outside their own community*

Principle 6.4

Remuneration should acknowledge and reward qualifications that certify competence in the provision of rural maternity care and reflect the skills, complexity and responsibility of the rural maternity care team

Strategies

- *Flexible funding should be designed to support team based antenatal, intrapartum and postnatal care*
- *Funding barriers to midwives providing antenatal and postnatal care to women in the community should be removed*

Photo credit: Dr Kim Pedlow

Glossary of Terms

Accredited: Being granted recognition for meeting designated standards for structure, process and outcome.[1]

Audit: The measuring and evaluation of care against agreed standards with a view to improving practice and care delivery.[2]

Cluster models: Rural clusters share human and physical resources between small units grouped geographically thus creating a critical mass for safe (safe for consumers and safe for providers) service provision. Within the cluster, care will be provided by clinical teams comprising all or some of the following: midwives, doctors, allied health and child health professionals, nurses, anaesthetists and Indigenous health workers, amongst others. The precise nature and composition of the team will depend on local conditions.[3]

Continuity of Care: This term is used to describe a situation where all the professionals involved in delivery of care share common ways of working and a common philosophy. The aim is to reduce conflicting advice experienced by women and to ensure the same philosophy of care is experienced by the woman throughout the period of her care.[4]

Continuity of Carer: The same health professional providing care throughout a woman's contact with the maternity services. Continuity of care refers to the care of a woman by a known carer/s throughout all stages of pregnancy, birth and the post birth phases.[5]

Hub and Spoke models: Larger regional centres where health specialists and specialist health technology are based, providing care for nearby rural communities (the 'spoke' towns) where primary health care is available.[6]

Informed Choice: Decision making based on informed choice requires respect for the autonomy of the client and respect for her right to self determination. It requires complete relevant objective information provided in the context of a non-authoritarian, collaborative relationship and the active involvement of the client.[7]

Integrated maternity service network: The coordination of activities and programs among healthcare institutions within defined geographic areas for the purpose of improving the delivery and quality of maternity care. Integrated maternity networks include clinicians (midwives, GPs, obstetricians and other health professionals), hospitals and related services to provide the complete spectrum of maternity care for women and their families.[8]

Midwife: A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognised in the country in which located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.[9]

Midwifery Models of Care: Midwifery care is based on a philosophy of pregnancy and birth as normal physiological processes. Its focus is on the promotion of normality and psychosocial support.[10] Midwives provide primary maternity care for women in collaboration with medical colleagues using national consultation and referral guidelines to guide their practice.[11] Midwifery models of care involve continuity of care/carer. This may be in a number of arrangements:

- Caseload midwifery model – involves one midwife in a primary or lead care role
- Team midwifery care – a small team of midwives care for the woman[12]

Multidisciplinary: An approach combining the knowledge, skills and expertise of a range of organisations and professionals.[13]

Maternity Care Team: Refers to midwives, GPs, and obstetricians who are qualified and regulated to provide maternity care. It also includes health professionals (such as anaesthetists, neonatologists, nurses and Aboriginal health workers) who collaborate with midwives, GPs and/or obstetricians in the provision of care to women and newborns.

Primary Health Care: Encompasses the principles of equity, access, the provision of services based on need, community participation, collaboration and community based. PHC involves using approaches that are affordable, appropriate to local needs and sustainable. These principles are outlined in the Ottawa Charter (1986).

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[5] Victorian Government (2004) Future Directions for Victoria's Maternity Services
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[11] Australian College of Midwives (2003) National Midwifery Guidelines for Consultation and Referral.
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Advisory Committee Representation

- Australian College of Midwives
- Australian College of Rural and Remote Medicine
- Australian General Practice Network
- Australian Medical Association
- Australian Nursing Federation
- Australian Rural Nurses and Midwives
- Australian and New Zealand College of Anaesthetists
- Australian Society of Anaesthetists
- Commonwealth Department of Health and Ageing
- Congress of Aboriginal and Torres Strait Islander Nurses
- Council of Remote Area Nurses of Australia
- Country Women's Association of Australia
- Health Consumers of Rural and Remote Australia
- Maternity Coalition
- National Aboriginal Community Controlled Health Organisation
- National Collaboration of Maternity Services
- Northern Territory Department of Health and Community Services
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- Royal Australian College of General Practitioners – National Rural Faculty
- Royal Australasian College of Physicians
- Rural Doctors Association of Australia
- Rural Doctors Association of Australia – Rural Specialists Group
- Rural Health Workforce Australia
- South Australia Country Health
- Tasmanian Department of Health and Human Services
- Western Australia Department of Health
- Women's Hospitals Australasia

Input from this group was complemented by feedback from over ninety individuals

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National Consensus Framework for **Rural Maternity Services**

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National Rural Faculty
The Royal Australian College of General Practitioners

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Caring for the Country

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