

# Report on Review of Maternity Services Enhancement Plans

for the  
Department of Human Services  
Effectiveness Unit  
Acute Health Quality and Care Continuity Branch

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Public maternity services are undergoing steady change in response to evidence about the need for cultural shifts from traditional hospital practices to more flexible, woman-centred practices and services. To facilitate such changes, the Department of Human Services (DHS) introduced funding in 1998/9, for a Maternity Services Program (MSP) (initially known as the Maternity Services Enhancement Strategy) with implementation over a four-year period. Objectives for the MSP are to:

- Promote measurable improvements in the continuity and quality of antenatal, intrapartum and postnatal care, individualised to the needs of particular women;
- Provide women with increased birthing options and with evidence based information on the benefits and risks associated with different options;
- Encourage improvements in models of care in line with best available evidence;
- Improve outcomes through appropriate performance measures and service audits.

The Strategy demonstrates DHS commitment to the enhancement of maternity services by improving the continuity and quality of care provided to women in Victoria. In September 2000, the DHS commissioned a mid term Review to focus of the first two of these objectives. In the report that follows, the even though the Review team

have made every effort to identify programs, initiatives and outcomes, there may be additional work that has been missed.

The Review has found that there have been many gains as a result of the Maternity Services Program. These include enhanced antenatal care and information for consumers, efforts to improve access to antenatal classes, improved Pre-Admission/Booking In processes, the establishment of additional midwifery models of care, and increased focus and improved service provision for marginalised or special needs groups of women such as Koori women, Non-English Speaking Background (NESB) women and chemically dependent women. There has been rapid growth in the provision of postnatal services especially for lactation and domiciliary care and efforts to improve collaboration between community care providers such as maternal and child health nurses, GPs, social workers, dieticians and others.

Whilst changes in maternity services are in transition, there are still some obstacles which currently impede the achievement of optimal maternity care in Victoria. Continuity of care is a challenging goal for maternity services and there are pockets of resistance to changing models of care. It remains a long term structural problem of maternity services that by and large, a woman in a public hospital maternity service can be given little certainty that she will be attended in labour by someone who she knows and trusts or that her preferences for birthing will be supported by the person who delivers her baby.

There are many issues to be resolved in relation to shared care. The WUDWAW (1999) Report on Models of Antenatal Care describes at least four different types of shared care. They are: public hospital with GP; GP with midwife; public hospital with midwife in private practice; public hospital with community health centre. Another variation is 'shifted care' between a GP and obstetrician. They are all a way of sharing out the care of women between different providers for which issues of fragmented care for women are yet to be overcome. Programs in the MSP have tried to address continuity of care issues but the Review has found that difficulties remain. Shared care options are essentially variations of obstetric practice. The model of care most common in rural areas is the private GP model.

Midwife models pertinent to this Review include public hospital midwife clinics and team midwifery in public hospitals that are based on the provision of a continuum of care. These models provide antenatal and intrapartum care to a woman, from a small group of midwives, and women are seen by an obstetrician or hospital doctor three times during the pregnancy. There is a need for greater support for models of care that enable the same provider to be involved in antenatal, intrapartum and postnatal care.

Nevertheless, shared care has provided opportunities for hospital midwives to be much more involved in antenatal care and together with education and training, there has been substantial professional development of a larger number of midwives over recent years than would have been possible without the Maternity Services Program.

This Review makes a distinction between primary and secondary birthing options. Primary birthing options requires a woman to make choices about the model of care (either obstetric incorporating shared care, or midwifery models of care as discussed above) she wishes to have. In turn, that decision will dictate who will provide her antenatal care and attend her during labour. A woman's secondary birthing options are about a range of other aspects of her care and her ability to make informed choices about secondary birthing options is underpinned by the quality of the information she is given at each stage. Her secondary birthing options are interpreted in this Review as those relating to the quality and kind of antenatal care and support she will get, the nature of her birthing plan, breastfeeding preparation and education, the mode of her birthing and who she wants to assist her in birth.

Enhancements to domiciliary and post-acute care are noteworthy and are undoubtedly providing benefits to women. Continued funding for the professional development of nurses will enable further enhancement of these vitally important services for the well-being and care of mothers.

It is important to note that this Review does not attempt to comprehensively consider the provision of Koori services. A separate project is being conducted in relation to Koori birthing issues, however, this Review has noted the increased efforts of maternity services to improve their services for Koori women.

This report recommends overall strategic directions as well as specific recommendations. The strategic directions are made on the basis of secondary consultation with the Advisory Group to the Maternity Services Project whose identified priorities have influenced the conceptual directions recommended for the next phase of the MSP.

## **Strategic directions for the MSP**

### **Collaboration, choice and continuity of care**

Collaboration between providers, the continuity of care for women and choice of provider endure as central themes for maternity services in Victoria. Some of the larger hospitals have been able to provide women with increased options including midwifery models of care and there is a widespread understanding especially in metropolitan areas, of the value of increased levels of involvement of midwives in antenatal care. Indeed, service developments in antenatal care may well need to focus on both continuity of care and cost effectiveness. There is more medical practitioner support in metropolitan than rural areas, for significantly expanded levels of midwife antenatal care in clinics.

While midwifery models of care are available in some metropolitan and rural hospitals, the continuing professional development of midwives is necessary to enable further development of midwifery models of care. In some hospitals, greater involvement of midwives in antenatal care and birthing is tempered by a lack of support for new models of care. In order to increase options for women, there is at least one hospital in every rural and metropolitan region, where a comprehensive midwifery model of care could be established without delay.

There are widespread efforts to increase the access of mothers to lactation consultants, ongoing breastfeeding support and settling clinics. Models of care for these services should be evaluated to enable best practice to be documented and this information should be disseminated to all maternity services.

This Review recommends that the next phase of the MSP should focus on the collaboration necessary to support the increased provision of choice for women including options of midwifery care. Across the State, these projects should be linked in order that they may collaborate and inform one another as they develop. Evaluation of MSP projects should focus on innovation and best practice in relation to continuity of care for women, cost-effectiveness, clinical outcomes and client satisfaction.

This Review also recommends mechanisms for improved collaboration over MSP projects, at sub-regional, regional and Statewide levels. Midwives were enthusiastic at the opportunities provided by the workshops, for the sharing of knowledge and dissemination of information about MSP projects. The workshops revealed the needs

of midwives to share experiences of MSP projects, materials and instruments and to learn from each other.

## **Consumer participation**

Much more needs to be done to advance and enhance consumer participation in maternity services developments. Further, there needs to be a Statewide approach to improving women's access to midwifery models of care. In small and large maternity services, there are some efforts to engage consumers in the design and delivery of services and in the design of physical facilities. However, the Review found that overall, consumer involvement in local maternity services is either absent or tokenistic, yet consumer involvement is known to be a strong enabler of change.

This Review recommends that the next phase of the MSP should provide guidelines to maternity services for increased consumer involvement in the planning and development of maternity services, especially at the project level and seek improved accountability from maternity services for consumer participation.

## **Effectiveness measures**

The Review brought to light the need for a greater emphasis on articulating and developing effectiveness measures for programs and services being developed with MSP funding. These should focus in particular on continuity of care in the various models of shared care. The Review notes the shared care project currently being conducted at the Mercy Hospital. In addition, there are priority areas of Postnatal Depression, domiciliary care and consumer participation where a centralised approach to best practice guidelines is likely to enhance practice and thus, the health of new mothers.

This Review recommends that the MSP take a statewide approach to the development of guidelines for best practice in postnatal depression, domiciliary care and consumer participation and that those guidelines be disseminated to all maternity services.

## **Provision of resources**

There is a compelling need to more efficiently develop and deliver resources such as information for NESB women and their families, PND guidelines and antenatal and postnatal assessment tools. Rural maternity services in particular need additional support to ensure they have information resources of comparable quality to metropolitan regions. In relation to postnatal care, isolation of mothers from services and distance, suggest that funding formulas for rural providers should be weighted to account for geographic isolation of their clients.

The Review recommends the pooling of information to enable more efficient development and delivery of information for women, especially in relation to NESB resources.

## **Specific recommendations by theme**

### **Continuity**

(1) This Review recommends that a statewide approach to the documentation of best practice in the continuity of care be taken by the MSP from the perspectives of obstetrics and midwifery, and best practice guidelines should be disseminated to all birthing services in Victoria.

The MSP should support and encourage hospitals to document best practice models for pre-admission clinics and early midwife involvement in women's care.

### **Collaboration**

Improved linkages between maternity services, general practitioners and Maternal and Child Health Services are critical to the quality of postnatal care. MSP projects should include local Maternal and Child Health Nurse representation where appropriate on working parties and reference groups in both rural and metropolitan areas. This would add value to the quality of postnatal services for women by the closer working relationships that would develop from such initiatives.

### **Choice and consumer participation**

The term 'birthing options' should be given greater clarity in MSP literature, by distinguishing between primary (choice of overall model of care) and secondary (care planning, birthing issues, breastfeeding preparation, length of stay, discharge planning etc) birthing options.

Best practice in consumer participation in the development of maternity services should be documented and disseminated widely among maternity services, with a requirement that maternity services increase the level of consumer participation in their MSP.

### **Nursing policy issues**

Issues of visiting rights for midwives should be addressed as a matter of priority to ensure that women who choose midwifery care, but require admission to hospital, have their continuity of care acknowledged as important for their outcomes.

In order to maintain the momentum of change in maternity services, the funding provided for education and training needs to be transparent to maternity units, and if necessary, some additional funds be available to subsidise fees associated with education and training including travel for rural midwives and for the backfilling of staff. Any opportunities should be taken to link MSP funded education and training to State and Federal Midwife upskilling programs.

### **Quality improvement**

Rural regions should appoint dedicated MSP coordinating project officers with specialist knowledge who may have sub-regional as well as local responsibilities and who have responsibility for disseminating best practice and evidence based practice.

This Review recommends that the decision be made by MSP, if Baby Friendly Hospital status is a gold standard for maternity services and if so, this be made clear within the industry and that first, incentives be provided through MSP for services to achieve MSP status and second, that a survey of all Victorian maternity services be undertaken to assess progress towards Baby Friendly Hospital status and that this information be provided on the internet for consumers.

The implementation of the next stage MSP should be on the basis of comprehensive strategic plans which include improved transparency and accountability at the local level, and with dedicated Project Officer hours to implement, Review and monitor the implementation and expenditure of MSP funding to ensure funds are used appropriately and effectively for maternity services developments, and not redirected to other areas of hospital expenditure.

### **Services for women with special needs**

MSP funding should be used to develop and share ways of providing outreach support for antenatal care services for women with special needs and commissions a Review of a cluster of case studies in order to develop models of best practice for outreach programs.

### **Post-natal care**

All women should have access to a qualified lactation midwife.

Both a statewide and regional approaches should be taken to the dissemination of post natal depression guidelines. All regions and networks should ensure that all their maternity service providers make use of approved guidelines.

Best practice in domiciliary care needs to be documented including breastfeeding guidelines, together with guidelines for assessment that encompass risk assessment, for the information of all services.

This Review recommends that a statewide approach to quality assurance in discharge planning and the provision of postnatal care be addressed to address areas of less than optimal provision of appropriate services.

### **Consumer Information**

A statewide approach to the provision of at least core information for consumers should be investigated. A small group of project officers representing rural regions and metropolitan Health Service Networks could form a small working party for this purpose with the requirement that they consult, including with consumer networks.

The MSP ensure the coordination and dissemination of breastfeeding information across the state and ensure it is available to all hospitals and health service providers of maternity services.

The establishment of a short-term statewide working party is recommended to assess the overall provision of NESB resources and to facilitate sharing of resources.

### **Funding**

This Review recommends that further studies of shared care arrangements be supported with a particular focus on cost benefit analysis in conjunction with consumer satisfaction and that funding mechanisms to support the midwifery components of shared care be more transparent and in the interests of public hospitals.

Formulas for brokerage funding and the standardising of contract rates for domiciliary care visits need to be established with attention to weightings for rural areas to ensure that small rural health services are not disadvantaged in their efforts to provide outreach domiciliary care services.