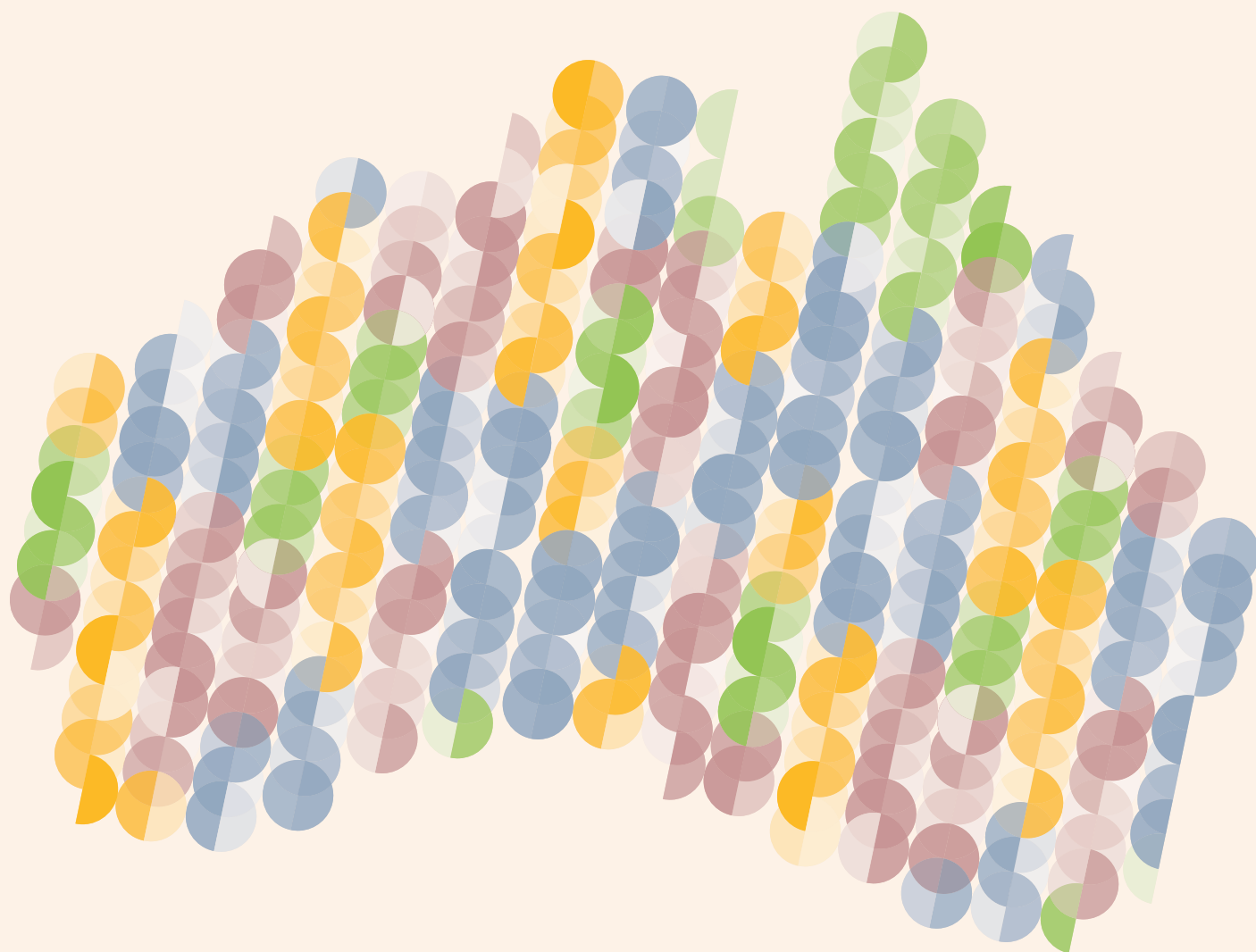


Strategic Directions for Australian Maternity Services

Draft for Consultation



AUSTRALIAN HEALTH MINISTERS'
ADVISORY COUNCIL

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Strategic Directions for Australian Maternity Services

Consultation paper number 2

DRAFT - FOR CONSULTATION

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Introduction

In Australia, maternity services are delivered through a mix of public and private services. The planning and delivery of maternity services is predominantly undertaken by the states and territories through publicly funded care models, with the Commonwealth providing national direction and supporting efforts to improve care and outcomes. Maternity services are provided by obstetricians, midwives, general practitioners, Aboriginal and Torres Strait Islander health workers, anaesthetists and allied health professionals. The initial contact for many women is with their general practitioner who may advise on models of maternity care and assist in accessing the relevant service in line with the woman's preferences and care needs. A smaller number of women present directly to a midwife or public service. Private services are offered in private hospitals and public hospitals by private providers, who are largely obstetricians and midwives. Three-quarters of hospital births are in public hospitals.¹

Australia is regarded as a safe country in which to have a baby and compares well on a number of international measures, however, there are areas where improvement is required. The Australian rate of obstetric trauma is higher than the average for Organisation for Economic Development and Cooperation (OECD) countries (7.2 vs 5.7 per 100 births).² Caesarean section rates are high relative to most OECD countries,² the Australian rate of perinatal deaths appears higher than the OECD average and between 1995 and 2016, the stillbirth rate increased (7.0 to 7.7 deaths per 1,000 births).³ Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse backgrounds, women living in regional, rural and remote areas, teenage mothers and women who experience family violence are all more likely to experience disparities in care and outcomes.¹

Significant progress in improving Australian maternity care services was made under the National Maternity Services Plan 2010–2015. *Strategic Directions for Australian Maternity Services* is intended to provide an overarching national approach to maintaining Australia's high-quality maternity care system and working towards further improvements in line with contemporary practice, research and international developments.

The strategic directions provide jurisdictions with direction while maintaining flexibility, in recognition of the diversity in geography, demographics, workforce and service delivery models between and within Australia's jurisdictions. It also provides initiatives for private health providers to consider in the delivery of maternity services. For consumers, the strategic directions give guidance on key nationally agreed priorities that they can expect to see reflected in local maternity service planning and delivery. Implementation of the strategic directions will require collaboration with consumers and between all health professionals involved in maternity care, maternity care service providers and governments and related agencies. To support this the final document will include a monitoring and implementation framework.

There is a range of other programs of work that link to *Strategic Directions for Australian Maternity Services*, which is informed and will inform the work of other government agencies, including the Australian Institute of Health and Welfare (AIHW), the Australian Commission on Safety and Quality in Health Care (ACSQHC), the Medical Research Future Fund (MRFF) and the Independent Hospital Pricing Authority (IHPA). The strategic directions will also link with other national strategies including those on Aboriginal and Torres Strait Islander health, breastfeeding, diabetes and mental health.

The document is structured around the four values — respect, access, choice and safety. Under each of the values are the principles for women-centred care, followed by strategic directions and the rationale that underpins each strategic direction. These are followed by enablers, which are the actions and activities that are seen as key drivers to achieving the strategic direction. In a number of instances it is anticipated that some of these will be reflected in service plans at a jurisdictional and service level. The implementation and monitoring framework will provide guidance on how achievement of the strategic directions will be monitored.

Strategic Directions for Australian Maternity Services

Purpose

Women are the decision-makers in their care and maternity care should reflect their individual needs throughout the pre-pregnancy period, pregnancy, childbirth and the postnatal period. *Strategic Directions for Australian Maternity Services* aims to ensure that Australian maternity services are equitable, culturally safe, woman-centred, informed and evidence-based.

Values and principles

The values (respect, access, choice and safety), principles and strategic directions are based on current evidence and feedback provided by consumers and health professionals. They are aligned with the charter of rights of childbearing women.⁴

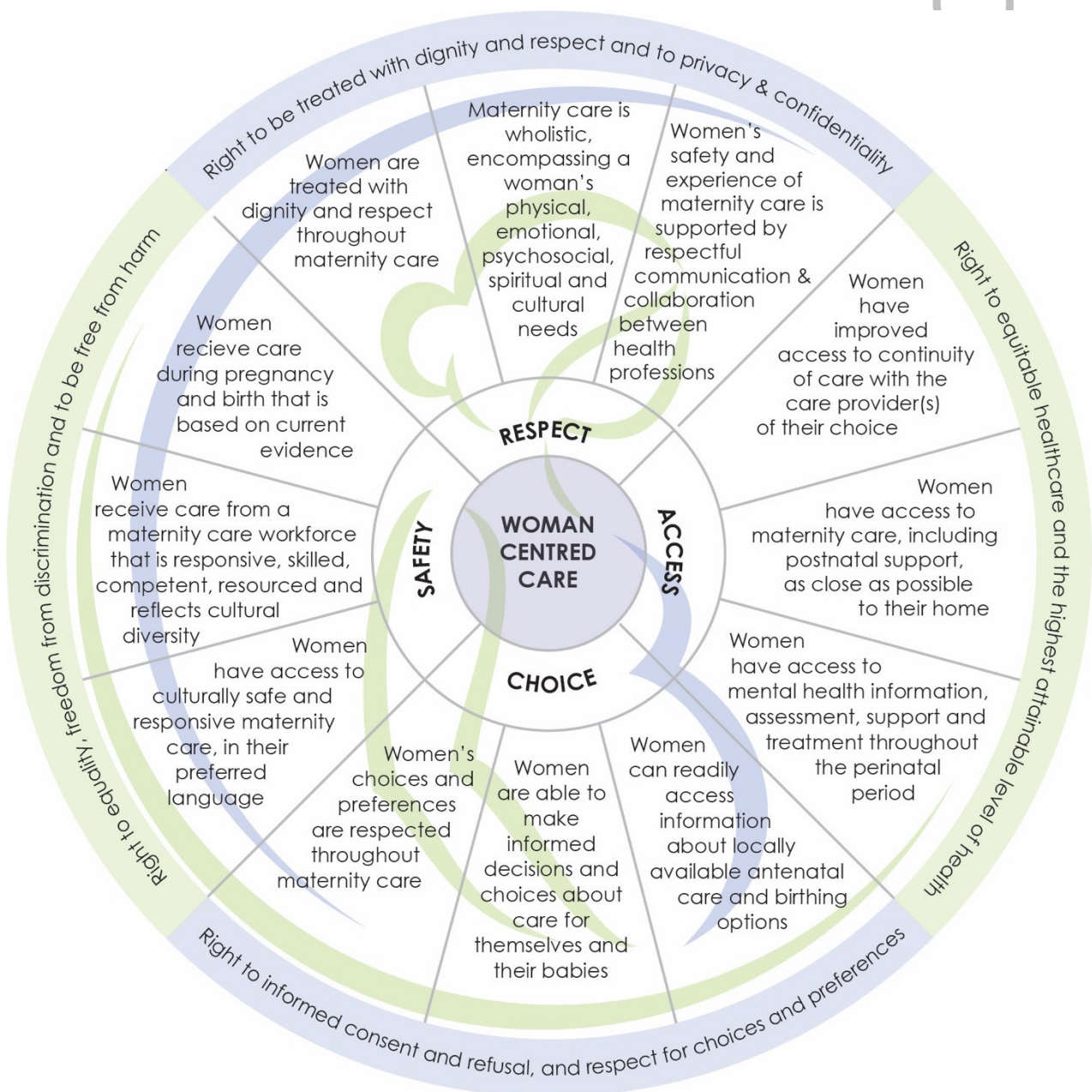


Figure 1 Purpose, surrounded by values, principles and the universal rights of childbearing women

1 Respect

1.1 Respectful, wholistic care

Principle

Women are treated with dignity and respect throughout maternity care.

Maternity care is wholistic, encompassing a woman's physical, emotional, psychosocial, spiritual and cultural needs

Strategic direction

Women's experiences and outcomes are respected and used to inform quality improvement in maternity care

Rationale

All childbearing women need and deserve respectful care and protection of their autonomy and right to self-determination; this includes special care to protect the mother-baby pair as well as marginalised or highly vulnerable women.⁴ Disrespect and abuse during maternity care are a violation of women's basic human rights.

Consumers want their experiences and outcomes to be routinely collected and made publicly available.

Enablers

- Adoption of the Respectful Maternity Care Charter.
- Develop, collect and report on patient reported experience measures (PREMs) and patient reported outcome measures (PROMs) in maternity services.
- The ACSQHC is currently scoping an appropriate role at national level to support the consistent and routine use of PROMs to drive quality improvement in a way that brings patients' voices and outcomes to the fore.⁵

1.2 Collaboration between health professionals

Principle

Women's safety and experience of maternity care is supported by respectful communication and collaboration between health professions

Strategic direction

Strengthen interdisciplinary collaboration, culture and communication

Rationale

Collaboration between all maternity providers supports improved communication and care outcomes. The regulatory framework and service leaders have a role to play in setting standards and role modelling positive behaviours.

Consumers expect all members of the health care team to work collaboratively to support well integrated care and care transitions.

Enablers

- Implementation of the National Health and Medical Research Council (NHMRC) National Guidance on Collaborative Maternity Care.⁶
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Australian College of Midwives (ACM), Royal Australian College of General Practitioners (RACGP), Australian College of Rural and Remote Medicine (ACRRM), and the National Association of Specialist Obstetricians and Gynaecologist (NASOG) issue a joint statement about working together for the benefits of women, babies and health professionals and develop mechanisms to support collaborative and respectful relationships between all health professionals involved in maternity care.

2 Access

2.1 Improving access to continuity of care

Principle

Women have improved access to continuity of care with the care provider(s) of their choice

Strategic direction

Expand the availability of models of care that promote continuity for women

Rationale

The World Health Organization (WHO) recommends midwife-led continuity of care as a health system intervention to improve the utilisation and quality of antenatal care.⁷

Current funding models are seen as supporting a more fragmented approach to care.

Women value continuity of care and continuity of carer. Women should be supported in their choice of carer.

Enablers

- Increase the range of continuity of care models available for women in their geographic location.
- Develop funding models to support access to continuity of care models.
- Conduct research on the cost benefit of models
- Continue to develop the Maternity Care Classification System (MACCS) and publicly report

2.2 Improving access to maternity care

Principle

Women have access to maternity care including postnatal support, as close as possible to their home

Strategic Direction

Re-design services around the needs of women and communities

Rationale

Women want to be able to access a range of models in their geographic location depending on their needs.

Care closer to home reduces the disruptions to family and work life.

Enablers

- Investigate inconsistent uptake of the Australian Rural Birthing Index to support its utilisation.
- Increase the availability of outreach services and telehealth for maternity care in rural and regional areas.
- Facilitate access to specialised models of care for women with a high risk of poorer outcomes for themselves and their babies.
- Co-design services in conjunction with communities.

Strategic direction

Improve care in the postnatal period

Rationale

Effective postnatal care in the community can prevent short, medium and long-term consequences for the woman and her family.⁸

Consumers and service providers have identified an inconsistency in the availability of postnatal care.

Australia does not have any nationally agreed evidence-based guidelines or standards for postnatal care.

The use of evidence-based guidelines has the potential to improve care of women and babies and ensure consistency of care across health sectors.⁸

Enablers

- Develop evidence based guidelines for postnatal care.
- Develop pathways to support smooth transitions for women between antenatal and postnatal services including links with Maternal and Child Health/Child and Family Health Services and general practice.
- Support implementation of the national enduring breastfeeding strategy.

2.3 Improving access to mental health support

Principle

Women have access to mental health information, assessment, support and treatment throughout the perinatal period

Strategic direction

Jurisdictions address the unacceptable morbidity and mortality associated with poor perinatal mental health

Rationale

For many women birth is an empowering and overwhelmingly positive experience but for a smaller proportion the experience is less than positive with lifelong effects. Up to one in ten women experience depression during pregnancy⁹ and one in six experience it in the first postnatal year.¹⁰ Around one in five women experience an anxiety disorder in late pregnancy¹¹ and one in six in the postnatal period.¹² Anxiety and depression frequently occur together.¹³ In 2012–2014 in Australia, there were five maternal deaths by suicide (8% of all maternal deaths), two of which were in women with no known pre-existing mental health condition.¹⁴

The availability of perinatal mental health services, in particular for acute needs, is variable.

Suicide in the perinatal period is a leading cause of maternal deaths in Australia¹⁵ and the rate of maternal deaths due to psychosocial health problems is rising.¹⁶

Enablers

- Develop a Perinatal Mental Health Plan, as an adjunct to the *Fifth National Mental Health and Suicide Plan*.
- Maintain the currency of national evidence-based perinatal mental health guidelines and promote their uptake by health professionals (such as *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*).¹⁷
- Update the Australasian Health Facility Guidelines¹⁸ to include inpatient requirements for perinatal mental health services

3 Choice

3.1 Providing information about local maternity services

Principle

Women can readily access information about locally available antenatal care and birthing options

Strategic direction

Improve availability of quality information

Rationale

Women want publicly available information to assist them in decision-making.

The Pregnancy, Birth and Baby website¹⁹ provides information on services and models of care and telephone guidance from maternal and child health nurses or counsellors.

General practitioners are a key source of information for women and often the first point of contact in pregnancy. They also have an important role in assisting women in the transition into and out of maternity care services and providing longitudinal family care.

Enablers

- Expand and promote the Pregnancy, Birth and Baby website.
- Support general practitioners to provide information on available models of care and arrange for timely access to the chosen model.
- Include locally available models in the development of Health Pathways on maternity care to assist in providing general practitioners with relevant information.

3.2 Supporting informed choice

Principles

Women are able to make informed decisions and choices about their care for themselves and their baby

Women's choices and preferences are respected throughout maternity care

Strategic direction

Enable women's decision-making through the provision of evidence-based information about outcomes associated with different ways of giving birth.

Rationale

Having prior knowledge about the risks and benefits of different ways of giving birth enables women to make informed choices during labour.

A simple to understand concise summary of the models of care available to pregnant women, and how these differ by facility size and type would assist women in making informed choices.

Enablers

- As part of antenatal care, provide women with evidence-based information about potential outcomes of different ways of giving birth.
- All maternity service providers contribute data to the MaCCS.
- Publicly report MaCCS.
- Continue to develop data linkages with MaCCS and National Perinatal data set

4 Safety

4.1 Supporting cultural safety

Principle

Women have access to culturally safe and responsive maternity care, in their preferred language

Aboriginal and Torres Strait Islander women

Strategic direction

Support implementation of culturally safe, evidence-based comprehensive models of care that have been developed and implemented in partnership with Aboriginal and Torres Strait Islander people and organisations

Rationale

Evaluated state-based initiatives have found improved outcomes associated with maternity care models that are culturally sensitive and responsive, provide continuity of care and involve partnerships with Aboriginal and Torres Strait Islander health staff and services.²⁰⁻²³

Enablers

- Support uptake of the *Characteristics of Culturally Competent Maternity Care for Aboriginal and Torres Strait Islander Women Report 2012*.²⁴
- Implementation of strategies relevant to maternity care in the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* and the associated Implementation Plan.
- Implementation of the 'Birthing on Country' Service Model and Evaluation Framework.

Women from culturally and linguistically diverse backgrounds

Strategic direction

Support implementation of culturally safe, evidence-based comprehensive models of care that have been developed and implemented in partnership with women from culturally and linguistically diverse backgrounds and their communities

Rationale

A systematic review identified the following barriers to immigrant and refugee women accessing reproductive health care:²⁵

- spoken and written language, including issues relating to interpreters
- health professionals' lack of knowledge regarding cultural norms
- systemic barriers relating to the health care system and difficulty navigating the system
- transport difficulties
- cost of services.

Enablers

- Improve access to language services and bilingual and bicultural workers.
- Develop a workforce strategy to improve training in working with interpreters and bicultural workers.

4.2 Supporting the maternity care workforce

Principle

Women receive care from a maternity care workforce that is responsive, skilled, competent, resourced and reflects cultural diversity

Strategic direction

Workforce planning enables the delivery of sustainable maternity services

Rationale

Services and models have been limited, reduced or closed due to workforce availability

Enablers

- Support implementation of strategies in the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023*.
- Support development and maintenance of skills, including clinical reflection, of health professionals working in maternity services and in particular those in rural and remote areas.
- Support the development of generalists in rural settings to promote the maintenance of services.
- Consider the impact of 'unqualified neonates' on cost and workload.
- Consider models that involve midwives working within general practice and obstetric practices, including through the postnatal period.

4.3 Supporting safety and quality in maternity care

Principle

Women receive care during pregnancy and birth that is based on current evidence

Strategic direction

Evidence is used to develop, design and deliver services and for continuous quality improvement

Rationale

The use of evidence-based guidelines has the potential to improve care of women and babies during labour and birth and ensure consistency of care across health sectors.

The national *Pregnancy Care Guidelines*²⁶ were developed to help ensure that women in Australia are provided with consistent, high-quality, evidence-based maternity care.

There is some evidence that preconception health promotion interventions are associated with positive maternal behavioural change.²⁷

Preconception care is of particular importance for women with severe mental illness.¹⁷

The ACSQHC, through the National Safety and Quality Health Care Standards and work on variation, supports continuous quality improvement.

Consumers expect health professionals to deliver care in line with available evidence.

Enablers

- Promote preconception health and convey the risks of smoking, alcohol and substance use in pregnancy and the risks associated with obesity and diabetes for pregnant women and babies.
- Maintain the currency of national evidence-based pregnancy care guidelines and promote their uptake by health professionals.
- Develop nationally consistent evidence-based guidelines for labour and birth, including consumer summaries.
- Develop a standards user guide for services that provide maternity care to support implementation of the National Safety and Quality Health Care Standards.
- Identify and report on variation in outcomes and practice in healthcare settings and support development of clinical care standards relevant to maternity care to address identified safety and quality concerns.
- Continue reporting on National Core Maternity Indicators to support continual improvement in the quality of maternity services.

Reducing the stillbirth rate

Strategic direction

Service providers implement measure to reduce the rates of stillbirth

Rationale

Independent evaluation of the UK National Health Service Saving Babies Lives Care Bundle shows that clinical improvements such as better monitoring of a baby's growth and movement in pregnancy as well as better monitoring in labour, led to a fall in still birth rates by one fifth in the maternity units where the Care Bundle was implemented.²⁸

Throughout the experience of stillbirth or neonatal death information and emotional support should be provided with sensitivity, clarity, genuineness and consideration of individual needs for care.²⁹

Enablers

- The Centre of Research Excellence in Stillbirth is conducting research into improving care and outcomes for women with risk factors for stillbirth, developing new approaches to identifying women at risk of stillbirth, implementing best practice care after stillbirth and in subsequent pregnancies and improving knowledge of causes and contributors to stillbirth and the actions that might be effective in reducing deaths (including information on fetal movements and sleep position in pregnancy).³⁰
- Services implement strategies to reduce stillbirth.
- Provide access to bereavement care for women who experience stillbirth, neonatal death or whose babies have major congenital anomalies.

Appendix: Summary of consultation feedback

This appendix presents the findings from consultations undertaken from May to July 2018 to inform the development of a National Strategic Approach to Maternity Services. These included stakeholder consultation workshops and focus groups in capital cities and regional locations, written submissions and stakeholder meetings.

The aim of the consultation was to:

- provide the opportunity for all points of view in the community to be heard and for stakeholders to identify areas of concern
- seek input on ways forward to improve outcomes for all Australian women and families
- seek guidance on what the key areas of focus should be for the Strategy.

Each of the various consultation approaches are summarised in the following sections. Where possible the language/descriptors are those used by the various participants. Overall themes that emerged through each of the approaches had some similarity. There were a number of 'state' and at times very local aspects also identified. There was also some overlap between strategies suggested under various themes.

Workshops

In May, June and July 2018 the Australian Government Department of Health as the lead jurisdiction for Strategy organised 11 workshops across Australia. Workshops were held in five capital cities (Melbourne, Adelaide, Canberra, Perth and Brisbane) and six regional locations (Dubbo NSW, Traralgon Vic, Tweed Heads NSW, Albury NSW, Campbelltown Tasmania and Alice Springs NT). Over 200 people attended the workshops including Aboriginal and Torres Strait Islander health workers and practitioners, academics, anaesthetists, consumers, dietitians, general practitioners, general practitioner/obstetricians, lactation consultants, maternal and child health nurses, midwives, obstetricians, occupational therapists, physiotherapists, psychiatrists, psychologists, researchers and speech pathologists.

Prior to each workshop, all participants received a copy of the *Developing a National Strategic Approach to Maternity Services Consultation Paper*. The paper provided background information and context for the Strategy and provided a snapshot of the current evidence on maternity services in Australia and some of the national initiatives underway. This included births in Australia, safety and quality, access, models of care, preconception care, pregnancy care, postnatal care, maternity services for Aboriginal and Torres Strait Islander women and families, maternity services for culturally and linguistically diverse families, perinatal mental health, family violence, when a baby dies and workforce.

Participants discussed the critical challenges for Australia in maternity services for which there is strong evidence of the need for national improvement, that constitute the most risk and that require a nationally consistent approach. Participants were then asked to think about what must be different in the future for more vulnerable populations, for those who need and use maternity services and for the way services and care are delivered in communities.

For the final session participants identified national strategies where there is strong evidence of success, models of good practice and innovation and the need for more research at a national level. The issues and strategies identified included a mix of national and state/territory provided service matters.

Strategy elements identified through workshops

Ensure all women have access to safe maternal health care

- Develop an agreed 'National Framework/Standards for Maternal Health Care' (or equivalent), including principles, minimum standards, and clear definitions. Acknowledge that access to safe maternal health care is a human right. As part of this include the requisite workforce, staffing, facilities and infrastructure models.
- Develop a digital platform that provides an overview of available services for all women.
- Consider funding models that remove current system barriers to continuity of care e.g. funding follows women.

Build the knowledge base needed for maternity services

- Develop a 'Registry' of maternity care providers to support improved information for consumers and providers.
- Analyse, evaluate and further research areas critical to success in maternal health.
- Develop more nationally consistent data, with key national data sets that provide evidence regarding access to appropriate models of care, workforce requirements and the needs of at-risk and vulnerable cohorts. This could include a national data base with key indicators and outcomes (including patient-reported outcomes).
- Facilitate sharing of data (for example through ACSQHC and IHPA links) and increase publicly available and easily accessible data.
- Develop a digital platform (e.g. App) to provide information on available services and principles for national models of care (potentially linked to MyGov and patient eHealth records)

The maternal health workforce is more sustainable

- Map, analyse and report on supply, distribution and composition of the maternal health workforce - both current and future.
- Develop strategies to address gaps and risks.
- Ensure appropriate practice by educating all maternity health workers in culturally safe practice and continuity of care, and ensure the scope of practice is appropriate to the models of care.
- Educate the workforce, especially midwifery, on mental health in the perinatal period.
- Develop and embed perinatal mental health into curricula for all clinicians.
- Develop and implement strategies for the rural and remote maternal health service workforce.
- Develop and implement strategies for the Aboriginal and Torres Strait Islander workforce.

Rural, remote and regional women have improved access and reduced variation in care

- Better stratify women, based on risk and choice.
- Facilitate and ensure that local health services in rural and remote Australia retain appropriate infrastructure, technologies and skills – better utilisation of the Australian Rural Birthing Index.
- Include risk and vulnerability domains in the acceptable levels of care.

Women are the centre of maternity care (listen)

- Develop national information and data (for example using patient-reported outcome measures and patient-reported experience measures), with clear measures and national reporting on outcomes. Include Maternity Care Classification Systems (MaCCS) in national perinatal data.
- Develop care approaches based on national clinical 'measures' and indicators.

- Provide women with information and education about the availability and effectiveness of care.
- Provide access to continuity of care.
- Develop clear models of care with sufficient evidence for comparability and examples of best practice.
- Ensure health care for the mother is evidence based and extends for the first 3 months of a child's life to enable the wellbeing of both the woman and child.
- Ensure vulnerable women have improved access and reduced variation in care.

Feedback from workshop participants

Workshop participants completed a brief feedback survey at the end of the workshop. The majority of participants were positive about their ability to participate in the discussion, and felt their views were heard. While participants were hopeful about outcomes to be achieved, some did express concern as to the amount of change that will ultimately be achieved.

Focus groups

Consumer focus groups were held in Melbourne, Perth, Brisbane, Sydney, Toowoomba QLD, and Nowra NSW. The Nowra group was specifically for Aboriginal and Torres Strait Islander women and the Melbourne groups were for culturally and linguistically diverse women.

The focus groups had a less formal structure than the workshops. Participants were asked to reflect upon their experiences with maternity services in Australia, pinpoint what in their experience currently works and identify issues and gaps. They were then asked to recommend improvements. Women attending the focus groups had experienced a variety of models of care including private obstetrician, private midwife, continuity models (Midwifery Group Practice and similar) in a public hospital, group practice models with limited continuity and routine public hospital care.

Key themes from focus groups

Similar themes emerged from all focus groups. The outcome women were seeking is a system that provides a woman-centred approach through meeting the individual needs of the woman where the woman feels listened to and respected. To achieve this, women need access to information, a range of models of care, continuity of care, funding, postnatal care and perinatal mental health care delivered in a respectful, culturally safe manner with specific strategies for women from culturally and linguistically diverse backgrounds.

Discussion 1: What works well?

Women were asked to discuss the aspects of maternity services that they felt were working well.

Aspects identified included:

- continuity of care
- a known midwife at the birth
- access to choices
- some improvements in staffing and health professionals' education
- emergencies are managed well in general.

Discussion 2: What are the gaps?

Women were then asked to discuss the gaps in services that they had experienced or of which they were aware. Gaps identified included:

- availability of and lack of information about
 - models of care so women can make informed choices,

- procedures and interventions throughout the pregnancy and birth so women can make informed decisions and give informed consent at times which are often stressful
- postnatal care and resources such as lactation consultants
- limited perinatal mental health services
- inflexible and restrictive criteria for some midwifery group practice models – these models should be all risk
- unnecessary closure of rural birthing services
- over medicalisation of birth
- lack of respect from health professionals towards the women — a number of women said they felt coerced, bullied, patronised, ignored.
- funding issues
- lack of evidence-based policies or implementation of same.

Discussion 3: What improvements could you suggest?

In this discussion the focus was on the improvements that the women thought would be of value in improving maternity services.

- Continuity of care for all women — some women indicated midwifery and some indicated that the practitioner was not as important as having continuity of care from one provider or in the case of midwifery group practice only a very small number of midwives so that the provider is well known and has an established relationship with the women.
- A known midwife at the birth regardless of the model of care — ideas such as midwives being employed within general practice and obstetrician practices were suggested.
- Inclusion of mental health education in antenatal classes.
- Choice/ access to models of care including publicly funded homebirth.
- Education of health professionals on models of care and locally available maternity services so they can inform women.
- Information from and a discussion with general practitioners about available models of care and the women's preferred approach at the commencement of the pregnancy to assist women to make a choice.
- Conversion of the pregnancy and baby helpline into an app.
- Review of discharge policies which see women discharged too early. (eg before passing urine) — this increases the cost to the system because of poor postnatal services.
- Evidence-based policies and consistent standards and guidelines with consistent implementation in all state and territories.
- More emphasis on postnatal care including postnatal debriefing, postnatal survey and mental health assessments, access to postnatal services eg child and family health nurses, physiotherapy and lactation consultants.
- Resolution of funding issues that reduce access, bundled payments, Medicare payments for lactation consultants.
- More publicly available information, data, statistics, patient-reported outcome and experience measures.
- Respect for the women embedded in the culture of services, education of health professionals and collaborative relationships between health professionals.
- Preconception education that starts at high school.
- Access to birthing services in rural areas.

- Timely access to female interpreters in the woman's preferred language.
- Maternity liaison officers working between hospitals and communities for culturally and linguistically diverse women.

Written submissions

Over 200 written submissions were received from consumers, individual health professionals, service providers, universities, consumer organisations and professional organisations. In addition, the Maternity Consumer Network converted the response template into a survey and provided another 535 submissions.

Key themes from submissions

Key themes arising from the submissions were similar to those discussed at the workshops and in the focus groups.

Question 1 Can you in one or a few brief sentences provide what you think would be an overarching key outcome statement for the National Strategic Approach to Maternity Services?

All respondents supported the use of an overarching key outcome statement with the inclusion of references to access, evidence based care, woman/women centred care, continuity of care, safety, quality, respect, choice, equitable, culturally safe care and mental health. One respondent suggested that the vision from the 2010-2015 Maternity Services Plan be maintained with the inclusion of the word 'safe.'

Another respondent suggested adoption of the WHO vision with an additional recommendation:

"that the definition of quality care also include the phrase: and delivered within the local community setting wherever possible or similar wording, to emphasise the importance of access to care close to home for Aboriginal and Torres Strait Islander women and women living in rural and remote areas."

Question 2 Do you think there should be a set of values that underpin the National Strategic Approach to Maternity Services? If so, could you list the top four values you would like to see included?

Respondents supported the inclusion of values. The four most popular values were Access, Respect, Safety and Choice. Other suggested values were (in order of preference) Continuity of care, Quality, Cultural safety, Evidence based, Woman/ Women centred, Equity, Mental health, Sustainable, Workforce, Effective.

Question 3 Can you outline three or four positive aspects of maternity services in Australia?

This next section asked respondents to consider positive aspects and gaps in maternity services — some issues/aspects appear in both the positives and the gaps. From some of the comments it would appear that, while some aspects were generally regarded as being positive, there was also a view that they could be further improved. Of the respondents, 17 indicated they could find no positive aspects to maternity care provision.

Positive aspects identified were as follows.

- The positive feature commented on by most respondents was the availability of free care accessible to all through the public health system.
- Access and choice — this included Medicare for midwives, as well as access to a range of models that were flexible and could be collaborative. The availability of choice (although it was noted this was not equal across the country) including access to birth centres, midwifery-led models and public and private homebirth as well as choice of provider including private midwives and obstetricians — these were all seen as positive especially access to midwifery-led models of care. The ability to make informed choices was also noted. A number commented

on the level of service provided by privately practising midwives. Several also noted that rights and choices were respected and that they felt they had more control of their body and how services interacted.

- Overall the standard of care in Australia was seen positively and as being safe, having good outcomes overall and with good equipment and facilities. There were a number of comments on the availability of expertise and facilities in emergency situations and also the ability to access specialist services when required. Care was seen as safe and of a quality standard. The availability of care that was both public and private around the country was viewed as positive.
- Skilled workforce with standards for accreditation — A number commented on the high standard of staff with specific mention of the care and expertise of midwives but also noting the high quality and expertise of medical staff. General practitioners received few mentions although one respondent commented that a positive was: *open minded GPs who understand that women should be offered a variety of birthing options early on*. A number commented on the good standard of training and education of health professionals. Collaboration between professionals was seen as a positive.
- Evidence-based care citing the availability of Pregnancy Care Guidelines, Mental Health Care in Perinatal Period Guidelines and an increased focus on social and emotional wellbeing
- Some innovative programs in rural areas and the role of the GP and Aboriginal Community Controlled Health Organisations. Opportunity identified to share some of the innovative successful models.
- Postnatal care was mentioned by a small number of respondents noting that where it is provided postnatal care after discharge was valued and the links into child and family health were also noted.
- Fewer respondents mentioned the availability of antenatal care and antenatal education, the availability of breastfeeding support and lactation services, and the access by midwives to MBS.
- A few respondents mentioned access to mental health services including some screening and help for postnatal depression.
- Limited respondents noted that in some rural and remote areas there was some choice and mentioned Birthing on Country.

Question 4 What do you think are the three or four key gaps or issues for maternity services in Australia? Of these which is most important to you?

Gaps and issues identified included the following.

- Lack of access to continuity of care — lack of continuity models and opportunities for every woman to have a known midwife throughout her maternity experience, lack of continuity of care with poor clinical handover from hospitals to general practice. Limited publicly funded homebirth models, access to vaginal birth after caesarean section and the impact of structural barriers such as insurance and endorsement requirements for privately practicing midwives.
- Rural access — respondents noted that there has been a progressive decline in the availability of maternity services, in particular birthing services, in rural and remote areas. These women and their families are often not only limited in the amount of choice available with respect to their care options but also in access generally. This was seen to be accompanied by an increased risk for any births occurring in centres where the service had been downgraded and staff deskilled. Limited availability of phone/retrieval support for rural services and inconsistent Patient Accommodation and Transport Schemes across Australia were also noted.

- Inadequate perinatal mental health services — perinatal mental health resource provision across metropolitan, regional and rural centres was noted to be variable and in many instances limited or non-existent. Also noted was the variable level of knowledge/awareness among health care professionals regarding mental health screening and support and the limited availability of mother-baby units.
- Strategies were required to address increasing intervention rates so that rates for example of caesarean section and induction are reduced.
- Lack of evidence based policies and care — respondents indicated that there should be transparency and consistency across Australia with all policies, guidelines and strategies to reduce inconsistent practices and increase access to care, as evidenced by the ACSQHC *Second Australian Atlas of Healthcare Variation*. Care based on evidence not local policy or current practice was required.
- Poor postnatal care — postnatal care that only extends to the first few days after birth was regarded as inadequate. The transitions from hospital into home and community were seen as poor.
- Access to information — Information about which services are available in which areas is difficult to source. Poor access to quality education (in particular antenatal) and information. Women and partners receive antenatal education on normal child birth.
- Lack of transparency — This also contributed to women not being sufficiently informed to be able to provide informed consent and failure to respect women and their wishes. Women should have access to data on health provider performance (including rates of interventions and woman satisfaction). Health professionals should use woman-friendly language when talking to women in labour and not be bullying or coercive
- Trauma related to birth is not adequately recognised or followed up.
- A number of respondents noted workforce issues and a lack of planning to address same. The inclusion of neonates in staffing models was highlighted.

Question 5 What four to six key improvements would you like to see in maternity services in Australia? Please consider these from a national perspective.

There were a range of suggestions for improvement and these have been grouped into themes.

Access

- Services and continuity of care/carer — Health providers receive education on available models of maternity care. Models support vaginal breech, there is support for delayed cord clamping and skin-to-skin contact, including for women who have a caesarean section.
- Information for mums and carers on maternity services.
- Perinatal mental health support for women.
- Service hubs providing information to women about their choices and options.
- Rural maternity services (reopening of closed services).
- Care by known midwife/ midwives; shared care with general practitioners; flexible models to meet mother's needs.
- Evidence based care — guidelines required for care – intrapartum and postnatal, existing guidelines to be implemented.
- Implement an agreed standard for specialist care; specialist care to be available in regional area.
- Generous funding support for transport and accommodation to access services for people in remote areas.
- Indigenous women should be able to make choices about where they birth their babies.

- The “Birthing on Country” projects should be enacted.
- All women have access to birth centres, vaginal birth after caesarean section is supported and women are given time for labour to progress naturally. Facilities to labour in water are available in hospitals.
- Facilities for partners/families are included in birthing units.
- The system allows for longer antenatal visits.

Data collection

- Improved data collection for perinatal mental health assessments to report on and evaluate data collected as part of nationally recognised and recommended screening methods.
- Streamlining of all maternity data (from national level right down to care provider level) and making it publicly available in a timely manner to promote transparency, accountability, so that women can make informed choice about where and with whom to birth.
- Include patient-reported and experience measures in data collected.

Continuity of care

- Access to care by known midwife/midwives.
- Access to free non-admitted postnatal care by midwives, ideally in the home, for up to 6 weeks following childbirth.
- Women of all-risk status should have the *option* of having the same midwife throughout pregnancy, birth and postnatal periods. These midwives should work collaboratively with doctors and allied health, and be able to demonstrate collaborative practice.
- More breastfeeding and postnatal support provided for at least 6 weeks.

Funding

- Funding review leading to funding reform of maternity services in Australia (including private health insurance, medical benefits schedule and insurance).
- Unique Patient Identifiers implemented by all states and territories to allow bundled payments to progress at a hospital level; review of unqualified neonates classification to better reflect care required than location.
- Increased Medicare rebates for services provided by privately practising midwives and all care around supporting birth at home.

Perinatal mental health

- Increased training for maternal health practitioners in mental health to support the mother and father from preconception through to extended postnatal period.
- Effective implementation of the Mental Health Care in the Perinatal Period Guidelines across maternity services in Australia.
- Improved data collection for perinatal mental health assessments to report on and evaluate data collected as part of nationally recognised and recommended screening methods.
- establishment of specific and targeted mental health services in maternity settings.
- Immediate improvement in women across Australia being able to universally access publicly funded mother baby units.
- Create a Perinatal Mental Health Plan, as an adjunct to the 5th Mental National Health and suicide prevention Plan.

Multidisciplinary collaboration

- Improved multi-disciplinary co-ordination to manage complex care within maternity services including mental health, family and domestic violence, substance abuse and other psychosocial complexity. Team-based approach in high risk cases.

A more collegial approach to interdisciplinary relations would be supported by:

- investment in multidisciplinary education to improve the capacity of teams to work effectively together;
- embedded interdisciplinary reflective practice; and
- collaborative clinical governance processes.
- There is collaboration between health providers involved in a woman's maternity care.
- The system allows for longer hospital stays.
- Doula/independent advocate are able to be present at a hospital birth.

Respect

- Respectful maternity care- this needs to be implemented and evaluated by asking women about their experiences (patient-reported experiences and outcomes).
- Introduction of the principles of Respectful Maternity Care.
- Human rights — The concept of "safe motherhood" is usually restricted to physical safety, but childbearing is also an important rite of passage, with deep personal and cultural significance for a woman and her family. Because motherhood is specific to women, issues of gender equity are at the core of maternity care. Thus, the notion of safe motherhood must be expanded beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights, including respect for women's autonomy, dignity, feelings, choices, and preferences, wherever possible.
- Mandate representation of pregnant women and mothers on public policy decision making-bodies.
- Women-centred approach.
- Informed consent is enabled and supported versus coercion and empowerment.

Other areas mentioned by some respondents included: screening for family violence, improved focus on stillbirths, decrease unnecessary interventions and improve preconception care.

Question 6 Are there specific strategies that you could suggest for rural and remote services and/or, Aboriginal and Torres Strait Islander women and/or, women from culturally and linguistically diverse backgrounds?

Strategies for rural and remote services

- Reopening of rural maternity services and maintenance of infrastructure.
- Regional hubs of health and community services.
- Funded travel assistance for mothers who have to relocate to birth.
- Access to upskilling and skills maintenance for health care professionals.
- Improved choice and availability of services in rural and remote – ideas such as travelling midwifery services, use of technology were mentioned.

Strategies for Aboriginal and Torres Strait Islander women

- Innovative and flexible service models to meet cultural needs of Aboriginal and Torres Strait Islander women and other cultural groups in the local community, but underpinned by national guidelines and accreditation standards.
- Individualised and tailored care for all Aboriginal women and families, regardless of obstetric risk, social risk or other factors.
- Aboriginal and Torres Strait Islander women are supported to birth on country.
- Acknowledgment of cultural birthing practices.

- Compulsory cultural training for midwives, GPs and obstetricians working in rural and remote areas.

Strategies for women from culturally and linguistically diverse backgrounds

- Development of a Culturally Competent Maternity Plan for Women from Culturally and Linguistically Diverse Backgrounds that includes policies and frameworks on:
 - language services
 - bilingual and bicultural workers
 - cultural competency training for all staff involved in providing maternity services
 - inclusion of female genital cutting in routine antenatal surveys of risk factors.
- Sign language interpreters.
- Health professionals and other staff are educated in culturally safe care and culturally sensitive — recognise different cultures and listen to women.

Question 7 How will success be measured or how will we know if strategies are being successful?

Patient-reported outcomes and experiences

Many respondents stated that patient-reported outcomes and experiences would be the best measure of success. Respondents also suggested how this might be achieved.

“Require the Australian Commission for Safety and Quality in Healthcare to provide a Partnering with Maternity Consumers Report that covers the spectrum of a woman’s maternity experience – physical, social, cultural, emotional, psychological and spiritual safety”

“Woman’s experience and satisfaction, as well as mental health indicators should be collected by facilities and private healthcare providers and included in local and national reporting. Yearly progress evaluations, conducted by an independent body, that includes engagement with maternity consumer advocacy organisations will assist in measuring the level of success. Making these progress evaluations publicly available will ensure accountability.”

Data

Many respondents suggested an approach to link existing and new data sets.

“There will be a need for an array of data sources to be drawn upon to make evaluation of the effectiveness of the strategies possible”

- *patient reported experience, satisfaction and outcomes*
- *outcomes based measures*
- *intervention rates*
- *quality and safety measures*
- *workforce satisfaction and retention*
- *cost effectiveness.”*
- Cooperation among the states and territories in providing both timely and comparable data on each of these elements would go a long way to making it possible to provide information in a manner that is timely enough to inform decision-making.
- An evaluative framework for measuring performance incorporating existing AIHW data, ACSQHC and National Maternity Care Indicators should be developed as part of the approach.

Mental health

- Reduction in women with mental health disorders, such as PTSD, due to childbirth experiences.
- An increase in mental health services for all women. Evidence that women are able to access timely and appropriate mental health services.
- Increased number of midwives with mental health qualifications.

- Incorporation into the Perinatal National Minimum Dataset (PNMD) of three nationally agreed data items covering routine psychosocial screening to allow evaluation of uptake of such screening across Australia and access to mental health services where appropriate.

Workforce

- Increased opportunities to work in continuity of care models for midwives.
- Skills development and maintenance.
- Benchmarks for the maternity care workforce to be set and reported against with strategies identified for progression.
- Workforce data and planning for the future.
- Increase cultural diversification of the workforce.
- There is a national increase of Aboriginal maternity health and wellbeing workforce and pathways into the workforce.
- Evidence of respectful, safe, collaborative arrangements between medical and midwifery providers for maternity services.

Continuity of care

- Increased numbers of women have access to continuity of care models across Australia.

Interventions – overall reduction based on evidence

- Adopt and work toward the WHO target of 85% of births not requiring interventions and work toward a 15% total intervention rate for birth.
- Adopt performance targets for care by a known midwife.
- Aim for a spontaneous labour rate of 85%. Reduction in Caesarean rates, instrumental deliveries, birth injuries.
- Postpartum traumatic stress will be greatly reduced.
- Reduction in birth trauma.
- The markers for measuring successful maternity care need to include outcomes based on more than just mortality, but include interventions and the emotional, physical and mental wellbeing of the mother, which need to be publicly available.
- Reduction in medical interventions on pregnancy.
- More positive reports of experiences of pregnancy, birth and post-partum care from women. Interventions, including caesarean section, episiotomy and anaesthesia, rates will decrease, rates of breastfeeding at 6 weeks, 6 months and 1 year will increase and there will be fewer neonatal deaths.
- Reduced incidences of instrumental births and caesarean sections, perineal injuries and unnecessary interventions.

Respondents indicated that measuring success should include a range of approaches in which data was collected to demonstrate:

- improvements in maternity indicators such as induction rates, caesarean section rates, 3rd and 4th degree tears and other indicators
- improved satisfaction measured by seeking the views of mothers on their experience
- a reduction in women with postnatal depression and PTSD
- improvement in breastfeeding
- improvements in available models of care.

Glossary

Caesarean section: Surgical removal of the baby from the uterus, which may be planned or due to complications in labour or birth.

Neonatal death: Death of a baby aged less than 28 days.

Obstetric trauma: Injuries experienced by women during birth. In the setting of a vaginal birth, this usually refers to tears of the skin and other tissues between the vagina and anus.

Perinatal period: The period covering pregnancy and the first year following pregnancy or birth.

Stillbirth: The birth of a baby that has died in the uterus after 20 weeks of pregnancy or reaching a weight of more than 400 g if gestational age is unknown.

Woman or women:³¹ The person giving birth. The term is inclusive of the woman's baby, partner and family. Therefore, the words woman or women include all the women, babies, newborn, infants, children, families, carers, groups and/or communities, however named.

Woman-centred care:³¹ Recognises the woman's baby or babies, partner, family, and community, and respects cultural and religious diversity as defined by the woman herself. Woman-centred care considers the woman's individual circumstances, and aims to meet the woman's physical, emotional, psychosocial, spiritual and cultural needs. This care is built on a reciprocal partnership through effective communication. It enables individual decision-making and self-determination for the woman to care for herself and her family. Woman-centred care respects the woman's ownership of her health information, rights and preferences while protecting her dignity and empowering her choices.

Abbreviations and acronyms

ACM	Australian College of Midwives	NHMRC	National Health and Medical Research Council
ACRRM	Australian College of Rural and Remote Medicine	OECD	Organisation for Economic Development and Cooperation
ACSQHC	Australian Commission on Safety and Quality in Health Care	PREM	patient-reported experience measure
AIHW	Australian Institute of Health and Welfare	PROM	patient-reported outcome measure
IHPA	Independent Hospital Pricing Authority	RACGP	Royal Australian College of General Practitioners
MaCCS	Maternity Care Classification System	RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
MRFF	Medical Research Future Fund	WHO	World Health Organization
NASOG	National Association of Specialist Obstetricians and Gynaecologists		

References

1. AIHW. *Australia's Mothers and Babies 2016 — In Brief*. Canberra: Australian Institute of Health and Welfare; 2018.
2. ACSQHC, AIHW. *The Second Australian Atlas of Healthcare Variation*. Sydney: Australian Commission on Safety and Quality in Health Care; 2017.
3. AIHW. *Perinatal Deaths in Australia, 1993–2012*. Canberra: Australian Institute of Health and Welfare; 2016.
4. White Ribbon Alliance. *Respectful maternity care charter: the universal rights of childbearing women*. Washington: White Ribbon Alliance; 2011.
5. ACSQHC. Patient-reported outcomes 2017. Available from: <https://www.safetyandquality.gov.au/our-work/indicators/patient-reported-outcome-measures/>. Accessed: 25 March 2018.
6. NHMRC. *National Guidance on Collaborative Maternity Care*. Canberra: National Health and Medical Research Council; 2010.
7. WHO. *WHO recommendations on antenatal care for a positive pregnancy experience*. Geneva: World Health Organization; 2016.
8. Haran C, van Driel M, Mitchell BL et al. Clinical guidelines for postpartum women and infants in primary care—a systematic review. *BMC Pregnancy Childbirth*. 2014; 14: 51.
9. Buist A, Bilsztra J. *The beyondblue National Postnatal Screening Program, Prevention and Early Intervention 2001–2005, Final Report. Vol 1: National Screening Program*. Melbourne: beyondblue; 2006.
10. Woolhouse H, Gartland D, Hegarty K et al. Depressive symptoms and intimate partner violence in the 12 months after childbirth: a prospective pregnancy cohort study. *BJOG*. 2012; 119(3): 315-23.
11. Giardinelli L, Innocenti A, Benni L et al. Depression and anxiety in perinatal period: prevalence and risk factors in an Italian sample. *Arch Womens Ment Health*. 2012; 15(1): 21–30.
12. Fairbrother N, Janssen P, Antony MM et al. Perinatal anxiety disorder prevalence and incidence. *J Affect Disord*. 2016; 200: 148–55.
13. Wisner KL, Sit DK, McShea MC et al. Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA Psychiatry*. 2013; 70(5): 490–8.
14. AIHW. *Maternal Deaths in Australia 2012–2014*. Canberra: Australian Institute of Health and Welfare; 2017.
15. Humphrey MD, Bonello MR, Chughtai A et al. *Maternal Deaths in Australia 2008–2012*. Canberra: Australian Institute of Health and Welfare; 2015.
16. Humphrey MD. Maternal mortality trends in Australia. *Med J Aust*. 2016; 205(8): 344–6.
17. Austin M-P, Highet N, Expert Working Group. *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*. Melbourne: Centre of Perinatal Excellence; 2017.
18. Australian Health Infrastructure Alliance. *Australian Health Facility Guidelines 2016*. Available from: <https://www.healthfacilityguidelines.com.au/full-guidelines>. Accessed: 17 September 2018.
19. Department of Health. *Pregnancy, Birth and Baby 2018*. Available from: <https://www.pregnancybirthbaby.org.au/>. Accessed: 17 September 2018.
20. Middleton P, Bubner T, Glover K et al. 'Partnerships are crucial': an evaluation of the Aboriginal Family Birthing Program in South Australia. *Aust N Z J Public Health*. 2017; 41(1): 21-6.
21. Murphy E, Best E. The Aboriginal Maternal and Infant Health Service: a decade of achievement in the health of women and babies in NSW. *N S W Public Health Bull*. 2012; 23(3-4): 68-72.
22. Barclay L, Kruske S, Bar-Zeev S et al. Improving Aboriginal maternal and infant health services in the 'Top End' of Australia; synthesis of the findings of a health services research program aimed at engaging stakeholders, developing research capacity and embedding change. *BMC Health Serv Res*. 2014; 14: 241.
23. Bertilone C, McEvoy S. Success in Closing the Gap: favourable neonatal outcomes in a metropolitan Aboriginal Maternity Group Practice Program. *The Medical journal of Australia*. 2015; 203(6): 262 e1-7.
24. Kruske S. *Characteristics of Culturally Competent Maternity Care for Aboriginal and Torres Strait Women*. Canberra: Prepared on behalf of MSIJC for AHMAC; 2012.
25. Mengesha ZB, Dune T, Perz J. Culturally and linguistically diverse women's views and experiences of accessing sexual and reproductive health care in Australia: a systematic review. *Sexual Health*. 2016; 13(4): 299-310.
26. Department of Health. *Clinical Practice Guidelines: Pregnancy Care*. Canberra: Australian Government Department of Health; 2018.
27. Whitworth M, Dowswell T. Routine pre-pregnancy health promotion for improving pregnancy outcomes. *Cochrane Database Syst Rev*. 2009; (4): CD007536.
28. Widdows K, Roberts SA, Camacho EM et al. *Evaluation of the implementation of the Saving Babies' Lives Care Bundle in early adopter NHS Trusts in England*. Manchester UK: Maternal and Fetal Health Research Centre, University of Manchester; 2018.
29. Peters P, Riitano D, Lisy K et al. *Providing Care for Families who have Experienced Stillbirth: a Comprehensive Systematic Review*. Adelaide: Prepared by the Joanna Briggs Institute for the Stillbirth Foundation Australia; 2014.
30. Centre of Research Excellence in Stillbirth. *Research program 2018*. Available from: <https://www.stillbirthcre.org.au/our-research/>. Accessed: 28 March 2018.
31. Nursing and Midwifery Board of Australia. *Midwife Standards of Practice*. Melbourne: Nursing and Midwifery Board of Australia; 2018. Contract No.: 28 August 2018.