ACT Government
Health

Ref FOI18-60

[redacted]

Dear [redacted]

Freedom on Information Request: FOI18-60

I refer to your application under section 30 of the *Freedom of Information Act 2016* (the Act), received by the ACT Health on 10 July 2018, in which you sought access to:

> *"...Chiarella, M., Homer, C., Dahlen, H., Hickey, P. (2007). Report of the Review into the Canberra Midwifery Program for ACT Health. Project No: C06 50 003."*

I am an Information Officer appointed by the Director-General under section 18 of the Act to deal with access applications made under Part 5 of the Act. ACT Health was required to provide a decision on your access application by 7 August 2018.

Decision on access

I have decided to grant access to the document requested, as detailed in the attached Schedule.

Charges

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Under section 28 of the Act, ACT Health maintains an online record of access applications called a disclosure log. Your original access application, my decision and documents released to you in response to your access application will be published in the ACT Health disclosure log not less than three days but not more than 10 days after the date of decision. Your personal contact details will not be published.

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Ombudsman review

My decision on your access request is a reviewable decision as identified in Schedule 3 of the Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

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GPO Box 442
CANBERRA ACT 2601

Via email: ombudsman@ombudsman.gov.au

ACT Civil and Administrative Tribunal (ACAT) review

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Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Level 4, 1 Moore St
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

If you have any queries concerning the Directorate's processing of your request, or would like further information, please contact the Freedom of Information Coordinator on 6205 1340.

Yours sincerely

Elizabeth Chatham
Executive Director
Division of Women Youth and Children

06 August 2018

FREEDOM OF INFORMATION REQUEST SCHEDULE

Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access.

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NAME	WHAT ARE THE PARAMETERS OF THE REQUEST	File No
[redacted]	Chiarella, M., Homer, C., Dahlen, H., Hickey, P. (2007). Report of the Review into the Canberra Midwifery Program for ACT Health. Project No: C06 50 003	FOI18/60

Ref No	No of Folios	Description	Date	Status	Reason for non-release or deferral	Open Access release status
1	1	Letter from Mr Mark Owens, Chief Executive ACT Health to Ms Vanessa Owen	22 March 2007	Full Release		Yes
2	2-120	Report of the Review into the Canberra Midwifery Program for ACT Health	February 2007	Full Release		Yes
Total No of Docs						
2						

ACT Health

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File No: XXXXXXXX

Ms Vanessa Owen
Director of Nursing and Midwifery
The Canberra Hospital
PO Box 11
WODEN ACT 2606

Vanessa.

Dear Ms Owen

Please find enclosed a copy of the Canberra Midwifery Program (CMP) Review Report (The Report).

As you are aware, ACT commissioned the review in June 2006. The Report was received in November 2006 and returned to the reviewers for some final amendments.

Some sections of The Report are blank. The blank sections do not relate to the skills and performance of the CMP, they refer to other agencies and issues of insurance that need to be considered further by Government.

Please circulate The Report to the CMP staff, who are to be congratulated on the high level of safe and quality care provided by the program.

Yours sincerely

Mark Cormack
Chief Executive

22 March 2007

CC: Mr Ian Thompson, Acting Deputy Chief Executive
Mr Bill Stone, Acting General Manager The Canberra Hospital
Ms Joy Vickerstaff, Executive Director of Nursing and Midwifery

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Report of the Review into the Canberra Midwifery Program

for ACT Health

February 2007

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1. EXECUTIVE SUMMARY

ACT Health commissioned a Review of the Canberra Midwifery Program (CMP) in June 2006. A four-person Review Team undertook the work from August to September 2006. Data collected for the review included a review of policies, clinical outcomes and clinical records of women who gave birth at home. Interviews with key stakeholders were conducted.

The CMP is based in the Birth Centre at The Canberra Hospital. CMP midwives provide continuity of midwifery care during pregnancy, labour, birth and up to two weeks afterwards for families who book onto the program. CMP midwives provide continuity of both care and carer by accompanying women wherever they birth, whether the Birth Centre, delivery suite or operating rooms. Medical support is provided by The Canberra Hospital obstetric and neonatal registrars and consultants as necessary.

Overall, the CMP clinical outcomes demonstrate a high level of safe and quality care and were comparable with other outcomes given the type of model and caseload. The most impressive indicators in this comparison are the CMP's low level of induction of labour and caesarean section. The TCH outcomes were in line with data provided from the Australian Council for Healthcare Standards.

There is a lack of clarity about the mission of the CMP model and whether it is a model for women from vulnerable groups or a model that provides midwifery continuity of care and promotes normal birth. A process to develop a mission statement or strategic direction may be one approach that could be taken to identify the philosophy of the model and as a recruitment and retention strategy.

The CMP demonstrated strong internal systems for professional support and development. It was very clear that the relationships between the midwives in CMP were effective and respectful. Some of the other professional issues identified included the need for succession planning and strategies to encourage recruitment of midwives to the CMP.

While relationships within the CMP were strong, it was evident that there was, at times, a need for improvement in the relationships between the CMP midwives and the wider maternity unit, in particular some midwives and doctors in the delivery suite.

Trust was a significant theme identified throughout the review. On the whole, those external to the CMP trusted the midwives and believed they offered a good service. It was also apparent the CMP midwives trusted each other and the women they provide a service for. The reviewers noted that the CMP midwives believed that they were not trusted or supported on the whole by others in and outside of the organisation. Communication and cultural development within the organisation as a whole needs to focus on building morale and trust and improving the level of positive feedback.

The review of the clinical records of the women on the CMP who had given birth at home demonstrated that, for the most part, the births were unplanned and the policy of the time had been followed. The policy introduced in November 2005 has been followed quite assiduously and it is obvious from the notes that **for all of the 2005/06 births reviewed under the new policy by the Review Team, there was no collusion on the part of the CMP midwives.** The current policy was causing considerable distress to the midwives and the women. The lack of availability of re-insurance was found to be the block to introducing a homebirth service in the ACT.

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2. RECOMMENDATIONS

Finding 1: There is a lack of clarity about the philosophical basis of the CMP and therefore the purpose of the work of the CMP.

Recommendation 1: The Review Team recommends that a clear mission or vision statement should be developed to ensure clarity about the service provided by the CMP and the philosophical basis for the program / of the service.

Finding 2: There is significant demand for the CMP and a strong view that the midwifery continuity of carer model would be of great benefit to disadvantaged women.

Recommendation 2: The Review Team recommends that consideration needs to be given to a process for ensuring that women from vulnerable or disadvantaged groups can access the midwifery continuity of care provided by the CMP.

Finding and Recommendation 3: The Review Team recommends that the annualised salary and flexible working conditions for CMP midwives work well and should continue.

Finding 4: The Review Team found that the postpartum haemorrhage (PPH) rate for the CMP was comparable overall with similar hospitals and models of care. The policy for the management of third stage of labour requires some clarification, although currently this does not appear to be putting women at risk of PPH. If home visits to assess early labour are part of the CMP service, then this policy must include the management of unplanned BBA third stage.

Recommendation 4: The Review Team recommends that the practice for managing third stage of labour should be examined then policy and education reviewed accordingly. While midwives continue to undertake home visits to assess early labour, the midwives and possibly also the ambulance officers, need to carry the necessary equipment to manage not only a birth but also the third stage of labour in order to manage the risk of post-partum haemorrhage. This in no way alters the current policy. It simply ensures that both the ambulance officers and the CMP midwives are properly prepared for an emergency.

Finding 5: The ACHS indicators are very specific and the CMP data are not collected or presented in a manner that permits easy comparison.

Recommendation 5: The Review Team recommends that efforts should be made to ensure that the CMP data collected are in line with ACHS Indicators to enable future comparisons and benchmarking.

Finding 6: Overall, the CMP outcomes are comparable with the other outcomes given the type of model and caseload. However, the TCH reporting of third-degree perineal tear rate is slightly higher. The Canberra Hospital's Maternity Unit has a strong

emphasis on correct identification of third-degree tears, with a policy for their immediate repair, postnatal care, and longer-term follow up. This emphasis may mean that midwives and doctors are more careful when examining a women's perineum and more skilled at identifying and reporting a third-degree tear. The establishment of the Perineal Tear Clinic at TCH may also encourage doctors and midwives to report a third-degree tear as they can now refer to a specialised service.

Recommendation 6: The Review Team recommends that the rate of third-degree perineal tears requires ongoing review as part of the usual review of practice.

Finding 7: The Review Team noted that for a midwifery model of care, the number of midwives who were competent or felt competent to undertake perineal repair was low compared to other similar models. This frequently led to women being taken to the delivery suite for perineal repair by obstetric registrars.

Recommendation 7: The Review Team recommends that the CMP midwives should be supported in gaining confidence in perineal repair and a program developed to encourage this to happen. A program that also included delivery suite midwives and medical staff would be ideal, as it would create a forum for them to interact and learn together.

Finding 8: The relationships within the CMP are indicative of a warm, collegial and professional culture. The CMP manager and team are to be commended for their professional collegial relationships.

Recommendation 8: The Review Team recommends that greater recognition and support of the CMP should be a goal for ACT Health and TCH.

Finding 9: The relationships between the CMP and Delivery Suite needs to be enhanced to ensure optimal patient centred care, achieve recruitment to both units and foster the potential to work in either unit.

Recommendation 9: The Review Team recommends that there is a need for all professional groups involved in maternity services to work in an integrated fashion in the interests of quality maternity care across the spectrum. Shared education and social events involving all midwifery and medical staff may be a strategy to overcome this current divide.

Finding 10: Most support and counselling (although well provided and ongoing) of the CMP staff occurred through relatively informal processes.

Recommendation 10: The Review Team recommends that support and counselling should fit within an appropriate performance management framework. A process of formal clinical supervision needs to be adopted for all midwives within the CMP.

Finding 11: Because of both the success and political nature of the CMP, the service experienced periods of relative independence and other periods of intense scrutiny and management. This was both confusing and difficult for local management.

Recommendation 11: The Review Team recommends that clear communication lines and management responsibilities across ACT Health need to be agreed and adhered to in relation to the CMP.

Finding 12: Concerns were expressed to the reviewers that boundary violation may be occurring between CMP midwives and their clients. However, even though there is no evidence of professional boundaries being breached, the CMP midwives recognised and conceded the risk due to the model of care and potential for recurrent involvement with the women over subsequent pregnancies.

Recommendation 12: The Review Team recommends that both TCH and CMP management need to be vigilant regarding the blurring of boundaries that can occur in models like the CMP. Strategies for clinical supervision and performance review should assist to manage this potential.

Finding 13: Great concern was expressed throughout the organisation over the impending retirement of the CMP manager.

Recommendation 13: The Review Team noted the concerns of staff regarding the impending retirement of the CMP Manager. While this may be a stressful time for the CMP, it is also an opportunity for the CMP to evolve even further as a mature functioning team. To ensure a safe and efficient handover, it is essential that all policy and processes are documented and current. This needs to be incorporated into the succession planning.

Finding 14: A recruitment innovation is the introduction of new graduates to the CMP. This may provide a stream of new staff to work in the CMP.

Recommendation 14: The Review Team recommends that careful monitoring and evaluation of the new graduate placement in the CMP will assist with future educational placements, which may in turn improve recruitment to the service.

Finding 15: Not all of the cases relating to birth at home that the Review Team were asked to examine were complete. Furthermore, the documentation was cumbersome and difficult to follow.

Recommendation 15: The Review Team recommends that that care be taken to ensure a complete and clear clinical record is written for each woman and stored appropriately using electronic means.

Finding 16: The review of letters of commendation and complaint demonstrated overwhelming demand and support for the continuity of carer model. A high level of

trust was present overall between CMP midwives and the women and families they cared for. The few complaint letters received were dealt with promptly and thoroughly.

Recommendation 16: Midwifery continuity of care should continue to be a central tenet of the CMP with a capacity for flexible working processes.

Finding 17: The policy introduced in November 2005 has been followed quite assiduously and it is obvious from the notes that for all of the 2005/06 births at home reviewed under the new policy by the Review Team, there was no collusion on the part of the CMP midwives.

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3. MAPPING OF THE TERMS OF REFERENCE TO THE REPORT

Major Terms of Reference	Sub headings	Location in document
The clinical records of homebirth cases for the period 1 January 2004 to present, expressing an opinion on whether the homebirths were unplanned and handled according to the policy in place at that time.		9.8 Appendix F
The incidence of unplanned homebirths and whether the ACT numbers are significantly different to other Community Midwife Programs that do not offer homebirth. The benchmark programs to be determined by ACT Health and the Review Team.		6.6 9.5
The concerns of the ACT Ambulance Service regarding recent incidents of births at home.		9.1.1 9.7 9.10
The policies and guidelines for consultation and management of unplanned homebirths within the CMP.		6.6 9.1
The current system of assuring quality outcomes in Canberra Midwifery Program, including:	The professional relationships within the CMP.	7.1
	A descriptive compilation of client satisfaction and complaint issues, current information and data sources.	6.5 9.1.3

Major Terms of Reference	Sub headings	Location in document
	The framework for demonstration of professional competence and practice against current ACT legislation, Australian Nursing and Midwifery Council Competency Standards for Midwives and proposed work conducted through the Australian College of Midwives Incorporated.	Section 7
	The clinical outcomes of clients who use the CMP to be benchmarked against agreed data sets as determined by ACT Health and the Review Team.	6.6 9.5
The best practice policies and procedures for controlling the financial risks associated with unplanned homebirths.		Section 10 Recommendations 1–19
Recommendations to ACT Health based on your findings.		Recommendations 1–19

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4. ABBREVIATIONS

ACT	Australian Capital Territory
ACM	Australian College of Midwives
ACHS	Australian Council for Healthcare Standards
ACTIA	Australian Capital Territory Insurance Agency
CMP	Community Midwifery Program
BBA	Born before arrival
CMPP	Community Midwifery Pilot Project
CS	Caesarean section
DRG	Diagnosis Related Group
FDIU	Fetal death in utero
FTE	Full-time equivalent
GP	General Practitioner
IPM	Independent Practising Midwife
MACH	Maternal and Child Health Care Nurses
MGP	Midwifery Group Practice (South Australia)
NND	Neonatal death
PPH	Postpartum haemorrhage
SROM	Spontaneous rupture of membranes
TCH	The Canberra Hospital
VBAC	Vaginal Birth After Caesarean Section
WHA	Women's Hospitals Australasia

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5. INTRODUCTION

ACT Health commissioned this review of the Canberra Midwifery Program (CMP) in June 2006. The membership of the Review Team is set out in Appendix A. The Terms of Reference stipulate that the Review is to make particular reference to:

- The clinical records of homebirth cases for the period 1 January 2004 to present, expressing an opinion on whether the homebirths were unplanned and handled according to the policy in place at that time.
- The incidence of unplanned homebirths and whether the ACT numbers are significantly different to other Community Midwife Programs that do not offer homebirth. The benchmark programs to be determined by ACT Health and the Review Team.
- The concerns of the ACT Ambulance Service regarding recent incidents of births at home.
- The policies and guidelines for consultation and management of unplanned homebirths within the CMP.
- The current system of assuring quality outcomes in Canberra Midwifery Program, including:
    - The professional relationships within the CMP
    - A descriptive compilation of client satisfaction and complaint issues, current information and data sources
    - The framework for demonstration of professional competence and practice against current ACT legislation, Australian Nursing and Midwifery Council Competency Standards for Midwives and proposed work conducted through the Australian College of Midwives Incorporated
    - The clinical outcomes of clients who use the CMP to be benchmarked against agreed data sets as determined by ACT Health and the Review Team
- The best practice policies and procedures for controlling the financial risks associated with unplanned homebirths.
- Recommendations to ACT Health based on your findings.

It was agreed between the Canberra Midwifery Program Review Governance Committee and the Chair of the Review, Professor Mary Chiarella, that this was to be a review, not an investigation, and that the report would exclude mention of the clinical performance of specific individuals. It was further agreed that, should any individual clinical performance

concerns arise, the Chair would relay these to the Acting Chief Executive for action distinct from the processes of the review. However, no clinical performance concerns arose during the process.

The review comprises three elements:

- scrutiny of policy and procedures relevant to the CMP
- analysis and evaluation of unplanned homebirth cases from 2004 to the present day and mapping those cases against current policies, and
- interviews with key stakeholders.

The interview schedule is attached as Appendix B.

6. THE CANBERRA MIDWIFERY PROGRAM

6.1 History of Canberra Midwifery Program

The CMP is based in the Birth Centre at The Canberra Hospital. CMP midwives provide care during pregnancy, labour, birth and up to two weeks afterwards for families who book onto the program. CMP midwives provide continuity of both care and carer by accompanying women wherever they birth, whether the Birth Centre, delivery suite or operating rooms. Medical support is provided by The Canberra Hospital obstetric and neonatal registrars and consultants as necessary.

CMP midwives look after the women from initial booking with the CMP program and provide all care for the woman and partner before, during and after the birth of their child. Continuity of care is provided through either a caseload or team midwifery model, both of which will be described in more detail later in this Report. After the birth, women and their partners may stay in the Birth Centre for up to 24 hours. Some mothers also may choose to stay on the postnatal ward for a few days. On their return home, postnatal support is provided by the CMP midwife for between 7 and 14 days, with visits arranged according to individual needs. During the home visits the CMP midwives provide advice and assistance concerning the establishment of breastfeeding and parenting. On discharge from the CMP, women and their families are referred to the Maternal and Child Health Nurses (MACH) for ongoing postnatal support.

The CMP, or the Community Midwifery Pilot Project (CMPP) as it was then known, was initially established in 1995 as part of the Alternative Birthing Services Program (ABSP)[1]. The initial philosophy was around continuity of midwifery care, a community-based service and choice of place of birth (home or hospital). It evolved out of the alternative birthing service pilot program, which was a response to women's requests for more control, continuity and choice in birthing[2]. Since its introduction the service has had a range of identity changes. In 1996, it became the Community Midwife Program, which continued until March 1999, when it merged with the Birth Centre (TCH) and became the Canberra Midwifery Program. The caseload model of care commenced in November 2002. A media release on 25 June 2002 announced that an additional $100,000 was to be provided to the CMP to employ independent midwives, presumably after the withdrawal of available indemnity insurance, and to offer homebirth services. Jon Stanhope, Chief Minister for the ACT, was quoted as saying:

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[1] Hambly, M (1997). *Community Midwives Pilot Project Evaluation, Alternative Birthing Services in the ACT*. Canberra, ACT Department of Health and Community Care

[2] Website information Canberra Midwifery Program <http://www.health.act.gov.au/c/health?a=da&did=10085627>

> We are meeting that commitment by expanding the Canberra Midwifery Program to include homebirth as one of the options in the midwifery led care program. Under this arrangement, The Canberra Hospital will employ the midwives—a model which represents an exciting addition to an excellent program and which will allow women to give birth safely in the comfort of their own home. We are also increasing the resources available to the Canberra Midwifery Program to cater for the growth in demand for midwifery led care. Many women prefer midwifery led care and choose to have their baby in the home-like environment offered at the birthing centre. This Budget provides the additional funding to support women in exercising that choice.

However, the Chief Minister advised that the inclusion of homebirth in the Canberra Midwifery Program was subject to the Government's ability to secure insurance, but added that 'We are confident of our ability to obtain insurance and aim to have the service operating by the end of the year'.[3]

Insurance was clearly not forthcoming, as can be traced through a series of policy changes over the ensuing six years, creating increasing strictures around the possibility of birth at home. This question of insurance for homebirth will be discussed in further detail in *Section 5: Homebirth.*

6.2 Demand for CMP

In 2003, the ACT Legislative Assembly Standing Committee on Health held an inquiry into maternity services in the ACT and delivered its report *A Pregnant Pause: The future for maternity services in the ACT*[4]. One of the key recommendations arising from this inquiry was that the government undertake a needs analysis of the CMP. The government acted on this recommendation. The needs analysis was undertaken by KPMG and published in August 2006. The KPMG report demonstrates that the demand for the CMP service is significant and growing:

> Demand for the CMP has increased since 1999 and women now have to book in for the service within four to five weeks of becoming pregnant to access the program. As a result, there is a substantial waiting list for the service. Many women on the waiting list are never able to access the service.[5]

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[3] ACT Government (2002) Media release *2002–2003 Budget Canberra Midwifery Project to Grow* 25 June 2002

[4] ACT Government Standing Committee on Health (2004) *8th report: A pregnant pause: the future of maternity services in the ACT.* 5 May 2004 ACT Government: Canberra

[5] KPMG (2006) *Canberra Midwifery Program Demand Analysis.* ACT Health: Canberra, p.6

The report demonstrates that the number of women on the waiting list unable to be accommodated by the CMP has grown from 64 in 2002 to 263 in 2005, a 310 percent increase over four years. This increase in demand is without any active marketing by the CMP.[6]

The KPMG Report undertook a benchmarking exercise to compare CMP structures and processes with waiting lists in other midwifery-run services; a survey of women in the early postnatal period to measure unmet demand; and an exercise to project births to women living in the ACT. Based on the survey and projections, the KPMG report made predictions on future demand, albeit with a number of caveats. The report concluded that:

> Despite these cautions, there is definite evidence that demand for the CMP in the future will be much higher than the service's current capacity. At present, only 23.7 per cent of survey respondents were able to access the program. 15.1 per cent of respondents wanted to use the CMP but were unable to access it. In addition, 19.1 per cent of respondents did not know about the CMP, but would like to have used the service had they been aware of it. The growth in the number of women on the CMP waiting list over the past three years corroborates the fact that the service is not meeting demand.[7]

The ACT Government has determined to look at 'how we can increase capacity within the CMP, whilst ensuring that we continue to provide a diversity of services for all the range of needs that exist'.[8]

6.3 CMP VISION STATEMENT

The TCH Maternity Practice Guideline 8.1. *The Canberra Midwifery Program Model of Care*[9] begins by stating:

> The Canberra Midwifery Program (CMP) aims to create an environment that fosters the normal process of childbirth, is responsive to the needs of women and their babies and promotes healthy birthing experiences.

The document outlines the responsibilities of the CMP staff and the women they will care for, and has an extensive list of exclusion criteria, which is set out under *6.4.1 Exclusions from the CMP*. There is a further extensive list of situations/conditions that will mean that women have their labour and birth care in the delivery suite with a CMP midwife working in consultation with the staff specialist and /or obstetric registrar and delivery suite team leader.

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[6] Ibid at p.7
[7] KPMG (2006) *Canberra Midwifery Program Demand Analysis.* ACT Health: Canberra, p.36
[8] ACT Government (2006) *Media release: Demand for Community Midwife Program Increases.* 18 August 2006
[9] The TCH Maternity Practice Guideline 8.1. *The Canberra Midwifery Program Model of Care* Revised January 2006

There is no vision or mission statement *per se,* and this may account for some of the lack of clarity over whether the service is designed to provide normal birth (as is stated in the aim above), or continuity of carer (as is stated in the list of situations or conditions where joint care may be coordinated). This lack of clarity is discussed further in *Section 7.2.2* on professional collegiality and in *Section 8: Philosophical issues.*

Recommendation 1: A mission or vision statement should be developed to ensure clarity about the service provided by the CMP and the philosophical basis.

6.4 DESCRIPTION OF THE CMP MODEL OF CARE

The Canberra Midwifery Program (CMP) evolved out of the Alternative Birthing Service Program (ABSP) in 1995. The evaluation of the pilot program concluded that the CMP appeared to be a viable method of woman-centred maternity service delivery and that it provided high-quality outcomes and value for money[10]. The Standing Committee on Health[11] recommended in their report, *A Pregnant Pause,* that the ACT Government increase funding to the CMP to meet existing demand.

The CMP is based in the Birth Centre at The Canberra Hospital (TCH). This is located on the ground floor near the maternity entrance of TCH so women can easily access it. The CMP offers women the opportunity to receive care with a known midwife throughout their pregnancy, birth and for up to two weeks postnatally. CMP is the only model of care at TCH, which provides this level of continuity. The midwives who work in the CMP believe that women should have continuity of care with a known midwife throughout all phases of the childbearing experience. The CMP midwives aim to promote and foster the physiological (i.e. natural) process of childbirth through a midwife/woman relationship that is responsive to the needs of women and their babies.

The CMP is funded to provide 13.0 full-time equivalent (FTE) midwives plus 1.0 FTE manager. The manager also takes on a caseload of women. Vacancies mean that the service currently runs at around 11.0 FTE. Three teams of midwives provide continuity of carer with a primary midwife, a model known as 'caseload midwifery' (North, Central and South CMP teams). One team of midwives provide care collectively to a group of women, a model known as 'team midwifery' (Tuggeranong CMP team). The teams are based on geographic location. The North, Central and South team operate under a caseload midwifery model and the Tuggeranong team operates under a team model. The difference in service model types between the teams is due to midwife choice of employment type. The program accepts women

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[10] Hambly, M (1997). *Community Midwives Pilot Project Evaluation, Alternative Birthing Services in the ACT.* Canberra, ACT Department of Health and Community Care

[11] ACT Standing Committee on Health (2004). *A pregnant pause: the future for maternity services in the ACT.* Canberra

who reside outside the ACT, mostly from Queanbeyan and Jerrabomberra, but also from as far away as Yass and Goulbourn (24–36 per year).[12]

The first visit with the midwives takes place at around 16 weeks. If the CMP is full, women are placed on a waiting list and told about the other options for antenatal care. Demand for the CMP has grown since 1999 and women now have to book in for the service within four or five weeks of becoming pregnant in order to access the program. The Review Team was told that: 'Monday morning the phone rings hot. They ring us to tell us to get in [to CMP] before they ring their husband'. The CMP midwives commented that 'people burst into tears when we ring and tell them there is a place [on the program]'. The waiting list has grown, with many women on it unable to access the service during their pregnancy. Even the local government member was unable to gain a position on the program. There were 263 women on the waiting list and unable to be accommodated by the program in 2005.[13]

Pregnancy care (antenatal visits) is conducted in the Birth Centre and at venues closer to the woman's own home, with some home visits also offered. For women having their first baby antenatal visits are at: 16 (1st visit), 20, 26, 30, 33, 36, 38, 40 and 41+ weeks. For women having a subsequent pregnancy, antenatal visits are at: 16 (1st visit), 20, 26, 30, 34, 38, 40 and 41+ weeks. Visits of half an hour are scheduled. Women are encouraged to have a 36-week visit with their GP. They also see their GP after the birth to have the baby's heart checked and for a six-week postnatal check. The woman's GP is asked to conduct a physical examination early in the pregnancy, order routine blood screens and ultrasounds. Twenty-four-hour telephone access to the CMP midwives is provided.

The CMP midwives described how they advise women that they should only call between certain hours and they give them a list of indicators for when to call and when not to call. All the CMP midwives said it was important to set boundaries in order for them to survive. Women are told that the midwives have every third weekend off and they might not be there for the birth. The midwives told the Review Team that women appreciated the CMP midwives setting boundaries. This is discussed in more detail under *7.2.3 Boundary issues*.***

6.4.1 Exclusions from the CMP

Women are excluded from the program for the following reasons:

- Existing medical conditions, including:
  - cardiac conditions with haemodynamic consequences;
  - chronic hypertension with or without medication;

[12] KPMG (2006) *ACT Health: Canberra Midwifery Program Demand Analysis.* ACT Health: Canberra, p.6
[13] Ibid

- severe asthma or other lung function disorder;
- haematological disorders specifically any thrombo-embolic process, coagulation disorders and haemoglobinopathies;
- pre-existing insulin or non-insulin requiring diabetes mellitus;
- thyroid disease—hyperthyroidism, Addison's Disease, Cushing's Disease;
- renal disorder, with or without dialysis;
- active infectious diseases –HIV, rubella, varicella, toxoplasmosis, parvovirus, cytomegalic virus, TB, syphilis;
- malignant hyperthermia or neuromuscular disease;
- neurological conditions—epilepsy with medication, subarachnoid haemorrhage, aneurysms, multiple sclerosis, AV malformations, myasthenia gravis, spinal cord lesion, muscular dystrophy or myotonic dystrophy;
- psychoses; and
- system/connective tissue disorders—systemic lupus erythematosus, anti-phospholipid syndrome, scleroderma, periarteritis nodosa, Marfan's syndrome, Raynaud's disease and other systemic and rare disorders. Women with rheumatoid arthritis require consultation.

- Pre existing gynaecological conditions, including:
  - surgery following prolapse, fistula and for incontinence;
  - cervical abnormalities—cervical amputation, cervical cone biopsy; and
  - myomectomy where uterine cavity breached, hysterotomy.
- Previous obstetric history, including:
  - uterine rupture or classical c/s;
  - eclampsia;
  - postpartum haemorrhage as a result of a cervical tear;
  - cervical incompetence (and/or Shirodkar procedure); and
  - active blood group incompatibility (Rh, Kell, Duffy, Kidd);
  - placenta accrete;
  - 3rd or 4th degree perineal laceration with no/poor function recovery; and
  - postpartum psychosis.

- Conditions that mean women transfer from the CMP include:
  - multiple pregnancy;
  - complete placenta praevia at 18 week scan; and
  - preterm labour and birth before 35 weeks.[14]

6.4.2 Medical involvement

An obstetrician sees women only if there is a problem. All women have a basic physical examination performed by their GPs. Antenatal blood tests and ultrasounds are also performed outside the hospital. This means that women have to pay (e.g. $180) for an ultrasound.

Women with more complex pregnancies have shared care between their CMP midwife, GP, registrars, specialist obstetricians and neonatologists as needed. Referrals to support services (e.g. physiotherapists, social workers, dieticians) are made as required. They include women who have had a previous caesarean, although these women have to give birth in the delivery suite. The success rates for vaginal birth after caesarean (VBAC) in women accessing the CMP program are excellent (70–80%)[15]. CMP midwives advised that the program especially aimed to include women from specific groups with high needs. Unfortunately, because the program is now so popular, the more socially advantaged women who know to book into the program as soon as they are pregnant are obtaining places to the disadvantage of other high-needs groups. This limitation was raised during interviews by many different health professionals, including the CMP midwives. It needs to be addressed. Midwives follow the Australian College of Midwives Consultation and Referral Guidelines[16] and TCH policies.

CMP midwives care for women wherever they give birth, be that in the Birth Centre, delivery suite or operating theatre, or at Calvary Hospital. The option to give birth at Calvary Hospital is being revisited as the midwives find it difficult to be available at two different sites. Women who labour in the Birth Centre can do so in a homelike environment with easy access to baths, showers, hot packs, birthing balls, mats and birth stools. Water birth is also an option in the Birth Centre.

Women can stay in the Birth Centre for 24 hours after the birth. They can be left alone in the Birth Centre with their partner overnight, able to contact postnatal staff should they need it. They can be transferred to the postnatal ward if necessary. They are visited by the CMP for 7–

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[14] The TCH Maternity Practice Guideline 8.1. *The Canberra Midwifery Program Model of Care* Revised January 2006

[15] Canberra Midwifery Program(2005) *CMP Comprehensive statistics 2002 & 2005*

[16] Australian College of Midwives (2004). *National Midwifery Guidelines for Consultation and Referral.* ACM, Canberra. Available from <http://www.acmi.org.au/text/publications/publications.html>

14 days. The women are then discharged into the care of the Maternal and Child Health Care (MACH) nurses and their local GP for continuing care.

Recommendation 2: Consideration needs to be given to a process for ensuring that women from vulnerable or disadvantaged groups can gain access to the midwifery continuity of care provided by the CMP.

6.4.3 Education

A 40-minute information session is held every Tuesday for interested women who want to find out about the CMP, and for women on the waiting list. This is run by the CMP manager.

The same team of midwives who provide the woman's care also provide the parenting education sessions. The CMP midwives offer a variety of education programs such as four sessions for first-time parents, a refresher group for women and partners who have already experienced birth, and a sibling session for older brothers and sisters. Women and their partners can borrow books and videos from the CMP. There are also sessions in which women in their last four weeks of pregnancy and new mothers in their first eight weeks post birth can come together and discuss the first few weeks of motherhood. These sessions are called SHARE (Support, Humour, Advice, Relaxation and Encouragement). They were considered by both women and midwives to be a source of great social support.

The CMP hosts a consumer group four times a year to obtain feedback and help define strategies for improving the service. Women and partners can submit agenda items a week before hand.

6.4.4 First stage of labour visits

A relatively unique aspect of the CMP program is that it provides home visits for midwifery review in early labour. There is no doubt that in some cases it has been the request for a home visit and review that has led to an unplanned homebirth, usually due to a precipitate labour, but occasionally due to the mother's reluctance to attend hospital. The midwives pointed out that a very small number of women who are visited in labour give birth at home. In 2005 this number was 1.2 percent of the total number of women who gave birth with the CMP. The CMP midwives emphasised that these reviews occur only where appropriate and that they are not common. Only 15 percent of the women who gave birth through the CMP in 2005 received home review.

Most of the women who are visited in first stage are primiparous and it was felt that this was the group that benefited most from these visits. The CMP midwives informed the Review Team that the first stage visits were about 'reassuring women that all is okay and keeping them at home as long as possible'. This is highly desirable given the level of demand on the Birth Centre and delivery suite. Others spoke to the Review Team about the benefits of the

first-stage visits. These include freeing up labour ward or Birth Centre beds as women do not come into the hospital until they are in established labour (currently up to one third of beds/rooms in the labour ward are occupied by women who are not in established labour); and the capacity to assess women and detect serious complications that require immediate transfer (e.g. placental abruption).

Labour assessment programs that aim to delay admission to a delivery suite until active labour have been found to be effective. A randomised controlled trial of a labour assessment program has reported benefits for women with term pregnancies, including less time in the labour ward, and that they are less likely to receive intrapartum oxytocics and analgesia than women who were admitted directly to the labour ward.[17]

The early assessment of labour at home on one occasion (Patient 17) probably saved the woman's life, as she had a placental abruption that was diagnosed by the midwife and handled with great skill and urgency.

Some CMP midwives were clearly anxious about attending first-stage labour visits at home in case of an unplanned homebirth. They were not necessarily fearful of the birth, but rather of the ramifications from management and ACTIA if an unplanned homebirth were to occur. One midwife said she would only attend a first-stage home visit if she felt 'it was safe'. When questioned about this, she explained that she really meant 'that the woman was not going to have a homebirth unexpectedly'.

Whether or not home visits in first stage should be continued is discussed under a range of options in *Section 10 Best practice for managing financial risks*. However, the Review Team believes that the benefits of first-stage home visits outweigh any disadvantages.

6.4.5 Arranging workload

Each month, the CMP manager allocates women to the different midwives. All the midwives complete time sheets which document their hours actually worked. Hours 'owing' to the midwives, because of hours worked over the standard amount allowed in the industrial agreement, are recorded on the white board in the CMP office. Midwives also undertake work to reduce any outstanding hours. This may involve doing an office day in the Birth Centre if needed. Flexible work practices and family-friendly policies mean that midwives can bring their children into the Birth Centre on their office days. The high satisfaction with these arrangements is demonstrated in the fact that the CMP midwives have the lowest rate of sick leave in the maternity unit. The midwives get seven weeks annual leave plus one week of professional development leave. The workload arrangements work well and should continue.

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[17] Lauzon L. Hodnett E. Labour assessment programs to delay admission to labour wards. *The Cochrane Library. 2006;(1): (CD000936)*

Recommendation 3: The annualised salary and flexible working conditions for CMP midwives work well and should continue.

6.4.6 Models of care within the CMP

The CMP is provided in a range of flexible ways. This includes one team model and three teams working in a caseload model The section below described the different models.

Team model

There is one team model in the CMP, the Tuggeranong Team. This team currently has three midwives who work 12-hour shifts (8 to 8). They explained this was their choice as they did not like being on call for 24 hours. Four to five women are booked into the team each month. The team meet every Monday to discuss what is happening with the women. If there are any women nearly due to give birth who have not seen one of the midwives they arrange for that midwife to undertake the antenatal visit at 40 weeks. The midwives also jointly allocate the on-call duties for the week each Monday. This way all the midwives get to know all the women. Antenatal visits are booked into three clinics a week and the midwives see all the women. There is no primary midwife.

Caseload models

There are three teams working in a caseload model; the North, Central and South teams. There are three or four full-time equivalent (FTE) midwives allocated to each caseload team. Each FTE midwife is allocated two primiparous and two multiparous women a month, giving them a caseload of 40 women a year. Some women will request the same midwife and the manager tries to accommodate this. Some of the midwives have a 'job share' arrangement alternating three days and two days per week between them. They book 2–3 women a month. The midwives who job share still have their own women but they make sure that the women also have a couple of visits with the other midwives on the team. The primary midwife is backed up by two or three other midwives who all try to meet the woman at least once. In this model, 85–88 percent of women give birth with their primary midwife. Postnatal care is attended by the woman's primary midwife. Annual leave needs to be organised at least nine months in advance. Most midwives get two clear days off a week. However, some midwives may ask to be called for certain women even on their days off. Once a month the midwives get a weekend off. They get a second weekend off a month but act as back up for the midwives on call. If a labour continues for longer than 12 hours the midwife concerned calls the backup midwife to come in and take over. The midwives described a very flexible system where they divided up their days off and were able to accommodate domestic as well as clinical responsibilities. Some of the teams meet on Monday morning and jointly allocate the on-call duties at that meeting.

6.5 ATTITUDES TO CMP

A significant feature of the interview process was the almost universal support and admiration expressed by all disciplines and consumers for the CMP. This support came from senior executives in both ACT Health and TCH, other clinicians working with and alongside the CMP midwives, related professional bodies, and consumer groups. Even though some interviewees may have had specific concerns about aspects of the CMP, almost all interviewees expressly recognised that the service offered was of a high quality; that the midwives themselves were experienced, committed and professional; that women had a right to choose the types of antenatal, intrapartum and postnatal care they received; and that the CMP was an extremely popular service wanted by the ACT consumers of maternity services. In only one interview was there antagonism and disrespect towards the CMP midwives. This was particularly surprising as it was so unlike the other interviews.

Within the CMP there was huge enthusiasm for the philosophy of continuity of carer and a significant sense of pride in the quality of care the midwives had been able to provide over the life of the CMP.

However, CMP midwives and other interviewees also expressed concerns about the service. Their concerns fall into four main categories:

- the ongoing demand for homebirth services and the question of indemnity insurance;
- the possibility of unplanned homebirth and the need for appropriate policies and insurance strategies to facilitate safe and appropriate practice in the event of unplanned homebirth;
- the need for improved collegiality and infrastructure to ensure seamless transitions when CMP clients need to move between services; and
- the need for strategies to ensure succession planning and increased recruitment and retention into the CMP to meet projected demand.

This report discusses each of these matters in detail.

6.5.1 Attitudes expressed by women

The Review Team was given for review forty-six (46) letters from members of the public who were commenting on one or more aspects of the CMP and/or matters arising from their involvement with the CMP. The letters have been analysed in relation to recurrent content, and as several letters raised more than one issue, the number of items will total more than 46.

Of the 46 letters, 35 contained expressions of gratitude, satisfaction, admiration and appreciation for their wonderful experience with the CMP, and referred to antenatal, intra-partum and postnatal care. Not all births had occurred in the Birth Centre—two had occurred

as precipitate births at home and several in the delivery suite—but on each occasion the CMP midwife had been in attendance, which the correspondents greatly appreciated. Six expressed specific support for homebirth and one expressed specific support for home visiting.

Eleven letters were complaints about not being able to access the CMP due to lack of available places or waiting lists. Needless to say, all of these expressed support for the CMP. One letter was a complaint about the fact that, during a precipitate birth, the midwife had attended but was no longer able to carry Syntocinon and had had difficulty persuading the ambulance officers to wait until after the delivery. Four complaints related to women who had received most of their care from CMP midwives (about which they were positive) but had then received poor care from other midwives elsewhere in the service.

Five complaints only were about the care provided by the CMP midwives. One of these related to the non-return of a placenta that the family wished to have returned to them for inclusion in a naming ceremony. Four related to attitudinal and intra-partum management issues and each seemed to reflect a breakdown in communication between the woman and her midwife at the time of birth. Each of these complaints was followed up and the Review Team was given documentation to demonstrate that the complaints were taken seriously and acted upon.

Overall the analysis of the correspondence was overwhelmingly positive for the CMP. That people in the postnatal period take the trouble to express their appreciation in writing when they are so busy with a new baby indicates the extent of their satisfaction.

6.6 CMP OUTCOMES OVERALL

6.6.1 Models used in the comparison of outcomes

The clinical outcomes of women who attended the CMP were compared with outcomes from similar programs and national data.

The comparative models and data included:

- Midwifery Group Practice (MGP), Women's and Children's Hospital, Adelaide[18];
- Ryde Midwifery Group Practice[19];
- Belmont Birthing Service[20]; and
- Women's Hospitals Australasia[21].

[18] Women's and Children's Hospital, Adelaide (2005) *Midwifery Group Practice: An evaluation of clinical effectiveness, quality and sustainability*. Government of South Australia, Adelaide
[19] Tracy SK, Hartz D (2005). *The Quality Review of Ryde Midwifery Group Practice, September 2004 – October 2005. Final Report.* Northern Sydney and Central Coast Health, Sydney
[20] Shaw R et al. (2006). *Belmont Birthing Service: Evaluation and Clinical Outcomes*. Hunter New England Health, Newcastle

The MGP at the Women's and Children's Hospital is the model most similar to the CMP.

This section provides a summary of the different models/data.

Midwifery Group Practice (MGP), Women's and Children's Hospital, Adelaide

The Midwifery Group Practice (MGP) model was established at the Women's and Children's Hospital in January 2004. During the period of the evaluation (2004–5), more than 600 women received MGP care. During this time, 13 full-time equivalent (FTE) midwives provided care within two group practices. The MGP is available to women within a particular geographical area and includes low-, moderate- and high-risk women. The key features of the MGP model are outlined in Table 1.

Table 1: Key features of the MGP model at Women's and Children's Hospital in SA

Antenatal care	
Care providers	Each woman has a lead MGP midwife plus a support midwife (1–3 associate midwives). Appropriate collaborative care with core hospital staff is provided whenever a risk factor is identified.
Number and location of visits	Regular scheduled antenatal visits are conducted at home, at the hospital or in a community setting. Midwives drive their own cars and are reimbursed at public sector rates.
Tests	Midwives order and interpret, on their own responsibility, routine pregnancy laboratory tests and ultrasounds.
Parenthood and health education	The MGP midwives provide one-to-one education and information during visits. Antenatal education is also available through the hospital.
Intrapartum care	
Early labour	Women contact their midwife by pager with any labour queries and can be assessed at home or in hospital, whichever is most clinically and geographically appropriate.
Labour care	Women with no risk factors labour give birth in 'birth centre'-style rooms and have many options for active birth. Where a risk factor has developed, or induction or epidural is required, women labour and give birth in the delivery suite with their MGP midwife, and are supported by core hospital staff.

[21] Buist R, Cahill A (2004). *Benchmarking in Obstetrics 2000–2003.* Women's Hospitals Australasia, Canberra

Postnatal care	
Location and main caregivers	Postnatal care and support is provided in the home. Women and their babies remain in MGP care until 6 weeks postnatally. Women are linked into community services during this time, including maternal and child health services.

MGP midwives doing labour assessments at home carry an Emergency Birth Kit to cover situations of unplanned birth at home. Oxytocic drugs (e.g. Syntocinon) are not carried routinely at the moment but this is likely to change soon with the release of new guidelines. Midwives currently call an ambulance if they are concerned about mother or baby, or feel they require additional equipment when they are in attendance at a home and birth occurs.

Ryde Midwifery Group Practice, Sydney

The Ryde Midwifery Group Practice (Ryde MGP) commenced in March 2004. The model offers pregnant women from the local area the opportunity to have continuity of midwifery carer throughout pregnancy, labour and birth and into the postnatal period. The women who are accepted into the Ryde MGP are low risk and the Australian College of Midwives' Guidelines for Consultation and Referral[22] are used as the basis of determining the need to transfer. Women who develop risk factors during pregnancy, labour and birth or in the postnatal period are transferred to the Royal North Shore Hospital. Their Ryde MGP midwife will accompany the women to the transfer hospital and continue to provide care.

Belmont Birthing Service

The Belmont Birthing Service is a low-risk midwifery-led service. The Belmont Birthing Service commenced in July 2005 and is an outreach service of the John Hunter Hospital in Newcastle, NSW. The service offers low-risk women continuity of midwifery caregiver. The service is based on the campus of the Belmont District Hospital but has no medical support on the campus. All medical consultation and referral takes place at the John Hunter Hospital, some 20 minutes drive away. Home visits in labour are not part of the Belmont Birthing Service.

Women's Hospitals Australasia

Women's Hospitals Australasia (WHA), a not-for-profit association incorporated in the ACT (1994), advocates for the health-care needs of women and babies in Australia and New Zealand. It represents many major women's hospitals and health units throughout Australia and New Zealand and is a peak advocacy body. Many member hospitals are also leaders in the

[22] Australian College of Midwives (ACM) *National Guidelines for Consultation and Referral*, ACM, Canberra, 2001

provision of neonatal care and neonatal intensive care, and there is a high proportion of neonatal intensive care beds based in member hospitals. WHA also provides a national voice for the common interests and concerns of Australian and New Zealand women's hospitals and major women's health units. Any hospital that provides health care to women, whether a stand-alone specialist hospital for women or a women's health service located within a general hospital, is eligible to become a member of WHA.[23]

The data used in this benchmarking exercise come from the latest publication from WHA, *Benchmarking in Obstetrics 2000–2003*, which is available only to WHA members.

The range of clinical indicators collected is dynamic and reviewed annually. This current collection includes indicators relating to:

1 Caesarean section (CS)
2 Vaginal birth after CS
3 Uterine rupture
4 Neonatal mortality
5 Stillbirth
6 Perinatal mortality
7 Instrumental delivery
8 Apgar score
9 Maternal age
10 Epidural anaesthesia
11 Episiotomy
12 Third and fourth degree tears
13 Intact lower genital tract
14 Preterm birth
15 Postpartum haemorrhage (PPH)
16 Blood transfusion
17 Admission to intensive care unit
18 Peripartum hysterectomy
19 HIE Grades 2 or 3
20 Breastfeeding

These indicators are chosen on the basis that they:

- are readily collectable
- have a significant degree of clinical relevance
- are capable of identifying a process/outcome that is capable of modification
- are able to be benchmarked with comparable facilities

Only a selection these indicators is used in this benchmarking exercise with the CMP. It should be noted that while The Canberra Hospital is a member hospital of WHA, it did not

[23] Women's Hospitals Australasia: About Us http://www.wcha.asn.au/index.cfm/spid/1_10.cfm Accessed 25 Sept 2006

provide data for the WHA *Benchmarking in Obstetrics 2000–2003*, so is not included in the comparative data.

6.6.2 Clinical comparisons with other models

Table 2 presents the clinical comparisons using the indicators as agreed with the Steering Committee. Not all the comparative sites collected or presented data in the same way as the CMP, hence the inability to calculate rates for some indicators. As stated earlier, the MGP at the Women's and Children's Hospital is probably the model that is most similar to the CMP, and the Review Team feels this comparison is the most useful. The Belmont and Ryde models are different in that they are stand-alone midwifery-led services that cater only for low-risk women. The WHA data included women with a diversity of risk profiles and hospitals with a range of levels of acuity.

Table 2: Clinical comparisons by obstetric indicators and model of care

	CMP 2005 N=486 %	MGP N=618 %	Belmont N=108 %	Ryde N=245 %	WHA 2002/2003 N=210,000 %
Induction of labour	13.3	18.4	13.8	7.1	NA
Epidural analgesia (labour)	23.6	21.2		14.4	25.5
Normal vaginal birth	62	74.3	83.0	83.7	NA
Caesarean section	15.5	15.7	5.6	9.6	25.0
PPH (>500mL)	12.2	11.0	5.6		1.9®
Third-degree perineal tear	4.4	1.9	4.6	2.2	2.1
Initiation of breastfeeding	98	NA	NA	NA	NA
Apgar <7 @ 5mins#	0.6	NA	NA	NA	NA
Perinatal mortality (FDIU, stillbirth & NND)	3/489 6.1 per 1000	0/618	0/108	0/245	13.6 per 1000

NA: Not available

®Blood loss greater than 1500mL

Only of live-born babies

Overall, the CMP outcomes are comparable with the other outcomes given the type of model and caseload. The most impressive indicators in this comparison are the CMP's low level of induction of labour and caesarean section. While the PPH rate is comparable to the MGP in Adelaide (probably the most similar of the models), there are some aspects of the management of the third stage, which will be addressed in the next section.

Third-stage of labour management

The CMP midwives are to be commended on the detailed statistics gathered on the methods and results of the management of the third-stage of labour (see summary below). The CMP's PPH rate of 12.2 percent is similar to that reported by the MGP in Adelaide (11%). However, additional data were presented to the Review Team and these will be addressed.

The CMP provided information about the 'method and results of third-stage management'. The different types of third-stage management are outlined in this report. These include:

- Active — Active management is defined as follows: IV or IM oxytocic within 2 min of the baby's birth
- Delayed Syntocinon — Syntocinon (or Syntometrine) given after 2 min of the birth
- Physiological — No oxytocic, no cord clamping and no cutting of the cord until after the birth of the placenta
- No Syntocinon — No oxytocic but cord cut before birth of placenta and/or controlled cord traction

The 'No Syntocinon' category concerned the Review Team as it suggests a combination of active and physiological management. While the data provided indicate that only 6 percent of women (27/487) had such management recorded and none experienced a PPH, it is recommended that the management of third stage be examined closely and the policy clarified.

The PPH rate in the CMP is consistent with national and international data. It is recognised that the rate of postpartum haemorrhage is increasing both nationally and internationally.[24] Recent research in NSW[25] has demonstrated that between 1998 and 2002, the rate of PPH has increased from 8.3 to 10.7 percent. This increase could not be explained by increased maternal

[24] NSW Health (2005) *Second Report on Incident Management in the NSW Public Health System, 2004–2005*, NSW Health, Sydney. Available <http://www.health.nsw.gov.au/pubs/2005/patient_safety.html> Accessed September 2006

[25] Cameron et al (2006) Trends in postpartum haemorrhage. *Australian and New Zealand Journal of Public Health*, 30(2): 151–6

age or higher rates of caesarean section. This study suggests that more needs to be done to examine the third stage of labour and manage PPH.

The overall PPH rate for the CMP in 2005 was 12.2 percent. The PPH rate for The Canberra Hospital for the years 2004–2005 was 14.2 percent. The rate of surgical birth (assisted vaginal birth plus caesarean section) was 27 percent. The majority (56%) of PPH occurred in this group of women who, by definition, received the most intervention and also would have had active management of the third stage. Among the women who had a spontaneous vaginal birth, the PPH rate was 7 percent. There was a similarly low level of PPH associated with physiological third stage (6%). The reviewers were concerned that a combination of methods (active and physiological) was used in 37 of the reported cases (Table 3).

During the course of the review it was noted that several of the women who had precipitous labours and births at home did not receive active management of the third stage. Precipitous labour is a risk factor for postpartum haemorrhage. The reviewers identified as a problem the fact that midwives were no longer allowed to carry oxytocic drugs and addressed this matter in a letter to the Acting Chief Executive Officer early in the review. The Review Team recommended that, while midwives continue to undertake home visits to assess early labour, the midwives and possibly also the ambulance officers, need to carry the necessary equipment to manage not only a birth but also the third stage of labour in order to manage the risk of post-partum haemorrhage. This in no way alters the current policy. It simply ensures that both the ambulance officers and the CMP midwives are properly prepared for an emergency.

Table 3: Summary of methods and outcomes of third-stage management (2005)

Mode of birth and 3rd stage management	Numbers of births	Numbers of PPH	PPH rate for each method	Proportion of total PPH rate
Spontaneous vaginal birth: active management of 3rd stage	248	18	7%	32%
Assisted vaginal birth or CS: active management of 3rd stage	130	32	25%	56%
Spontaneous vaginal birth: physiological management of 3rd stage	72	4	6%	7%
Mixed methods	37	3	8%	5%
Total	487	57	12%	100%

In summary, the review found that the PPH rate for the CMP was comparable overall with similar hospitals and models of care. The management of third stage requires some clarification, although currently this does not appear to be putting women at risk of PPH. In addition, it may be useful to provide women with information about third stage to assist in decision-making. An example of such information provided to women at a NSW hospital is included in Appendix E.

Recommendation 4: The practice for the management of third stage of labour be examined then policy and education reviewed accordingly.

The rate of third-degree perineal tears requires further analysis and discussion. This is discussed in *Section 2.6.3*, and includes a comparison with ACHS data.

6.6.3 Further benchmarking against the Australian Council for Healthcare Standards

CMP data and the ACHS[26] were compared as part of the agreed Terms of Reference for the Review. This analysis, however, is limited for most of the Obstetric Indicators. This is

[26] Australian Council on Healthcare Standards (2006). *ACHS Clinical Indicator Results for Australia and New Zealand 1998–2005: Determining the Potential to Improve Quality of Care 7th Edition*. ACHS Sydney. http://www.achs.org.au/

because the ACHS indicators are very specific and the CMP data are not collected or presented in a manner that permits easy comparison. For example, the induction of labour indicators is for 'IOL for other than defined indications' (Indicator 1.1), which is different to the total IOL rate as reported by the CMP. Another example is in relation to emergency caesarean section. The relevant ACHS indicator (Indicator 3.2) is for 'Patients undergoing primary non-elective caesarean section for failure to progress after a period of labour with cervical dilatation >3cm'. The CMP data provide the rate of emergency caesarean section regardless of whether it is primary caesarean section or cervical dilatation, making direct comparisons difficult. Therefore, the only valid contrast was to compare the data for The Canberra Hospital in total (which includes the CMP data) with the aggregate rate for all organisations using the Peer Group Comparison data[27] and then with the ACHS national data released in 2006.[28]

Recommendation 5: Efforts should be made to ensure that the CMP data collected is in line with ACHS Indicators to enable future comparisons and benchmarking.

Overall, the TCH data are in line with most other institutions and national summary data. Some of the indicator comparisons are worth further discussion, for example, vaginal birth following previous primary caesarean section (Indicator 2.1). While the desired rate is unknown, the TCH rate is considerably higher than the national data. The other indicator of note is the surgical repair of the lower genital tract, third-degree tear (Indicator 5.4). The TCH rate is 6.2 percent, which is higher than the aggregate rate for all organisations in the Peer Group Comparison (4.1%), and the subsequent national rate (2.94%).

[27] Peer Group Comparison—*O&G—Obstetrics Indicators Version 5.* ACHS Organisation Code 810551, Second half 2005, Public Facility (Data provided to Consultants by ACT Health), Printed 24 March 2006

[28] Australian Council on Healthcare Standards (2006). *ACHS Clinical Indicator Results for Australia and New Zealand 1998–2005: Determining the Potential to Improve Quality of Care 7th Edition.* ACHS Sydney. http://www.achs.org.au/

Vaginal birth after caesarean section

The CMP provided an analysis of the VBAC data for the past six (6) years. This is presented in Table 4.

Table 4: VBAC attempts and outcomes for the CMP 2000–2005

Year	Attempted VBAC	Successful vaginal birth	Caesarean section	% successful VBAC
2000	11	8	3	11
2001	18	15	3	83
2002	21	15	6	71
2003	27	10	17	59
2004	20	18	2	89
2005	16	12	4	75
TOTAL	113	78	35	69

These overall rates are impressive and higher than most reported for Australia. The *WHA Benchmarking in Obstetrics Report 2000–2003*[29] stated that of the member hospitals, only 41 percent of the 4,000 women who had had one previous baby born by caesarean section laboured either spontaneously or following induction of labour. Of these, 53 percent gave birth vaginally, although the rates ranged from 1.7 percent to 86 percent.

The ACHS (2006) reported a VBAC success rate of 15.2 percent in 2004 and 13.6 percent in 2005 and prefaces their analysis by saying:

> Evidence supports the finding that vaginal delivery after a previous caesarean birth is a reasonable option for many women. The recommended rate, however, is not known. Five years ago, a higher rate was assumed to be desirable, but recent studies have suggested a lower rate may reduce the proportion of poorer outcomes for the baby. Given the current uncertainty as to the desirable rates, this report does not specify the potential gains, but provides the trends and variations in the rates. Since there is no agreement as to whether a high or low rate is desirable, the potential gains cannot be determined. However, there were units with significantly lower rates less than 8% and higher rates greater than 20%. The variation in vaginal delivery after a caesarean

[29] Buist R, Cahill A (2004). *Benchmarking in Obstetrics 2000–2003*. Women's Hospitals Australasia, Canberra

> section is therefore considerable. Research into why the major decline in rates and the variation between units would be worthwhile.[30]

Nonetheless, the CMP rate of successful VBAC is striking. It is possible that the high level of continuity of caregiver is one of the major reasons for this high VBAC rate. In 2005, 88% of women in the CMP were attended by their primary midwife for labour and birth. Previous Australian research[31] has suggested that women may be encouraged to attempt labour rather than opt for a repeat caesarean section if they have had the opportunity to develop a consistent relationship with their midwives.

Perineal outcomes—third-degree perineal tears

The perineal trauma outcomes in the CMP require additional analysis and consideration. The ACHS (2006) states that:

> A high incidence of an intact perineum is considered to be a desirable outcome. Lower genital tract is defined as those structures below and not including the cervix. Surgical repair is defined as suture of the lower genital tract following delivery. This indicator relates to those patients who are having their first delivery. Factors leading to a high rate are a lower use of episiotomy (rates lower than 10 percent have been recommended) and less tears while delivering.

The ACHS indicator relating to an intact perineum is *5.1 Primiparous patients—intact lower genital tract.* The ACHS rate in primiparous women in 2005 was 29.8 percent. The CMP rate for primiparous women in 2005 was 20 percent (28/140). It is not clear why the CMP rates are lower than those reported for primiparous women nationally, although this may be an artefact of the small numbers. Nonetheless, the rate of third-degree perineal tears requires discussion.

In the ACHS data, a third-degree perineal tear is associated with potentially undesirable outcome and the desirable level is 'low'. The CMP rate of third-degree perineal tears for 2004 was 3.1 percent (15/488) and in 2005 was 4.4 percent (18/412). In 2005, the CMP rate in primiparous women was 10 percent (7/140). This is higher than the ACHS indicator (*5.4 Primiparous patients—surgical repair of the lower genital tract, third-degree tear*), which was 2.9 in 2004 and 3.1 in 2005.

There are a number of hypotheses for the higher rates of third-degree tears in the CMP. The Canberra Hospital's Maternity Unit has a strong emphasis on correct identification of third-degree tears, with a policy for their immediate repair, postnatal care, and longer-term follow

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[30] AHCS (2006) page 324

[31] Homer CS, Davis GK, Brodie PM, Sheehan A, Barclay LM, Wills J, Chapman MG. Collaboration in maternity care: a randomised controlled trial comparing community-based continuity of care with standard hospital care. *BJOG* 2001, 108, 16–22

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up. This emphasis may mean that midwives and doctors are more careful when examining a women's perineum and more skilled at identifying and reporting a third-degree tear. The establishment of the Perineal Tear Clinic at TCH may also encourage doctors and midwives to report a third-degree tear as they can now refer to a specialised service.

It is sometimes suggested that performing episiotomies will avoid large tears, including third-degree tears. This is not supported by much of the evidence, which does not demonstrate that a policy of routine episiotomy results in less severe perineal trauma.[32] However, the debate continues in clinical practice and in the literature. Some studies have shown that episiotomy is a risk factor for a third-degree tear, along with primiparity, forceps delivery, fetal birth-weight greater than 4,000g and increased duration of the second stage of labour.[33] A recent study reported that the strongest clinical risk factors for anal sphincter tear (third or forth degree) in multiparous women were episiotomy, shoulder dystocia, previous sphincter tear, prolonged second stage of labour, and forceps delivery.[34] Nonetheless, other studies have shown that in multivariate analysis, mediolateral episiotomy appeared to be protective in regard to third-degree tears.[35]

The episiotomy rate in the CMP in 2005 was 8.9 percent. This is consistent with the MGP at Women's and Children's Hospital in Adelaide, who reported a rate of 8.4 percent in a similar population of women.[36] Two of the episiotomies performed in the CMP in 2005 extended to a third-degree tear, suggesting that in these cases, the episiotomy was not protective. The Review Team believes that a more liberal policy of episiotomy would not reduce the third-degree perineal tear rate. In addition, the investigation into the obstetric service conducted at the TCH in 2005 found that the 'incidence of third and fourth degree tear was not higher than in other obstetric hospitals in Australia'.[37] This report stated that the TCH should not be complacent about its performance in this [third-degree perineal tears] area. The CMP Review Team has a similar view, that is, that the third-degree tear rate requires ongoing review as part of the usual review of practice.

Recommendation 6: The rate of third-degree perineal tears requires ongoing review as part of the usual review of practice

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[32] Carroli G, Belizan J. Episiotomy for vaginal birth. *Cochrane Database of Systematic Reviews* 1999, Issue 3. Art. No.: CD000081. DOI: 10.1002/14651858.CD000081

[33] Wood J, Amos L, Rieger N (1998) Third degree anal sphincter tears: risk factors and outcome. *Australian and NZ Journal of Obstetrics and Gynaecology*;38(4):414–7

[34] DiPiazza D, Richter HE, Chapman V, Cliver SP, Neely C, Chen CC, Burgio KL (2006) Risk factors for anal sphincter tear in multiparas. *Obstetrics & Gynecology. 107(6):1233–7*

[35] Aukee P. Sundstrom H. Kairaluoma MV. (2006) The role of mediolateral episiotomy during labour: analysis of risk factors for obstetric anal sphincter tears. *Acta Obstetricia et Gynecologica Scandinavica. 85(7):856–60.*

[36] Women's and Children's Hospital, Adelaide (2005) *Midwifery Group Practice: An evaluation of clinical effectiveness, quality and sustainability.* Government of South Australia, Adelaide

[37] Community and Health Services Complaints Commissioner, ACT (2005). An own initiative investigation into the obstetric service at The Canberra Hospital. Page 15

Perineal suturing

The number of midwives in the CMP who are skilled and confident at perineal suturing also requires attention. Currently, few midwives in the CMP undertake perineal suturing. In 2005, doctors undertook 87 percent of suturing. Perineal suturing generally seems to require a transfer to the delivery suite.

The Review Team noted that for a midwifery model of care, the number of midwives who were competent or felt competent to undertake perineal repair was low compared to other similar models. This frequently led to women being taken to the delivery suite for perineal repair by obstetric registrars who were generally unhappy to suture with women on the beds in the Birth Centre. It was also noted that in a couple of the unplanned homebirth cases, the women were transferred to TCH simply for suturing. If a homebirth model were ever to be introduced into the CMP program, the midwives would need to be able to suture to avoid this unnecessary inconvenience to women and cost to the health system. When asked about this the midwives agreed that few of them sutured and on further discussion, it appears that a legal case several years ago involving a CMP midwife and client has made the midwives fearful of performing perineal repair. This needs to be addressed and midwives need to regain their skills and competence in perineal repair. When this was explored in interviews with medical staff they recognised it as an ongoing problem and said they would be happy to be involved in teaching the midwives. There needs to be multidisciplinary training and a support program for midwives (CMP and delivery suite) to undertake perineal suturing. The outline of such a program is included at Appendix D.

Recommendation 7: The CMP midwives should be supported to gain confidence in perineal repair and a program be developed to encourage this to happen. A program that also included delivery suite midwives and medical staff would be ideal as it would be a forum to get them to interact and learn together.

Table 5: ACHS Clinical Indicator Results for Australia and New Zealand 1998–2005—Obstetric Indicators

	Desirable level[38]	Canberra Hospital (July–Dec 2005) %	Aggregate rate for all organisations (July–Dec 2005)	National ACHS data[39]
1.1 Induction of labour for other than defined indications (excluding augmentation)	Low	11	22.8	32.8
1.2 Induction of labour for other than defined indications (all deliveries)	Low	2.18	5.52	8.25
2.1 Vaginal delivery following previous primary caesarean section	N/A*	29.23	17.83	13.6
3.1 Primary non-elective caesarean section for failure to progress, cervical dilatation 3cm or less	Low	5.5	10.21	11.4
3.2 Primary non-elective caesarean section for failure to progress, cervical dilatation more than 3cm	Low	46.79	35.96	31.5
4.1 Primary caesarean section for fetal distress—all deliveries	N/A#	2.67	3.66	3.75
4.2 Primary caesarean section for fetal distress—primary caesarean section deliveries	N/A#	17.76	21.75	18.6

[38] Australian Council on Healthcare Standards (2006). *ACHS Clinical Indicator Results for Australia and New Zealand 1998–2005: Determining the Potential to Improve Quality of Care 7th Edition*. ACHS Sydney. <http://www.achs.org.au/>
[39] Ibid

5.1 Primiparous patients—intact lower genital tract	High	27.33	27.80	29.8
5.2 Primiparous patients—surgical repair of the lower genital tract, first degree tear	Low	13.98	13.17	11.5
5.3 Primiparous patients—surgical repair of the lower genital tract, second degree tear	Low	36.34	32.34	27.8
5.4 Primiparous patients—surgical repair of the lower genital tract, third-degree tear	Low	6.21	4.10	2.94
5.5 Primiparous patients—surgical repair of the lower genital tract, fourth degree tear	Low	0.31	0.28	0.38
6.1 Term babies born—Apgar score of 4 or below at five minutes	Low	0.22	0.29	0.28
6.2 Pre-term babies—Apgar score of 4 or below at five minutes	Low	1.56	1.25	1.36
7.1 Term babies—transferred to a neonatal ICU other than for congenital abnormality	Low	0.89	1.30	1.14

*N/A: Not available—The ACHS state that recommended rate is not known

#The ACHS have assumed that desirable rates, high or low, for indicators CI 4.1 and CI 4.2 are unknown, although a lower rate in CI 4.1 may imply a smaller proportion in distress. However, for CI 4.2, a higher rate may be appropriate, since it reflects that fetal distress should be a major reason for a caesarean section.

7. CMP ISSUES IN GENERAL

Section 3 considers a range of issues arising from the interviews and documentation supplied to the Review team. These matters are discussed under the following headings:

- professional relationships
- culture within TCH
- leadership
- competencies and skills
- documentation

The leadership discussion addresses education, professional collegiality, boundary issues, succession planning, and recruitment and retention.

7.1 PROFESSIONAL RELATIONSHIPS

The interviews with the CMP midwives revealed strong internal systems for professional support and development. The midwives meet regularly, and conduct a Journal Club, case reviews and other education programs, in addition to regular administrative meetings. All midwives mentioned strong professional, clinical and emotional support from their Level 3 manager, including the ability to call the manager if they needed advice or assistance. The midwives were confident in their ability to openly discuss and analyse difficult or complicated cases with each other, and to raise performance issues with each other should the need arise. The midwives felt able to call on their own team members and also midwives in other teams for backup or cover for leave or special occasions. Overall, the impression gained was of a highly collegial and professional group, who felt supported by their manager and were supportive of each other.

Recommendation 8: The CMP manager and team are to be commended for their professional collegial relationships.

It was very clear that the relationships between the midwives in CMP were effective and respectful. Midwives made the following comments:

> 'I get wonderful mentoring from the team'
>
> '[XX] is a wonderful leader, very woman centred'
>
> 'I love these women [CMP midwives] to bits'
>
> 'I love my job. I wouldn't have done it for 13 years if I didn't'
>
> 'Everyone supports everyone else. I have never worked like this before'
>
> 'The feedback from the women makes me very happy to work here. It helps you to go on when you are really tired.'

'It's a wonderful program. I am happy to work in a team'

'Lots of respect for each other'

This assessment confirms the findings for the CMP in the Best Practice Australia survey undertaken in August 2005 as part of a total survey of TCH.[40] The answers of the 13 CMP respondents to the survey placed the CMP in the top tenth percentile of nursing /midwifery organisations across the country for satisfaction with the manager and direction and guidance from their manager. The majority of comments in relation to their manager were unstinting in their praise, describing her as (*inter alia*) 'approachable, fair, flexible, collaborative, enthusiastic, hardworking, inspirational and strong'.[41] The respondents also scored highly on their satisfaction with pay, workloads, hours/shifts, job security, physical conditions and opportunities for the future. In addition, on the Best-Practice score card, the CMP respondents scored very highly against organisational nursing/midwifery norms for the statement 'There is high trust in team/service management'.[42] In addition, comments relating to the reasons the CMP was a 'truly great place to work' included the following:

'Flexible and the autonomy of my job'

'I feel the area I work in is a great place to work but am glad to be removed from main area of hospital'

'Not sure of other areas but CMP is a great place for midwives and for women and their families as we give our best for the clients'

'The wonderful, supportive, caring individuals who make up the CMP'[43]

However, the references to being 'removed from the main area of the hospital' resonate with comments made by the CMP midwives during the interviews. Several CMP midwives commented on their occasionally strained relationships with other maternity staff, most particularly a few specific individuals in the delivery suite (although there was a sense that the culture had begun to improve in recent months). When we informed the midwives of the high regard in which they were held almost universally throughout the ACT, they all expressed surprise, and overall there was a strong feeling within the team of a small bonded cohort who perceived themselves to be 'under siege'. Indeed, one comment within the Best Practice Australia Work Unit Report reflects precisely this sentiment. In response to the question 'what barriers are there to becoming a truly great place to work?', one CMP

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[40] Best Practice Australia (2005) *Best Practice Nursing Report ACT Health, TCH W&CH–CMP*
[41] Best Practice Australia (2005) *Best Practice Australia Work Unit Report TCH–W&CH–CMP*, p.985 of 1248
[42] Best Practice Australia (2005) *Best Practice Nursing Report ACT Health, TCH–W&CH–CMP* at p.395
[43] Best Practice Australia (2005) *Best Practice Australia Work Unit Report TCH–W&CH–CMP*, p.970

midwife had responded 'constantly hearing "we can close you down if you don't fall into line"'.[44]

The issue of trust came up repeatedly during the review. There was an obvious lack of trust between the CMP midwives and a small number of midwives and doctors in the delivery suite, although the CMP midwives explained this was not an issue with all delivery suite staff.

> 'Most of the staff in delivery suite are great. One or two make it hard'
>
> 'We will get in and help if it's busy. I do respect a lot of delivery suite midwives'
>
> 'Very good response in an emergency'

However small the number involved, lack of trust seemed to be a significant issue. It was also mentioned by some of the medical staff. It was manifested in attitudes towards the nature of CMP practice, the types of women who sought it, and the workload and work practices of CMP midwives.

In relation to the attitudes of some individual midwives and doctors in the delivery suite towards the nature of CMP practice and the fact that the CMP staff followed their women to the delivery suite for the birth, the CMP midwives made the following comments:

> 'We are trying to hold the space for that woman'
>
> 'They don't trust us'
>
> 'We don't have a relationship with the medical staff like [they do in] delivery suite. We have to work at it'

In relation to the attitudes of some midwives and doctors in the delivery suite toward women who were transferred to the suite from the Birth Centre, the CMP midwives explained that:

> 'Women in CMP get lots of information because of the long relationship'
>
> 'When you have women with alternative views you get doctors irritated with midwives. It's all our fault, we are the ones teeing them up—they have made a choice!'
>
> 'It's always our fault if women don't comply'

In relation to the opinions of some midwives and doctors in the delivery suite on the workload and work practices of CMP midwives, the greatest concern of the CMP midwives was that adverse views about the CMP may discourage new recruits from joining the CMP.

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[44] Ibid

'Newer midwives, by the time they are ready to come to CMP would be talked out of it by delivery suite'

'Delivery suite see us after working long hours when we come in with transfers. They don't see the benefit such as when your child is sick you can reorganise'

'They only see the negative stuff'

The new delivery suite Level 3 manager was supportive of the CMP team and expressed 'zero tolerance' for any unwillingness to work together. There are now regular meetings between the Level 3 managers across the Women's and Children's Services and there was a sense of optimism about this from the CMP midwives: 'the new manager is permanent so it should get better'. Notwithstanding this development, there is a pressing need for the services to work in an integrated fashion in the interests of quality maternity care across the spectrum. Shared education and social events between all midwifery and medical staff may be a strategy to improve relationships.

It is possible that some of the problems experienced in the relationship between the CMP midwives and other TCH staff reflect the differences in culture between the CMP in particular and the WCH service in general. Although the numbers of respondent to the CMP culture survey is relatively small (n=13) in comparison to the WCH overall (n=133), the cultural survey demonstrates higher Nursing Quality of Working Life indices for CMP midwives on all indices, most specifically pay and conditions, satisfaction with the manager, and direction and guidance. It is not possible to assess how these differences in culture affect the relationships between the groups, but the cultural differences are marked, and cannot be overlooked as a possible contributing factor to relational difficulties.

7.2 Leadership

The question of leadership in relation to the CMP at all levels across the ACT is important, as the CMP is clearly a flagship program for which there is significant demand, strong consumer support and great potential. Leadership within this section is addressed under the headings of education/peer review, professional collegiality, boundary issues, succession planning and recruitment and retention.

7.2.1 Education/ peer review

The education and peer review processes within the CMP are strong and rigorous. The meeting procedures and regular in-service programs have been described in *Section 2.5.2.* Mandatory skills are updated every year. Most of the midwives were described by their immediate manager as good at updating their knowledge and going to conferences. All the CMP midwives had completed the Advanced Life Support in Obstetrics course. The individual groups of midwives meet with the CMP manager and review women's clinical

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notes to see how they could have improved their care and whether it was in line with the policy. The midwives were acutely aware of their need to comply with TCH policies and stressed to the Review Team that they did so, despite their concerns about the effect of the existing unplanned homebirth policy on safe practice. They also follow the ACM Guidelines on Consultation and Referral.[45]

The external educational programs with other groups within the WCH did not appear to be as robust and they require further work. There are regular multidisciplinary case meetings, but the CMP midwives felt that they were always last on the agenda and often didn't get a chance to discuss their cases. It is strongly recommended that greater educational opportunities be created with other midwifery and multidisciplinary groups outside the CMP in order to improve relationships, understanding and professional collegiality (see Recommendation 9).

Recommendation 9: There is a need for the services to work in an integrated fashion in the interests of quality maternity care across the spectrum. Shared education and social events between all midwifery and medical staff may be a strategy to overcome this current divide. Greater recognition and support of the CMP should be a goal for the organisation.

Every year the midwives are required to produce a performance agreement. Although peer review in relation to clinical management was strong within the CMP, the Review Team felt that not all CMP midwives thought formal performance management, particularly in relation to professional issues, was valuable. Performance management would provide an excellent avenue for reviewing some of the more difficult issues raised within the review, such as boundary management and self-care, and requires further development and emphasis.

Recommendation 10: Performance review processes need further development and emphasis in the CMP. A process of formal clinical supervision needs to be adopted for all midwives within the CMP.

7.2.2 Professional collegiality

Professional collegiality has already been discussed as part of the culture of the CMP in Section 7.2, but it was such a strong feature of the CMP that it deserves individual mention. The team has strong leadership and this was recognised not only by the CMP midwives but also by the medical staff interviewed by the Review Team. There was a robust sense of professionalism and excellent rapport between team members. Such a culture is a benchmark for staff satisfaction. In addition, the CMP had wonderful relationships with consumers and the Review Team read numerous letters of thanks and gratitude. The very few negative

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[45] Australian College of Midwives (2004). *National Midwifery Guidelines for Consultation and Referral.* ACM, Canberra. Available from <http://www.acmi.org.au/text/publications/publications.html>

letters related mainly to an inability to get into the program or to be able to access homebirth through the program. Of the 46 letters provided to the Review Team, five were actual criticisms of the practices of the CMP. There is also strong support through organised consumer groups: members of the Maternity Coalition met with the Review Team and vigorously supported the CMP.

Overall the management of both ACT Health and TCH expressed support for the CMP, but with a few reservations. Some of the management expressed concerns about over-involvement of the CMP midwives with their clients, but as discussed under *7.2.3 Boundaries*, the Review Team gained the strong impression that this was the exception rather than the rule. However, where over-involvement occurs, it is essential to manage it promptly and appropriately. Another reservation was about the passionate commitment of the CMP midwives to normal birth. This commitment was evident during the interviews, but at no time did the commitment seem to outweigh clinical judgement, either in the cases reviewed or in discussions with the CMP midwives. However, as discussed in *Section 8: Philosophical issues*, there is a sense of some confusion as to whether the CMP philosophy relates predominantly to normal birth or to continuity of carer. This confusion may well spill over into perceptions about the CMP, and a clear vision and mission statement would do much to overcome this uncertainty (See Recommendation 1).

There was also a sense from all the interviews that the CMP was under the 'political microscope'. This seems to result in two divergent management responses. The first is to leave the program to its own devices when things are going well and to let the midwives get on with their work. The second is for all levels of management to get involved when something untoward occurs, such as an unplanned homebirth, and for several levels of management to take action. Neither of these responses is particularly helpful. While it is clear that the CMP does a good job overall and is well managed locally, the process of non-involvement with the rest of the culture of the WCH perpetuates the 'them' and 'us' mentality. Conversely, the involvement of all levels of management should an incident arise could leave local management feeling that they have responsibility but no control.

Recommendation 11: Clear communication lines and management responsibilities across ACT Health need to be agreed and adhered to in relation to the CMP, and active encouragement of integration of the CMP with other peer groups for education and social events also needs to occur.

7.2.3 Boundary issues

A concern that was raised by some of the management interviewees in particular was the way in which CMP midwives manage boundaries. Given the close and necessarily intimate nature of the relationship between midwife and the pregnant woman and her significant others

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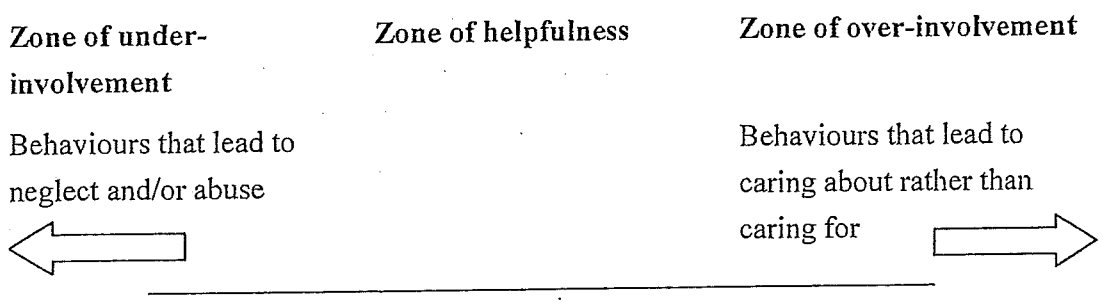
during pregnancy, birth and the postnatal period, it is inevitable and desirable that strong bonds form between the women and the CMP midwives. Indeed, the midwives made the point that because the women trusted them, they would transfer to the delivery suite or come into hospital when the midwives advised them to do so. Contrary to the argument of one interviewee that the CMP midwives colluded with women to facilitate homebirth, the CMP midwives pointed out that the relationship of trust and preparedness of women to listen to the CMP midwives was a critical factor in persuading women who might have wanted homebirth to attend the Birth Centre.

There were good strategies in place overall to manage boundary issues. The CMP midwives described how they counsel women that they should only call between certain hours, and they give the women a list of indicators for when and when not to call. All the midwives said it was important to set boundaries in order for them to survive. Women are told that the midwives have every third weekend off and they might not be there for the birth. The midwives told the Review Team that women appreciated the CMP midwives setting boundaries.

The NSW Nurses and Midwives Board commissioned a study on boundaries for professional practice in 1998. The study identified a continuum of professional boundaries from a zone of under-involvement at one end of the spectrum to a zone of over-involvement at the other. In the centre was the appropriate professional zone known as the zone of helpfulness. The document also identifies sixteen principles of safe practice.[46]

[46] <http://www.nmb.nsw.gov.au/Boundaries-of-Professional-Practice/default.aspx>



The majority of CMP midwives were firmly and clearly established in the zone of helpfulness. No midwives were under-involved. However, there were some concerns that in certain cases, a small minority of the midwives could tend towards the zone of over-involvement, particularly in relation to women with whom they might have had a longstanding relationship over a number of pregnancies. This is, of course, difficult in a small town such as Canberra, where people tend to know one another and their children attend the same schools or sporting activities.

There was no indication that any women had been harmed as a result of any over-involvement. The greater concern in this situation is that the midwives themselves are scrupulous about their professional boundaries, as straying into the zone of over-involvement can lead to burnout, exhaustion, favouritism and poor judgement. In a service as successful and skilled as the CMP, it would be a great pity if a blurring of boundaries by one or two midwives were to damage in any way the professional reputation of the service. It is critical that management is vigilant and takes immediate steps to address any signs of over-involvement as they arise.

Recommendation 12: Management needs to be vigilant to the blurring of boundaries that can occur in models like the CMP.

7.2.4 Succession planning

The Review Team heard concerns from numerous CMP and medical staff about the fact that the CMP manager is planning to retire in July 2007 and the significant void this would create. The manager obviously has a central role in both the culture and the success of the CMP. Both CMP midwives and manager identified the fact that the manager's workload is huge (she is often at work until 9pm and will come in at 4.30am should she be required to give support to her staff). Such a workload would be untenable for many other potential managers.

However, the CMP cannot be reliant on one person and there is no success if the program falters because one (albeit excellent) member of staff leaves. Because of the central role the

CMP manager has played in the program's success and culture, planning needs to begin now around ensuring that all information about how to manage the CMP is meticulously recorded and that other staff members take over some of the manager's functions before she retires to facilitate continuity of the management culture. There are clear policies/protocols for the clinical care of women in the CMP, but less evidence of human resource management policies for the unit.

Recommendation 13: Succession planning to ensure that all information about how to manage the CMP is meticulously recorded and that some of the functions of the CMP manager can be taken over by other staff members prior to the manager's retirement to facilitate continuity of the management culture.

7.2.5 Recruitment and retention

It has been difficult getting midwives to work in the CMP. CMP work is still seen as a demanding and onerous job by many midwives and if one midwife leaves, the waiting list extends even more. Concerns were expressed regarding the local and national shortage of midwives and it was recognised that strategies were required to address the retention and sustainability of midwives with in the CMP and also across TCH maternity services. Addressing tensions between the different groups of maternity care staff was seen as essential both to improving the working environment for CMP midwives and to offering the women in the CMP access to a seamless maternity service with improved professional and clinical relationships and outcomes. In the past, many graduates of midwifery programs were unable to gain employment in the CMP until they had acquired at least two years of post-graduate experience. It is often difficult for a new graduate at TCH to work in this area of midwifery practice. Graduates of the one-year Graduate Diploma of Midwifery were seen by TCH as not having enough experience or confidence to work as autonomous midwives within the CMP. However, the inclusion of the CMP in the new graduate program is to be commended and the Director of Nursing at WCH is to be congratulated for the foresight in supporting and facilitating this initiative. Careful evaluation of the new graduate's experience will be essential to ensure successful ongoing recruitment of new graduates.

One of the long-term local solutions to the midwifery shortage in the region is the development of a Bachelor of Midwifery program at the University of Canberra, to commence in 2008. Planning needs to begin now to ensure clinical placements with the CMP are viewed as the norm rather than the exception.

Recommendation 14: Careful monitoring and evaluation of the new graduate placement in the CMP will assist with future educational placements, which may in turn improve recruitment to the service.

7.3 DOCUMENTATION

The clinical records of the 24 women who gave birth at home were reviewed. This process demonstrated deficiencies in the documentation, the records themselves, and in the amount of duplication required.

The deficiencies in documentation were particularly evident in the earlier (2004) cases. It is likely that gaps in the policy of the time regarding unplanned homebirth meant that documentation guidelines were insufficient. The earlier policy was rather vague on aspects of reporting and subsequent documentation. Documentation deficiencies may also be a reflection of the times. Historically, documentation in clinical records has been poor, and recent years have seen an emphasis on improvement in hospitals and health settings. The improvements since the earlier cases could be a reflection of an overall improvement in the standard of documentation.

In four of the 24 clinical records reviewed there was insufficient documentation provided for the Review Team to be able to assess the level of care. In some of these cases, this seems to be because little was documented. In the others, it seems that parts of the record are missing. This maybe because they were not scanned by the medical record department at the time of discharge and have not been retained.

The more recent cases demonstrated a high level of care and clarity in the documentation. The advice given antenatally and the information regarding the inability to provide a homebirth service through the CMP have been carefully documented, as was other information (e.g. excellent documentation about the advice regarding blood loss provided to one woman). In other cases, the description of the events once the midwife arrived at the home and the explanation as to why it was not possible to transfer to hospital was also detailed. Some of these records were clearly completed retrospectively as the midwife was engaged with caring for the women during the birth and could not complete the record. It seems evident from the review of these cases that for the majority of cases, significant efforts have been made to document in a clear and contemporaneous manner.

The number and design of the forms used in the clinical records were also reviewed. The forms are, at times, cumbersome. In addition, information is repeated in several different places, which increases the margin for error and the time taken to complete the forms. The use of the care pathways, where boxes are ticked to denote care, was often hard to follow.

Recommendation 15: It is strongly recommended that care be taken to ensure a complete and clear clinical record is written for each woman and stored appropriately using electronic means.

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8. PHILOSOPHICAL ISSUES

The CMP, or the Community Midwifery Pilot Project (CMPP) as it was then known, was initially established in 1995 as part of the Alternative Birthing Services Program (ABSP).[47] The initial philosophy was around continuity of midwifery care, a community-based service, and choice of place of birth (home or hospital). The CMPP did not have a needs-based criterion as the philosophy assumed that all women would benefit from continuity of care. The CMPP only included low-risk women.

Over time, the CMPP became the Canberra Midwifery Program. The philosophy of continuity of midwifery carer continued and this is a strong thread today in both the caseload and team approaches. The commitment to being community-based seems to have varied over the past decade and is gathering momentum again. Currently, a number of the antenatal clinics are being offered from community-based locations rather than at the Birth Centre at TCH.

There has been a change to a needs-based criterion (target groups) and the risk status (not only low risk) has been altered. These two issues will be addressed in the following sections, as will the philosophical issues of 'normal birth' versus 'continuity of carer'. Finally, the risk issues related to the current model of unplanned homebirth will be discussed in relation to what is proposed as a safer alternative of careful screening and planning.

8.1 TARGETING WOMEN FROM THE MOST VULNERABLE GROUPS

The CMP has at least 20 target groups. These are detailed in the following Table.

[47] Hambly, M (1997). *Community Midwives Pilot Project Evaluation, Alternative Birthing Services in the ACT.* Canberra, ACT Department of Health and Community Care

Table 6: Target groups for the CMP

1	Aboriginal or Torres Strait Islanders
2	Unemployed women or families (lower socio-economic group)
3	Limited English
4	Substance users—drugs or alcohol
5	A history of sexual abuse
6	In an abusive relationship
7	History of depression
8	Previous/current antenatal or postnatal depression
9	Physically challenged
10	Mentally challenged
11	Single or newly separated
12	No transport
13	Lesbian
14	Young—<18 years
15	Mature—>40 years
16	Previous stillbirth or neonatal death
17	Three or more children
18	Home schooling
19	Accommodation issues (refuge etc)
20	Has high needs child or children

In 2005, 43 percent (209/486) of the women in the CMP were identified as having been in one or more of the target groups. The most common target group indicator was a history of depression (26 women); three or more children (18 women); and single or newly separated (15 women). There were few women who were identified as Aboriginal or Torres Strait Islander (4); from lower socio economic groups (8); or with limited English (4).

Despite almost half of CMP women in 2005 being identified as belonging to a target group, it is likely that the need is greater than the demand in the more vulnerable groups. The analysis

undertaken by KPMG[48] suggests that there is a significant unmet demand for the service. The Review Team heard from a number of stakeholders (midwives, consumers and others) that women are known to book in as soon as they find out they are pregnant. It is likely, therefore, that women from the most vulnerable and marginalised groups are unable to find a place on the CMP as the 'well informed' women have accessed the service first. A strong theme throughout the review consultations was that women from 'high needs' groups were unable to access the CMP.

On a number of occasions the Review Team was told about the typical 'Canberra women'. This was a well-informed, well-educated, generally older woman who had a clear understanding about the type of care she wanted and the way to ensure that her needs in this regard were met. The Review Team was told that 'Canberra women were different' in that they knew what they wanted and would seek this out. It is evident that many women from vulnerable or marginalised groups would not meet this image of a typical 'Canberra woman' and therefore often missed out on being accepted into the CMP due to a lack of places. The KPMG (2006) report recognised this, stating that *targeting those most vulnerable* should be a principle that guides service provision.

> ***Targeting those most vulnerable:*** Women who are identified as being particularly vulnerable during their pregnancy should be targeted for specific assistance in order to ensure they are supported and have the skills required to develop a positive relationship with their child.

8.2 Supporting normal birth or continuity of carer?

Initially, the CMPP was established for low-risk women only. This meant that the commitment to normal birth and physiology was strong. It is likely that the CMPP attracted women who were committed to normal birth. This emphasis on normal birth seems to have changed as women with risk factors have entered the program. Women with risk factors may not always be committed to normal birth and equally, the hospital policies and guidelines may not make a commitment to non-technical intervention (known as a physiological approach) and therefore, normal birth is difficult.

The continuity of midwifery carer remains a strong philosophy of the CMP. This commitment increased in recent years with the development of caseload models within the CMP and a flexible approach to rostering and workload. The annualised salary has also made it easier for midwives to provide continuity of carer. Research has demonstrated that continuity of carer provides midwives with the opportunity to develop 'meaningful

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[48] KMPG (2006). *ACT Health – Canberra Midwifery Program Demand Analysis*. ACT Government, Canberra

relationships' with women and this is an essential element of job satisfaction and as a strategy to avoid burnout.[49]

This does set up a philosophical tension—is the CMP about supporting normal birth or continuity of midwifery carer? While it is possible, and indeed preferable, to have both, there are situations where continuity of carer may not mean normal birth, especially if women with significant obstetric or medical risk factors are included. Women with these types of risk factors are still likely to benefit from continuity of carer in ways other than achieving normal birth, for example, through a sense of personal control, increased positive birthing experiences, and breastfeeding success.

This philosophical tension can set up scenarios where the woman and the midwives have different goals and needs. For example, the questions of choice versus safety for women can create conflict and a sense of 'failure' for either woman or midwife, or both, when intervention or transfer is required. This may be seen again when women are required to spend time in the postnatal unit and their expectations for continuity of carer may not be met. One interviewee stated that:

> 'Women feel let down when they go to postnatal. They [postnatal ward midwives] don't understand the women's needs and this makes the women protective of themselves and their babies.'
>
> 'Other women are used to the 'merry-go-round' but not CMP women.'

Once women with risk factors are included in a model such as the CMP, a proportion will require collaborative care in a labour-ward-type setting with access to technology. **This also requires a high level of collaboration between CMP and labour ward midwives and CMP midwives and obstetric staff.** While there is evidence that this occurs, there is also evidence that at times, relationships between all these groups are strained and non-productive.

At least one stakeholder interviewed during the review spoke of a vision to expand the basic premise of the CMP, that is, continuity of carer, into a more mainstream approach. If this occurred, there may be opportunities to have different models/group practices for different groups of women. For example, the low-risk 'birth centre' option that promotes normal birth; the high obstetric/medical risk model, and the high social and emotional risk group of women. While this may be possible, it is not always so simple to 'pigeon hole' women into such groups and considerable flexibility would be required.

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[49] Leap, N (2001). Caseload practice that works. *MIDIRS Midwifery Digest* 7(4): 416–418.
Sandall, J (1997). Midwives' burnout and continuity of care. *British Journal of Midwifery* 5(2): 106–111

The lack of clarity around what the CMP actually offers requires attention. However, it is clear that, whatever service is decided, the strong relationship the continuity-of-carer model fosters in the CMP must be central. A process to develop a mission statement or strategic direction may be one approach to identify the philosophy of the model and to use as a recruitment and retention strategy. It is possible that once the philosophy is clearer, some of these debates may be more easily resolved (see Recommendation 1).

Recommendation 16: Midwifery continuity of carer should continue to be a central tenet of the CMP with a capacity for flexible working processes.

8.3 TRUST

Trust has featured as a major philosophical concept throughout the review, and as a major issue. A model of trust has been developed using the concerns raised in the interviews to highlight the complexity of the problem and its pervasiveness through the relationships across ACT Health.

The Trust Model (Figure 1), which was adapted from work by Messina and Messina,[50] demonstrates the different levels of trust and distrust that individuals and groups can move through. Factors constantly influencing trust/distrust are: personality, gender, cultural and social background, and past history. It is not expected that people will remain only in one quadrant of the model throughout their experience in a system, but rather that they will find their level of trust and/or distrust dominates in one quadrant, depending on the issue at hand.

The two continua identified in the trust model move horizontally from belief to fact, and vertically from negative perception to positive perception. Where there is a negative perception based on belief, this is described as *unhealthy*. A negative perception held while in possession of the facts is described as *unhelpful*. A positive perception based only on belief is described as *potentially unwise,* whereas a positive perception based on fact is described as *healthy*.

For example, the CMP midwives had enormous trust in their colleagues within the CMP. They also trusted the women they provide a service for, and this appeared to be reciprocated. When it came to the way the CMP midwives viewed others in the organisation they tended to distrust them and believed that they were not supported or trusted by others, even though the Review Team found this was generally not the case.

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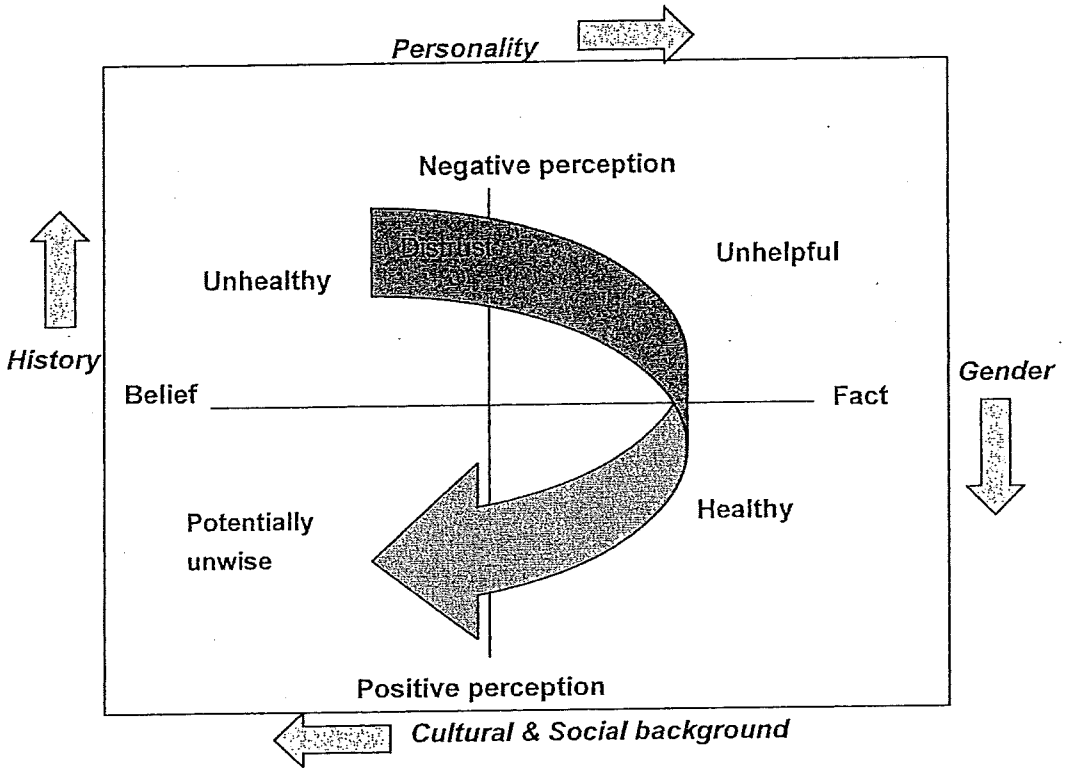
[50] Messina, J & Messina C (2006). *Tools for coping with life's stressors*. Retrieved 25 September 2006 from <http://www.coping.org/growth/trust.htm>

Figure 1: The Trust Model



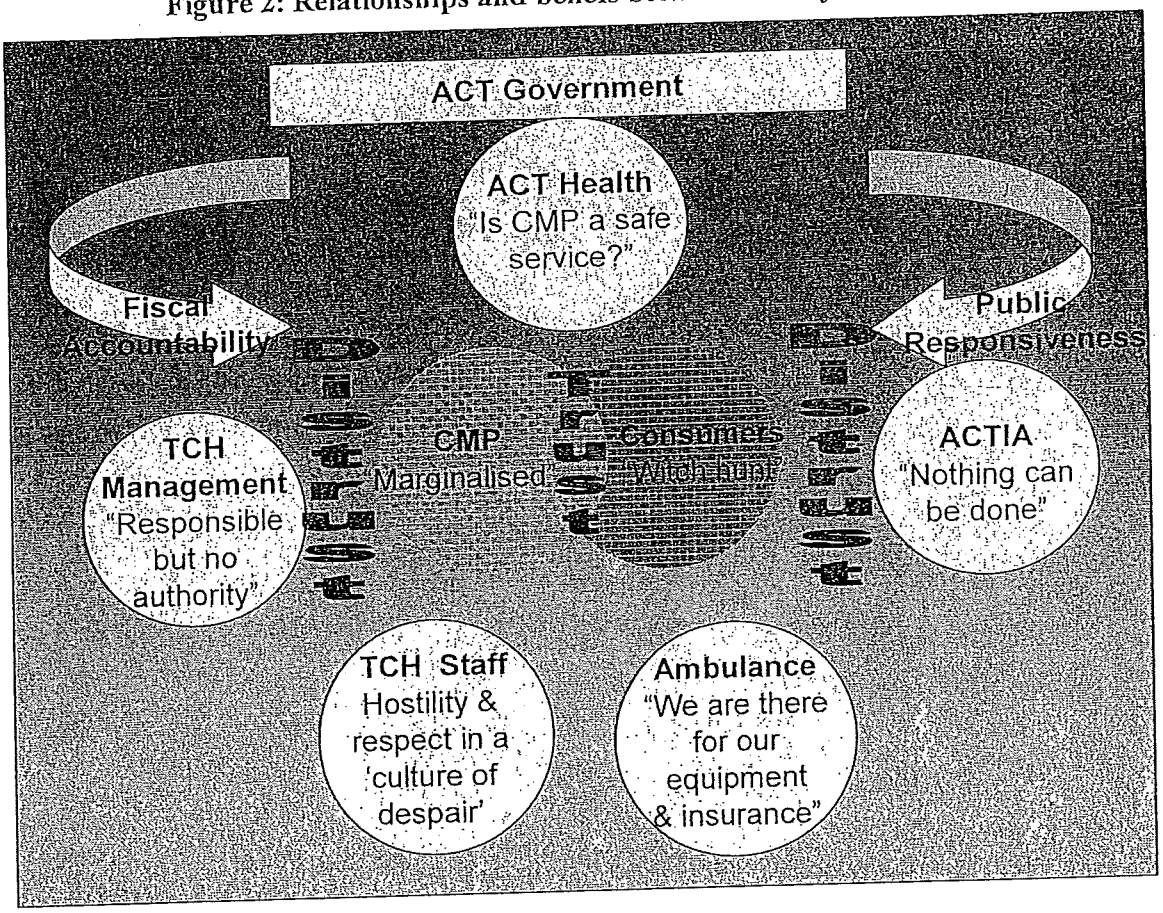
CMP midwives moved from a position of having a great deal of trust to a great deal of distrust, depending on the situation. Individuals or groups with negative perceptions combined with either facts or beliefs are more likely to experience distrust in their relationships with others and remain in the upper half of the model. An *unhealthy* level of distrust occurs when negative perceptions based on belief or opinion rather than on fact or reality, dominate.

Those who use facts to form opinions but do so in a negative way are more likely to be distrusting; this is *unhelpful* in facilitating healthy group or interpersonal relationships. Some of the doctors and midwives in the TCH delivery suite may have had less favourable perceptions of the CMP midwives based on the fact that they usually saw them when they transferred women to the delivery suite, often when there were complications.

Others in the delivery suite held positive views of the CMP midwives based on the fact that women were transferred to delivery suite appropriately and outcomes and satisfaction with the service were excellent. These people were more likely to trust and respect the CMP midwives, demonstrating a *healthy* attitude. As facts are perceived positively, individuals and groups are more likely to experience trust.

As facts give way to beliefs and are combined with a positive perception, this trust can become potentially *unwise*. This can lead to midwives and women pushing the boundaries of safety based on a strong belief that birth should be normal. The reviewers did not find evidence this was occurring. The reviewers found that on the whole those external to the CMP trusted the midwives and believed they offered a good service. It was also apparent the CMP midwives trusted each other and the women they provide a service for. The reviewers noted that the CMP midwives believed that they were not trusted or supported on the whole by others in and outside of the organisation (Figure 2). Communication and cultural development within the organisation as a whole needs to focus on building morale and trust and improving the level of positive feedback.

Figure 2: Relationships and beliefs between the key stakeholders



9. HOMEBIRTH

9.1 HISTORY OF HOMEBIRTH IN THE CMP

Prior to the late 1990s, homebirth was offered in the ACT through a number of independent practising midwives (IPM). The IPMs were accredited through the Australian College of Midwives and had professional indemnity insurance from the Guild insurance company. On 30 May 2002, Guild ceased insuring IPMs as the volume of demand was thought to be insufficient and therefore not viable. There was pressure at the time (and this has continued) for ACT Health to provide a homebirth option. Despite the pressure, ACTIA has continued to maintain that it is not possible to obtain reinsurance for homebirth and therefore publicly funded homebirth cannot be an option of care.

From January 2004 to June 2006 there have been 25 unplanned homebirths in the CMP. One additional woman was reviewed at home in labour, a severe antenatal haemorrhage (placental abruption) was diagnosed and she was transferred immediately to hospital. A summary of the cases and whether they adhered to the policy of the time is presented in *Section 5.8*.

9.1.1 TCH Guidelines

In 2001, a guideline/policy on unplanned homebirth was released.[51] This policy stated that 'the TCH does not currently support homebirth as a planned option for women in the CMP.' The guideline/policy outlined the process that should be undertaken if women indicate an interest in homebirth during the antenatal period. This includes reiterating that TCH does not offer homebirth and documenting all events and decisions. A revised policy developed in February 2005 was never endorsed and so is not included in the Review Team's analysis of cases against policy.

In November 2005, a revised version of the initial policy was endorsed and released.[52] This reiterated the initial policy but now stated that 'the TCH Canberra Midwifery Program **does not** provide a homebirth service'. This version included the need to call an ambulance in the event of a homebirth. The policy recognised that the midwife (if in attendance) would continue to provide care for the woman in the event of a homebirth even after the arrival of the ambulance as 'the most qualified person'. The 2005 policy stated the many notifications to be made in the event of a homebirth, including the obstetric register, CMP coordinator, and Director of Nursing and Midwifery, in addition to completing the incident monitoring forms (AIMS) and a notification to ACTIA.

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[51] TCH Maternity Practice Standards. Canberra Midwifery Program: Unplanned Homebirth (8.9). July 2001. File 820

[52] TCH Maternity Practice Standards. Canberra Midwifery Program: Homebirth (8.9). July 14, 2005 FINAL

Neither policy outlined the equipment that the midwife should/might carry in the event of a homebirth. Nonetheless, in late 2005, the midwives were instructed to stop carrying equipment to first-stage home visits (e.g. oxytocic drugs and neonatal resuscitation equipment) or baby bundles (which contain a blanket). It seems that this initiative was taken to further deter homebirths. It is possible that it was thought that if women knew midwives carried equipment, they would be more likely to pressure the midwives into attending the homebirth. When this was put to the midwives during the review, they were of the view that women generally were unaware of the nature or extent of equipment carried by midwives, and this had never seemed to be an encouragement or a deterrent. The Review Team identified the lack of equipment as a source of risk, discussed this with the Acting CEO, and wrote him a letter outlining their concerns.

The CMP midwives are diligent in reporting each homebirth through the incident monitoring system. The Review Team was advised by ACT Health senior management that the CMP is 'meticulous about reporting'. Women are now given a letter during pregnancy that states the CMP does not provide a homebirth service.

In the past 12 months, the ambulance officers have been called to unplanned homebirths even if there is no 'emergency' *per se*. The Ambulance Service is of the view that the only reason for this is for 'their professional indemnity cover'. This has led to difficulties for the ACT Ambulance Service, as its officers need to wait for the birth, often while sitting outside. With only seven ambulance vehicles in the ACT, tying up one car in this way is a problem. In addition, the blurred role of the ambulance officers and the midwives in these situations is difficult and unhelpful to all professional groups. Having made this point, the ambulance officer with whom the Review Team met both supported and respected the CMP midwives, but was clearly and understandably frustrated by the current situation.

9.1.2 Clinical Review Committee

In April 2005, the TCH Clinical Review Committee was asked to conduct a review into homebirth within the CMP for the calendar year 2004. The objective of the review was:

> To identify any significant adverse outcomes associated with The Canberra Hospital's Community Midwifery Program, to verify effectiveness of the CMP: Unplanned Homebirth Policy 8.9, and to identify any areas for improvement.

The records of 17 homebirths over a 12-month period (2004) were reviewed. The findings demonstrated that there were clearly some women who had 'planned' their homebirths (without or without knowledge of the midwives). The outcomes for the women and babies involved were mostly positive with some gaps in the current policy identified. The recommendations included:

- a review of the policy to ensure that it reflected the organisation's stance on homebirth;
- an education program and written information for women regarding homebirth;
- advice from the Government Solicitor in relation to formal agreement to be signed by women acknowledging the scope of the CMP;
- review of documentation and reporting systems;
- reporting the nine cases not previously reported to ACTIA; and
- consideration of alternative indemnity scheme for homebirths.

The policy was reviewed and a revised policy was released in November 2005. Written information for women was developed and is now provided to all women on the CMP, and the reporting of homebirths to ACTIA has been streamlined.

9.1.3 Consumer demand and choice issues

Women in the ACT have lobbied strongly for midwifery continuity of care and homebirth services since the late 1990s. Women have lobbied government, politicians, ACT health and the TCH in a variety of ways over the years. The issue of homebirth and the need for insurance has been raised in Question Time in the Legislative Assembly a number of times. In 2002, Mr Stanhope, the then Health Minister, expressed government support for insurance for midwives, saying:

> We have actively sought reinsurance cover to allow a home birthing system to be developed in the ACT. It has always been my desire and my intention to see homebirth as an option for women in the ACT.

In November 2005, the Minister of Health was again asked about the issue of insurance. He stated that:

> In relation to midwives employed by the public sector, at this stage the government's insurance policies do not cover regular homebirths that are aided by public sector midwives. We have protocols in place whereby homebirths can be conducted in an emergency by a public sector midwife but the standard protocol is that, wherever possible, the woman going into labour should seek to go to either the birthing centre or one of the public hospitals to be assisted by a midwife in that setting. We have insurance cover for those practices.[53]

53 Legislative Assembly for the ACT: 2005 *Week 14 Hansard (22 November)*. Page 4412. <www.hansard.act.gov.au/Hansard/2005/week14/4412.htm>

The Minster went on to say that:

> I have asked my department to do further work on other options to facilitate the option of homebirth for women in the ACT because I believe it is important that we do everything possible to give women that choice. If they want to and are able to give birth to their child or children in their own homes, that option should be open to them. I have asked my department to explore all possible avenues to facilitate that.

Of the 46 letters from consumers provided to the Review Team, six (13%) were in relation to a demand for homebirth. These letters are summarised in the Table below.

Table 7: Summary of consumer letters to TCH regarding homebirth

1	This woman had a history of short labours and unexpected births at home. She expressed distress over the possibility of unassisted homebirth or an induction of labour to ensure the birth took place in hospital.
2	This woman had previous births at home with an independent midwife at considerable cost. She wanted other women to be able to have publicly funded homebirth.
3	A woman with a precipitate labour with her second baby. She was in the CMP and the CMP midwife was called in the first stage of labour and was present at the birth at home, as was the Ambulance Service. Neither midwife nor Ambulance Service had Syntocinon or any other equipment.
4	This was written by the mother of a woman who had recently given birth. The writer was concerned about the pressure on the CMP midwives to avoid a homebirth. Knowing that the midwives were not able to provide support at a homebirth distressed this family.
5	This was written by a pregnant woman who was unable to book into the CMP and also wanted to be able to have the option of homebirth.
6	Another letter from a woman currently pregnant and in the CMP who also wanted to be able to have the option of homebirth.

9.2 Requirement for insurance under the ACT Nurses and Midwives Act

When the Review Team met with the President of the Nursing and Midwifery Board of the ACT, she immediately raised the issue of the requirement under the ACT regulatory legislation that midwives must declare their insurance status, regardless of whether they are

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employees or self-employed. In the future, this requirement for declaration will be included as an audit of competence.[54]

9.3 SAFETY OF HOMEBIRTH

The Cochrane Library's review of home versus hospital birth recognised that in some countries almost all births happen in hospital, whereas in others, homebirth is considered the first choice for healthy and otherwise low-risk women. The change to planned hospital birth for low-risk pregnant women in many countries during the last century was not supported by good evidence. Planned hospital birth may even increase unnecessary interventions and complications without any benefit for low-risk women. The review on homebirth in the Cochrane Library found only one small trial, which provided no strong evidence to favour either planned hospital birth or planned homebirth for low-risk pregnant women.[55]

A meta-analysis of six controlled observational studies of homebirth analysed the outcomes for 24,092 selected and primarily low-risk pregnant women in developed countries. The perinatal mortality for the homebirth group was not significantly different from the hospital birth group (OR=0.87, 95% CI 0.54–1.41). The principal difference in the outcome was a lower incidence of low Apgar scores (OR=0.55; 0.41–0.74) and a lower incidence of severe lacerations (OR=0.67; 0.54–0.83) in the homebirth group. Obstetric interventions were much less common in the homebirth group. No maternal deaths were observed in any of the studies.[56]

The most recent large prospective cohort study[57] studied the outcomes of 5418 women who had planned to give birth at home attended by a professional midwife. The intrapartum and neonatal mortality for low-risk women was 1.7 deaths per 1000, which was consistent with most other North American studies of intended births out of hospital and studies of low-risk hospital birth. The study concluded that: 'Planned home births for low risk women in high resource countries where midwifery is well integrated into the healthcare system are associated with similar safety to low risk hospital births' (page 1421).

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[54] Unable to find this information directly from the Nursing and Midwifery Board website as the professional midwifery services section of the document was currently under review.

[55] Olsen O, Jewell MD (2006) Home versus hospital birth. The Cochrane Database of Systematic Reviews Issue 3. *The Cochrane Collaboration*. Published by John Wiley & Sons, Ltd.

1.1.1.1 [56] Olson O (1996) *Oral presentation:* Meta-*analysis of observational studies: safety of home birth,* Adelaide 1996 O2.19 <http://www.cochrane.org/colloquia/abstracts/adelaide/ADELO219.htm> Accessed 5 October 2006

[57] Johnson KC, Daviss B-A (2005). Outcomes of planned home births with certified professional midwives: A large prospective study in North America. *BMJ*, 330:1416–1422

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Another recent study compared the outcomes of 862 planned homebirths attended by midwives with the outcomes of planned hospital births attended by either midwives (n =571) or physicians (n = 743) in Canada. Women in comparison groups were similar in their obstetric risk status and were from hospitals in which the midwives who were conducting the homebirths had hospital privileges. The results demonstrated no increased maternal or neonatal risk associated with planned homebirth under the care of a 'regulated' midwife. However the rates of some adverse outcomes were too low to draw statistical comparisons and the authors recommended ongoing evaluation of homebirth.[58]

In Australia, no large-scale prospective studies have investigated the efficacy of planned homebirths. A retrospective epidemiological study of 975 planned homebirths in Western Australian from 1981 to 1987 showed that for women at low risk of complications, homebirth was a safe and satisfying birth option.[59] Subsequent research with this cohort compared the 975 women who booked to have a homebirth with 2928 women who planned a hospital birth.[60] Women were matched on important demographic and physical characteristics. Women who planned a homebirth were less likely to have complications during pregnancy or labour but were more likely to have a postpartum haemorrhage (PPH) than women planning a hospital birth. The perinatal mortality rate was not significantly different between the two groups. Planned homebirths were generally associated with less intervention than hospital births and with less maternal and neonatal morbidity, with the exception of PPH. It is possible that the increased rate is to do with the definition of PPH (in terms of amount of blood loss) and reporting by midwives but may also be related to the higher use of physiological third-stage management techniques in planned births at home. A small retrospective review of 165 women who chose homebirth in regional Western Australia also showed favourable results with low intervention rates and few complications.[61]

A retrospective review of homebirths from 1976 to 1987 in South Australia showed that obstetric intervention rates were lower in women planning a homebirth compared with those planning a hospital birth, although again the rate of PPH seemed to be higher.[62] The perinatal mortality rate in this study was higher in women planning homebirth than in hospital-planned

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[58] Janssen PA, Lee SK, Ryan EM, Etches DJ, Farquharson DF, Peacock D, Klein MC (2002). Outcomes of planned home births versus planned hospital births after regulation of midwifery in British Columbia. *CMAJ Canadian Medical Association Journal.* 166(3):315–23

[59] Woodcock HC, Read AW, Moore DJ, Stanley FJ, Bower C (1990) Planned homebirths in Western Australia 1981–1987: a descriptive study. *Med J Aust* 153:672–8

[60] Woodcock HC, Read AW, Bower C (1994) A matched cohort study of planned home and hospital births in Western Australia 1981–1987. *Midwifery* 10:125–35

[61] Howe KA (1988) Home births in south-west Australia. *Med J Aust* 149:296–302

[62] Crotty M, Ramsay AT, Smart R, Chan A (1990) Planned homebirths in South Australia 1976–1987. *Med J Aust* 153:664–71

births. The authors' close examination of the individual deaths led to the conclusion that the majority of these deaths could not be directly attributed to the place of birth.

A retrospective review of 7002 homebirths in Australia from 1985 to 1990 concluded that homebirth was a safe option for women with no complications, but was inadvisable for women deemed to be at 'high risk'.[63] One of the key messages from this research was that: 'while homebirth for low risk women can compare favourably with hospital birth, high risk homebirth is inadvisable and experimental' (p 384).

9.4 UNPLANNED HOMEBIRTH VERSUS CAREFULLY PLANNED HOMEBIRTH

The best homebirth outcomes are likely when women are carefully screened and homebirth is planned. The recent policy statement from the NSW Health Department in relation to publicly funded homebirth services[64] has clear guidelines and recommendations to ensure the safety and quality of planned homebirth (Figure 3). The policy statement outlines risk minimisation strategies, including:

- having two clinicians (both credentialled or privileged) present at each birth at home;
- providing a minimum of two antenatal contacts in the home, at booking and 36 weeks;
- using the ACM National Midwifery Guidelines for Consultation and Referral; and; and
- having appropriate structures and processes that ensure there is a smooth transition between the levels of services as required.

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[63] Bastian H, Keirse MJ, Lancaster P (1998) Perinatal death associated with planned homebirth in Australia: population based study. *BMJ* 317:384–8

[64] NSW Health (2006). Policy Directive: Maternity – Public Homebirth Services (PD2006_045). <http://www.health.nsw.gov.au/policies/pd/2006/PD2006_045.html> Accessed September 2006

Figure 3: Recommendations from the NSW Health Homebirth Policy Statement[65]

Each Area Health Service should have local protocols/guidelines for:

1. Establishment of collaboration with health professionals practising homebirth in that Area.

This should include:

- Development and maintenance of a list of identified health professionals who practise homebirth.
- Involvement of health professionals practising homebirth in the development of a homebirth transition of care protocol.
- A designated liaison officer within each hospital, who will facilitate communication with homebirth health professionals.
- Inclusion of homebirth health professionals in ongoing education activities.
- A system to facilitate compliance with Infection Control Standards as required by the relevant Regulations (made under the Nurses Act 1991 and the Medical Practice Act 1992). For example, sterilisation of equipment using Area Health Services Sterile Services Department (SSD) facilities.
- It is acknowledged for this recommendation to be progressed, that Area Health Services need to establish the practice rights to be granted to visiting homebirth health professionals.

2. Transition of care from home to hospital.

Each hospital to have a current written protocol for homebirth transfer to hospital to encourage continuity of care. This protocol should incorporate the following:

- A system to encourage women planning a homebirth to book-in with a hospital of the woman's choice so that if in the event that hospital care is required, communication lines have been established.
- Provision for the homebirth health professional to arrange admission with an obstetrician or paediatrician, for mother or baby, where necessary.
- A positive environment for the woman and her family by encouraging an empathetic attitude from all staff.
- A framework that promotes collaboration, consultation and communication between all care providers, the woman and her family, acknowledging the

[65] ibid

professional responsibility, opinions and actions of both the medical officer and the homebirth health professional.

- Definition of the role of the homebirth health professional in the ongoing care in the hospital. A collaborative arrangement should be encouraged.
- Adoption of the National Health and Medical Research Council (NHMRC) Homebirth
- Guidelines for Parents when hospital transfer should occur.
- A system to link Aboriginal and Torres Strait Islander women where transfer occurs, to Aboriginal Health Liaison Officers, Aboriginal Health Education Officers or other staff that have experience working with Aboriginal women and communities.

The publicly funded homebirth model that has been established at St George Hospital in Sydney has careful screening and planning processes. There are guidelines for acceptance into the program and transfer to hospital if necessary, as well as consent forms for the woman and her support people to read and sign. These processes were part of the agreement with NSW Health's Treasury Managed Funds to ensure professional indemnity insurance. Figure 4 provides an example of the planning process that must be undertaken. Screening for suitability for homebirth uses the ACM National Midwifery Guidelines for Consultation and Referral (2004). An obstetric staff specialist reviews the antenatal records of all women requesting homebirth and acts as a referral source for the midwives. In addition, the care of each woman booked for a homebirth is reviewed during a case review process after she has given birth.

Figure 4: Process for women who are screened as suitable to give birth at home[66]

- Women requesting/booking a homebirth will be given the *Choosing to Give Birth at Home* information sheet at initial visit.
- Women will be requested to sign the appropriate consent form during her pregnancy prior to the home visit at 36 weeks gestation.
- The booking and caring for women requesting homebirth will be in accordance with ACM National Midwifery Guidelines for Consultation and Referral
- A RAP Obstetrician will review the medical records of all women requesting a homebirth.
- Antenatal care will be provided in the Birth Centre. Medical consultations will be provided in the hospital as necessary after discussion with the RAP Obstetrician.
- At 36 weeks gestation a home visit will be conducted with the woman's support people present in order to discuss and plan for the labour, birth and postnatal care. Support people will be asked to read the information sheet and sign a consent form.
- Intrapartum care will be provided in the woman's home unless transfer to hospital is required. At a homebirth, two midwives will be present.
- All midwives will carry a homebirth kit containing the appropriate equipment.
- When birth is imminent, or whenever appropriate, the back up midwife is requested to attend the home.
- After the birth the midwife will continue care until the conditions of mother and baby are stable. Observations will continue until a minimum of one hour after the passage of the placenta.
- The attending midwife will examine the newborn after the birth. If there are indications of abnormality the baby will be transferred immediately to St. George Hospital for neonatal assessment
- The midwife will visit the woman within 24 hours and postnatal care is planned in accordance with the woman's and baby's needs.
- The attending midwife will complete all relevant documentation.

[66] South Eastern Sydney and Illawarra Area Health Service (developed 2005, updated 2006). Homebirth Guideline. St George Hospital, Sydney. Accessed September 2006

9.5 BENCHMARKING HOMEBIRTH RATES WITH OTHER BIRTH CENTRES

The Review Team examined the incidence of unplanned homebirths in the CMP. There have been 25 unplanned homebirths in the period from January 2004 to June 2006. The review benchmarked the unplanned homebirth numbers in the CMP with other community midwife programs that do not offer homebirth.

The five programs to use as benchmarks for the CMP were determined by ACT Health and the Review Team. The programs were birth centres in metropolitan areas in Australia. The managers of the five birth centres were asked to provide data on babies born before arrival on the understanding that their identity would be anonymous. Three of the five birth centres provided their data (Table 8). None of the birth centres that provided data provide home visits by a midwife in the first stage of labour. It is difficult therefore to make direct comparisons, as the models are inherently different.

Table 8: Babies born before arrival (BBA) in Australian birth centres

Hospital	Year	BBA: Out of total annual birth centre births	%
TCH CMP[#]	2004	16:568	**2.8**
	2005	6:490	**1.2**
	2006 Jan–June	3:175	**1.7**
Birth Centre A*	2004	5:500	1
	2005	5:510	1
	2006 Jan–July	4:405	1
Birth Centre B*	2004	10:358	2.8
	2005	6:341	1.8
	2006 Jan–July	5:139	3.6
Birth Centre C*	2004–2005	8:300	2.7
	2005–2006	5:327	1.5

[#]Includes unplanned homebirths and BBAs

*All information supplied by birth centres on request

The mean BBA rate over the 2.5 years for the CMP was 2.0 percent. The mean BBA rate for the three other birth centres over a similar period of time was 1.6 percent. This benchmarking exercise demonstrates that the CMP rate is very similar to the rates reported by other birth centres in Australia. It may have been expected that the CMP would have a BBA rate that is

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higher than in other models because they offer first stage labour visits at home. However, this was not the case.

There will always be a percentage of babies BBA in hospital. A study in the UK[67] showed that the most common morbidity associated with being BBA was hypothermia. No cases of hypothermia were reported with the unplanned homebirths the Review Team examined. The sequale of hypothermia can have serious consequences for neonates and require admission to special care nursery. The high perinatal mortality rate observed in the study population was related to immaturity and low birth weight rather than to birth before arrival itself. Thus the attendance by a midwife at a precipitous birth, rather than creating increased risk or liability for the health service, may in fact reduce the risk due to appropriate management of both mother and baby. In this study, women who gave birth before arrival in hospital tended to be either inner city Asian multigravida women who lived a long way from hospital, or unmarried, unbooked younger white European women. A retrospective case-control study of 326 babies BBA in a Caribbean developing country found that BBA occurred significantly more often in Afro-Caribbean women compared to Indo-Caribbean women, in grand multiparous women, in women who had poor antenatal care, and in those who had a previous similar event.[68]

9.6 Unplanned homebirth: midwives' duty of care

The CMP midwives were clearly distressed with the position they felt they had been put in where they were unable to attend precipitous births at home. They said the nature of the CMP allocation of women to midwives meant that the midwives often lived near the women they cared for. They also cared for the women throughout their pregnancy and had a strong rapport with them. CMP midwives made the following comments:

> 'What do you do when a woman rings up and wants to push and you are a couple of minutes away?'
>
> 'What's best for women? This policy is about covering the risk for management. How is this safe?'
>
> 'It is unfair not to be able to go to a woman who is about to give birth and lives only three houses away.'

This position was made even more difficult when in late 2005, the midwives were instructed to stop carrying equipment to first-stage home visits (e.g. oxytocic drugs and neonatal

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[67] Boopalam PS, Watkinson M. (1991). Babies born before arrival at hospital. *British Journal of Obstetrics and Gynaecology* 98(1): 57–64

[68] Ramsewak A, Narayansingh G et al. (1997). Born before arrival (BBA) in Trinidad—a seven year case-control study. *Journal of Obstetrics and Gynecology* 17(3): 242–244

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resuscitation equipment). Midwives spoke of the trauma of 'driving away from their home or hospital and seeing the equipment left behind'.

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9.8 Mapping cases to homebirth policies

To assessing whether the pregnancy and birth was handled according to the policy in place at the time, the Review Team mapped each of the unplanned homebirth cases against the relevant policy in operation since 2004. The only two policies that have been used as references are *July 2001 File 820 Canberra Midwifery Program: unplanned homebirth* and *November 14 2005 File 8.9 Canberra Midwifery Program: homebirth*. The policy dated *February 2005 File 8.9 Midwifery Program: unplanned homebirth* has not been used because it is headed *Draft Only*. In addition, each case was checked against the AIMS

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register to see if it had been reported as an adverse event. Of the case notes received, those for patients 2, 8, 12 and 13 were either partially or significantly incomplete, thus no adequate conclusion could be drawn. Even when records are written up retrospectively, as was the case with many of these records, it is strongly recommended that care be taken to ensure a complete record is filed (see Recommendation 15).

The complete map of cases to policies is attached at Appendix F. Each dot point in the policy has been identified and numbered as a standard. In the July 2001 policy, there are 13 dot points under the heading *Standard*, therefore 13 standards were identified, and in the November 2005 there are 20 dot points in total, therefore 20 standards were identified.

When examining the cases chronologically, a clear trend can be seen in the practice of the midwives in relation to women who expressly requested homebirth. Up until about August 2004, it seems clear from the CMP midwives' notes that women were requesting homebirth and expecting that the CMP would provide it if they refused to attend hospital. The July 2001 policy states that 'TCH does not currently support homebirth as a planned option for women in the CMP'. However, the purpose of the policy is stated as being: 'To provide guidelines for safe practice for midwives in the event that labour progresses quickly and transfer to the Birth Centre is inappropriate or in the event a woman chooses not to be transferred to the Birth Centre to birth'. This statement of purpose suggests that it is expected that some women will refuse to attend hospital and thus sets out guidelines to ensure that in these circumstances the women birth safely at home. This is consistent with the views expressed by the then Minister for Health in November 2005 when he said:

> We have protocols in place whereby homebirths can be conducted in an emergency by a public sector midwife. We have insurance cover for those practices.[69]

In the case notes of patients 18, 20, 21, 22, 23 and 24, the midwives record quite explicitly that the women wanted a homebirth and that this had been discussed at some length. The notes record that for patients 18, 21 and 23 the midwives recorded that they informed the women of the TCH policy on homebirth. There is no record of such a discussion in the notes of patients 20, 22 and 24. What is evident from some of these earlier records is that the midwives are quite explicit in documenting their care and preparation for the birth at home when the women refused to attend the Birth Centre. Such openness in documentation does not suggest that the midwives believed they were acting contrary to policy and 'colluding' with the women to provide a clandestine service. It seems clear that they considered they were acting in accordance with the woman's choice 'not to be transferred to the Birth centre to birth' as stated in the purpose of the policy.

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69 Legislative Assembly for the ACT: 2005 *Week 14 Hansard (22 November)*. Page 4412. <www.hansard.act.gov.au/Hansard/2005/week14/4412.htm>

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Of the early cases reviewed, where homebirth was obviously still considered as an 'opt-out' position, patient 17 is of particular significance. The Maternity Card for this woman records that at 30+ weeks the midwife 'discussed staying at home as feeling no desire to birth in hospital—would do it on own if not (sic)'. This woman's other children were home schooled so she was obviously a person with strong lifestyle convictions. The midwife visited her at home in first stage of labour and the notes record that the midwife became concerned about her abdominal pain and suspected a concealed bleed. She discussed this with the woman who agreed to go to hospital. The woman was found to have a placental abruption and sadly lost her baby. However, if she had not agreed to go to hospital, the woman herself could have died. There is no doubt that it was the woman's faith in this midwife that made her agree to transfer to hospital so speedily as it was contrary to the location she had wished for her birth. The woman was asked by the midwife if she would have come in to hospital of her own accord and she said she would not have as she did not recognise anything was seriously wrong. In addition, in the records there is a note from the woman to the midwife asking if she would be her midwife again.

After August 2004 it is clear that the midwives became aware of the concerns of TCH and ACT Health management in relation to homebirth. Well before the policy actually changed, it is clear from the records that the midwives are telling all women who wish to discuss homebirth about the TCH policy and that many more of the unplanned homebirths are in fact precipitate births, referred to in datasets as BBAs—Babies Born before Arrival.

The attendance of CMP midwives at a precipitate birth can be of immense reassurance to the women. One woman submitted her story to the Review Team. She absolutely did not want to have her baby at home and tried to get to the hospital but had diarrhoea and could not leave the house. She wrote":

> I felt scared I would have the baby on the toilet as the urge to push got stronger...I felt relieved that everything would be alright once I heard my midwife's voice and was then able to relax a little.[70]

The policy introduced in November 2005 has been followed quite assiduously and it is obvious from the notes that **for all of the 2005/06 births reviewed under the new policy by the Review Team, there was no collusion on the part of the CMP midwives**

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[70] Submission by Lyndell McNevin 30 August 2006 *ACT Government enquiry (sic) concerning unplanned homebirths: The unplanned homebirth of Casey*

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APPENDIX A. REVIEW TEAM

Chair

Mary Chiarella

Professor of Clinical Practice Development and Policy Research

Faculty of Nursing, Midwifery and Health

University of Technology, Sydney

Members

Caroline Homer

Professor of Midwifery

Faculty of Nursing, Midwifery and Health

University of Technology Sydney

Hannah Dahlen

Clinical Midwifery Consultant

Sydney South Western Area Health Service

Patrice Hickey

Clinical Midwife Consultant

Western Health

Victoria

Reporting

To the ACT Health Portfolio Executive through a Steering Group of the Clinical Council Executive chaired by the Deputy Chief Executive, Mr M Cormack.

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APPENDIX B. SCHEDULE OF INTERVIEWS

Tuesday 15 August 2006

Time	Invitee	Title
0830–0930	Governance Meeting	
0930–1000	Mark Cormack	Acting Chief Executive ACT Health
1000–1030	Morning Tea	
1030–1130	Peter Matthews	General Manager, ACTIA
1130–1230	Wayne Ramsey	Director, Clinical Governance Unit
1230–1300	LUNCH	
1300–1330	Travel	
1330–1430	David Foot	ACT Ambulance Service meet at 123 Carruthers Street, Curtin, ACT, 2605
1430–1500	Travel	
1500–1530	Afternoon Tea	
1530–1600	John Mollett	General Manager TCH (meet @ TCH)
1600–1700	Joy Vickerstaff	Exec Director of Nursing & Midwifery TCH (meet @ TCH)

Wednesday 23 August 2006

Time	Invitee	Title
0830–0930	Alison Chandra	CMP Manager
0930–1030	Victoria Clare, Melissa Pearce, Gill Kruzins	North CMP TEAM
1030–1100	Morning Tea	

1100–1200	Dale Lilley and Roya Shamsi (line sharing), Gill Hall - PM, Young-Oak Wells and Arwa Hadid	Central MP TEAM
1200–1300	Leanne Meddemmen, Anne Maree Maher, Luise O'Reilly	South CMP TEAM
1300–1330	LUNCH	
1330–1430	Virginia Proust, Debbie Ellis, Fiona Snedden	Tuggeranong CMP TEAM
1430–1500	Jeanne McLauchlan / Robyn Blake	Acting CNC – Delivery Suite
1500–1530	Afternoon Tea	
1530–1600	Penny Maher	CNC – Postnatal Ward
1600–1630	Kaye Ranson	CNC – Centre for Newborn Care

Wednesday 30 August 2006

Time	Invitee	Title
0930–1030	Imogen Mitchell, Bobby Antoniou & Tracey Bessell	Clinical Review Committee
1030–1100	Morning Tea	
1100–1130	Dr Anne Sneddon	Medical Support for Canberra Midwifery Program
1130–1200	Dr David Knight	Acting Director Obstetrics & Gynaecology
1200–1300	David Ellwood	Assoc. Dean. Canberra Clinical School
1300–1330	LUNCH	
1330–1400	Graeme Reynolds	Director of Paediatrics and Child Health
1400–1500	Ingrid McKenzie	Maternity Coalition
1500–1530	Afternoon Tea	

Thursday 31 August 2006

Time	Invitee	Title
0830–0930	Vanessa Owen	Director of Nursing and Midwifery
0930–1030	Christine Fowler	CNC Antenatal Clinic
1030–1100		
1100–1130	Julie Nugent	Acting CNC – Antenatal Ward
1130–1230	Australian College of Midwives	ACM ACT Branch
1300–1330	Lunch	
1330–1430	Ms Mary Kirk.	President, ACT Nursing and Midwifery Board

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APPENDIX C. POLICY DIRECTIVE FOR HOMEBIRTH (NSW HEALTH) (PART 1)

Maternity -Public Homebirth Services

Document Number PD2006_045

Publication date 29-Jun-2006

Functional Sub group Clinical/ Patient Services -Maternity

Summary - This Policy Directive has been developed to reflect current evidence about the provision of homebirth. Area Health Services (AHSs), when providing public homebirth services, must comply with the standards set out in this document. Clinicians providing public homebirth services must be employees of, or have clinical privileges with, AHSs.

Replaces Doc. No. Homebirth Policy Statement [PD2005_176]

Author Branch Primary Health and Community Partnerships

Branch contact Ann Kinnear 9424 5891

Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, Public Health Units, Public Hospitals

Audience Maternity clinicians, obstetricians, midwives, GPs, paediatricians, neonatologists, emergency depts

Distributed to Public Health System, Divisions of General Practice, Government Medical Officers, Health Associations Unions, Health Professional Associations and Related Organisations, NSW Ambulance Service, NSW Department of Health, Public Health Units, Public Hospitals, Tertiary Education Institutes

Review date 29-Jun-2011

File No. 04/3435-5

Status Active
Director-General

Compliance with this policy directive is **mandatory**.

APPENDIX C HOMEBIRTH SERVICES OFFERED BY NSW HEALTH (PART 2)

This Policy Directive supersedes Policy Directive PD2005_176 (2000/53).

This Policy Directive should be read in association with the following documents:

- NSW Health 2000 The NSW Framework for Maternity Services, NSW Health Department
- NSW Health 2003 Models of Maternity Service Provision Across NSW, NSW Health Department
- NSW Health 1999 Framework for Managing the Quality of Health Services in NSW, NSW Health Department
- NSW Health 2002 Draft Supporting Families Early, *Families First* Health Home Visiting Guidelines, NSW Health Department
- NSW Government 2002 A Support Network for Families Raising Children, The Cabinet Office

1. Introduction

1.1. NSW Health recognises that the place of birth is a decision for women and their families and that a small number of women will choose to birth at home. It is recommended that AHSs make arrangements for the provision of a range of models of care, which may include public homebirth services. Public homebirth services, when provided, must comply with the standards set out in this document.

1.2. Until recently, the availability of homebirth services was restricted to the private sector, usually provided by an independent (private) midwife or medical practitioner[1].

1.3. Wherever the setting that birth takes place, safety is a priority and practitioners with the necessary knowledge, skills and attributes should attend women.

1.4. The *NSW Framework for Maternity Services*[2] (the Framework) is the current policy that forms the platform for maternity services across NSW. It promotes continuity of care and consistent information as essential aspects in the provision of care that is culturally sensitive and appropriate. Within the stated five-year goals of the Framework, the provision of publicly funded homebirth is supported.

1.5. *Models of Maternity Service Provision Across NSW'*[3] further articulates the models of care and level of services outlined in the Framework. It recommends AHSs further develop primary maternity services that are effectively linked and networked across secondary and tertiary levels of care.

1.6. NSW Health's first obligation is to provide women with models of care where the appropriate safety controls and processes for the local population needs are the first priority. This includes risk assessment, strict exclusion criteria, consultation and referral guidelines, networked arrangements providing appropriate obstetric support and transfer, credentialling of the midwives, clinical privileges for medical practitioners and rigorous evaluation of the models.

All women require timely access to appropriate levels of care. Service response is reliant on robust processes and systems. Collaborative networks within these systems rather than any one factor such as the geographical location of the service are critical.

1.7. Public homebirth services, when provided, must comply with the standards set out in this document. These standards are provided under the *Framework for Managing the Quality of Health Services in NSW*[4] and further developed in *Models of Maternity Service Provision across NSW'*. These standards are applicable to public homebirth services and are articulated under the following headings:

- Safety and risk minimisation;
- Continuity of care;
- Competence of the workforce;
- Information management to support effective decision making;
- Networked services;
- Education and training;
- Consumer participation; and
- Monitoring and evaluation.

2. Safety and Risk Minimisation

2.1. The focus of primary health care is to provide local services that are developed with the local community taking into consideration their unique context. When developing homebirth services, AHSs must include a risk assessment methodology that identifies the necessary processes, training and guidelines to

minimise harm and maximise client safety.

2.2. Risk assessment should always include consideration of local issues such as travel to the nearest maternity unit (Role delineated Level 3 and above) and the size of the caseload.

2.3. Clinicians providing homebirth services are required to comply with all incident reporting requirements of NSW Health.

2.4. Two clinicians (both credentialled or privileged) are required to be present at each birth at home. Student midwives/medical students under supervision may also attend with the prior consent of the woman and her family.

2.5. Guidelines for occupational health and safety issues are provided elsewhere by NSW Health.

3. Continuity of Care

3.1. Continuity of care is defined as the provision of care throughout the antenatal, intrapartum and postnatal periods.

3.2. Existing continuity of care models could be extended to incorporate homebirth services.

3.3. Area Health Services are to provide the appropriate structures and processes that ensure there is a smooth transition between the levels of services as required.

3.4. It is recommended that the primary clinician provides postnatal care in the community for a minimum of fourteen days but not exceeding six weeks post partum. This clinician is responsible for:

Arranging care according to the woman's needs

Liaising with local community services where appropriate

Ensuring a smooth transition from maternity services to child and family health services

Early and effective engagement with child and family health nursing services in the care of families requiring additional support. This should commence in the antenatal period as per the Families First Initiative

3.5. It is advisable to provide a minimum of two antenatal contacts in the home – i.e. booking and 36 weeks. Other contacts will be arranged between the woman and clinician according to individual circumstances.

3.6 It is acknowledged that the woman may decide to change her planned place to birth. In this event, AHSs are required to provide a smooth transition to accommodate this need.

4 Competence of the Workforce

4.1 Medical practitioners providing homebirth services will have clinical privileges delineated according to NSW Health Policy Directive[7].

4.2 All midwives providing home birth services will be credentialled according to the NSW Health Credentialling policy directive.

5 Information management to support effective decision making

5.1. Women and their families have a right to sufficient and appropriate information necessary for making an informed choice regarding the option of homebirth.

5.2. Access to the service will be determined utilising the *Australian College of Midwives Inc. National Midwifery Guidelines for Consultation and Referral*[9].

5.3. Clinical information will be managed and reported in accordance with existing requirements in the NSW public health system.

5.4. Clinicians are required to comply with the reporting requirements of the Midwives Data Collection (MDC).

5.1 The records that women hold should contain comprehensive, contemporaneous clinical information to maximise communication between health professionals.

6 Networked Services

6.1. All maternity, neonatal and community health services must maintain effective linkages and networks across primary, secondary and tertiary levels of care, focusing on prevention, early recognition of risk, timely referral, consultation and clinical effectiveness. Collaboration between all health workers at all levels is a critical factor in ensuring safe services.

6.2. The clinician must register women with their local maternity unit following their booking appointment.

6.3. AHSs may make arrangements for pathology and pharmaceutical services through local hospital services.

6.4. Examination of the newborn is to be negotiated locally and could involve local General Practitioners, paediatricians or appropriately trained midwives.

6.5. Access to the State-wide Infant Screening Hearing Program (SWISH) services is to be arranged with the local SWISH team.

6.6. AHSs must include discussions with local ambulance, paramedic services and the NSW Newborn and Paediatric Emergency Transport Service (NETS) when planning and implementing local public homebirth services.

7. Education and Training

7.1. All midwives working in midwifery managed primary maternity services including public homebirth services must be credentialled as per the policy directive PD2005_615.

7.2. Mandatory education about domestic violence and child protection must be available as per the NSW Health Policy Directive *Identifying and Responding to Domestic Violence* and Child Protection legislation.

8. Consumer Participation

8.1. Liaison with local consumers is essential at all stages of implementation and ongoing evaluation.

8.2. AHSs are encouraged to provide information and develop education strategies to inform and educate pregnant women, the community, clinicians, allied health staff and health services about the availability and safety of home birth for women with uncomplicated pregnancies.

9. Monitoring and Evaluation

9.1. The introduction of new models of maternity care must include comprehensive evaluation.

9.2. Components of data collection for ongoing monitoring and evaluation purposes should include:

- Clinical maternal and neonatal outcomes
- Costs associated with the provision of the model
- Women's experience of care during pregnancy, birth and the postnatal period
- Staff satisfaction including retention rates of clinicians working in this model of care
- Transfer rates

9.3 Reporting will include an analysis of incidents reported through the Safety Improvement Program.

Robyn Kruk

Director-General

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APPENDIX D. EXAMPLE OF A PROGRAM FOR PERINEAL SUTURING EDUCATION

SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

PERINEAL CARE

&

REPAIR WORKSHOP

FOR

MIDWIVES

Created by Hannah Dahlen

Insert appropriate graphic

SYDNEY SOUTH WESTERN AREA HEALTH SERVICE (EASTERN SECTOR)
WOMEN'S & CHILDREN'S HEALTH

Midwives are expected to be able to provide women with advice regarding perineal care and to undertake perineal repair. This falls within the scope of practice for a midwife (ICM 2005). Midwives can gain a higher level of satisfaction when they are responsible for total care during the intrapartum period. Women appreciate being sutured by the same professional who assisted with the birth (Ho, 1985; Sullivan, 1991; Hulme & Greenshields, 1993). Benefits include decreased waiting times, continuity of care, empathy and good information regarding expected outcomes and care of the perineum.

The skill of the operator is important in ensuring appropriate perineal repair. Draper & Newell (1996) studied in-depth the consequences and outcomes of midwifery management of perineal trauma and found that the skill of the operator was most important for a successful repair, if not more important than the method chosen or the material used (Grant, 1989; Sleep, 1984).

The perineal care and repair workshop forms an important part of the perineal care and repair accreditation program that midwives can undertake

The workshop builds on midwives' knowledge and experiences in perineal care and repair. It enables them to discuss, learn and apply knowledge in a practical way before they commence perineal repair

The workshop aims to equip midwives with the ability to give evidence based advice regarding perineal care and to be able to perform perineal repairs in a safe and accountable manner.

The workshop will run over four hours and needs to be undertaken before midwives begin perineal repair.

All midwives working with childbearing women who want to enhance their skills in perineal care and obtain accreditation to undertake perineal repair should attend this workshop. This workshop can also be very useful for student midwives wanting to obtain more information and hands on experience in this area.

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The workshop is the first important step in the perineal repair accreditation program. Other parts of the program leading to accreditation include:

- completing a workbook provided during the workshop
- performing five perineal repairs under supervision
- performing a further two repairs without supervision that are then assessed
- inspecting all seven repairs in the days following the repair, as is possible
- completing a clinical assessment of skills which is signed by the appropriate supervisor

At the end of the workshop participants should be able to:

- Discuss the importance of perineal care and repair and the midwife's role
- Understand factors that assist with the prevention of perineal trauma during childbirth
- Identify the anatomical layers of the perineum requiring repair
- Be cognisant of the properties, effects and safe use of local anaesthetic
- Be aware of the advantages and disadvantages of different suture material and suture needles
- Be competent in the use of instruments required for the procedure
- Be competent in various suturing techniques required for perineal repair
- Demonstrate the application of infection control principles in repair of the perineum
- Demonstrate an understanding of the midwifery responsibilities associated with performing perineal repair
- Have an understanding of best practice with regards to postpartum perineal care
- Have an understanding of the available evidence to inform practise

The perineal care and repair workshop will be a combination of discussions, lectures, group work, video and hands on practical sessions. It is expected that the participants have read widely, are able to discuss research and have a basic understanding of research methods.

A selection of readings will be handed out during the workshop that the participants can use to inform them further and assist in completing the workbook.

Insert names and details of workshop leaders

A. DISCUSSION OF GROUP BELIEFS AND AIMS

- Reasons midwives should have expertise in perineal care and repair
- Scope of practice of a midwife

B. OVERVIEW OF STATISTICS

- National and international data on incidences of perineal trauma

C. DEFINITIONS

- Degrees of trauma
- Spontaneous and intentional perineal trauma

D. ANATOMY AND PHYSIOLOGY

- External genitalia
- Pelvic floor
- Deep and superficial muscles
- Perineal body

E. FACTORS INFLUENCING PREVALENCE/DEGREE OF PERINEAL TRAUMA

- Maternal and fetal factors contributing to perineal trauma
- Methods for perineal preservation
- Factors leading to increased perineal trauma

F. INFECTION CONTROL AND OCCUPATIONAL HEALTH AND SAFETY

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- Asepsis, eye protection, double gloving
- Vaginal packs

G. PRODUCTS USED IN PERINEAL REPAIR

- Local anaesthetic
- Suture material
- Needle type

H. SUTURE TECHNIQUE

- Using different techniques
- Suturing different types of trauma (vaginal, labial, perineal)

I. PROFESSIONAL ISSUES

- Documentation
- Auditing and updating

J. SPECIAL CONSIDERATIONS

- Female genital mutilation
- Severe perineal trauma

K. POSTNATAL ISSUES

- Maternal morbidity following perineal trauma
- Postnatal care

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APPENDIX E. EXAMPLE OF INFORMATION FOR WOMEN ABOUT MANAGEMENT OF THIRD STAGE

RPA WOMEN & BABIES: BIRTH CENTRE

Third Stage Information Sheet

The third stage of labour is the period of time from the birth of the baby to the delivery of the placenta.

Physiological Third Stage

RPA Birth Centre has always offered women the option of third stage occurring spontaneously, also known as a physiological third stage. This involves leaving the baby attached to the umbilical cord until it ceases pulsating and separates from the uterus spontaneously. The placenta is then expelled with minimal assistance, usually involving a few pushes by the mother. In this situation, the natural process of the third stage occurs without interference. A physiological third stage will usually be complete within 20 to 30 minutes of the birth of the baby.

Active Third Stage

An active third stage involves clamping and cutting the umbilical cord within a few moments of the birth of the baby, and an injection of Syntocinon is given into the mother's thigh. Some gentle traction is then applied to the umbilical cord when signs of separation of the placenta from the uterus are apparent, and the placenta is expelled with minimal effort required of the mother. An active third stage will usually be complete within 5 to 10 minutes of the birth of the baby.

These two methods should not be mixed.

The research indicates that the incidence of post-partum haemorrhage (excessive blood loss after the birth) is significantly reduced if an active third stage occurs. This includes women who are considered to be at a low risk of post-partum haemorrhage. It is important that women are aware of the information available and, when it is appropriate, base their decision to have a physiological third stage with the evidence in mind. It is also important that if you choose a physiological third stage you are aware that circumstances may occur where the midwife advises that an active third stage is more appropriate than a physiological third stage.

These include:

- When the baby requires resuscitation, and the umbilical cord has to be clamped and cut for this reason
- Prolonged second (pushing) stage

- Irregular contractions in second stage
- Excessive blood loss after the birth of the baby
- Cord blood donation
- Previous post-partum haemorrhage
- Prolonged third stage duration >1 hour
- A particularly long or a very rapid labour.

You can discuss this information with any Birth Centre midwife

JULY 2005

APPENDIX F: COMPLETE MAP OF CASES TO POLICIES

Case	Birth date	Planned or unplanned	Handled according to policy*
1	25.6.05	Unplanned—by both mother and midwife	No conversation antenatally as HB was neither planned nor contemplated so S1–S5 irrelevant S6 missing i.e. not documented S7–13 completed Incident number 42564
2	8.6.06	Unplanned: the woman self-referred with SROM. They were preparing to go to BC—bags in the car. The midwife was obviously nervous about the possibility of the birth at home.	Because this was clearly not a planned HB dot points 1–7 under planned HB not relevant Dot points 8 and 9 not relevant Midwife in attendance DP15 irrelevant DP 10–20 completed AIMS Incident forms only available until April 2006 so unable to give AIMS number

Case	Birth date	Planned or unplanned	Handled according to policy*
3	14.9.05	Definitely unplanned—'concerned about birth at home' Would come to BC when child minder arrived	Although an unplanned HB, given the previous obstetric history standards S3–S13, excluding S6, were all met. AIMS incident number 45881.
4	12.10.05	Definitely unplanned; the woman's last baby was admitted to the special care nursery. She wanted to have this baby in hospital	See letter for policy questions too. S1–S13, excluding S6, all met AIMS report 44856.
5	22.1.06	Unplanned—no expectation of precipitate labour	Dot points 1–7 not relevant as definitely an unplanned HB. Dot points 8–9 irrelevant as RM present. ? DP 11, DP 16. DP 10 yes DP 14, 15 irrelevant AIMS report not available in our records

Case	Birth date	Planned or unplanned	Handled according to policy*
6	1.5.05		NB: In between policies at this stage 'confusion regarding new policy over unplanned homebirth' S1, S2, S3, S4 all met, S5 & S6 irrelevant S7–S13 all met AIMS Report 41323
7	11.1.05	Unplanned—called for ambulance	No A/N notes so not possible to assess S1–4 S5, S6 irrelevant S7 yes S8 ?? S9–S13 AIMS Report 38844

Case	Birth date	Planned or unplanned	Handled according to policy*
8	31.12.04	Planned—by woman, Absolutely not planned by RM Unable to obtain IPM over Christmas and New Year Ultimately woman did not intend to labour in hospital—midwives placed in an extremely unpleasant position—to support woman or leave her untended	Pre 2005 policy ? change to legislation? S1–S4 met S5 not met S7 met S8 unclear S9 met S10 met S11 met S12 N/A S13 AIMS report 37860

Case	Birth date	Planned or unplanned	Handled according to policy*
9	14.12.04	Unplanned	S1–S4 N/A S5, S6 missing S7 met S8 unsure S9–S13 met AIMS report 37712
10	20.8.04	Planned by woman	S1–S4 met S6 met S7–S13 met (S12 N/A) AIMS 35618
11	3.6.04	Unplanned—agreed to meet at BC—rang back to say baby born	S1–S9 N/A S10 met S11–S13 AIMS Report 29725

Case	Birth date	Planned or unplanned	Handled according to policy*
12	24.6.04	Unplanned—thinking about going to BC but contractions kept going off Probably was planned by mother as birth pool already set up.	S1–S4 missing S5, S6 unmet S7 met S8 not met S9 met S10 no S11 met S12 no S13 AIMS report 30648
13	13.6.04	Wanted HB—planned HB—came in to hospital at RM's request	See letter S1 met S2, S3, S4 ? S5–S13 N/A AIMS report 29727

Case	Birth date	Planned or unplanned	Handled according to policy*
14	6.6.04	No pretence of going to BC. This was a planned HB	S1 – met S2–S5 unmet S7 partly S8 no S9 yes S10–S12 no S13 yes AIMS Report 30119
15	1.6.04	This was a precipitate labour despite the planning	S1–S4 not met S5 N/A S6 no S7–S13 met S10 N/A AIMS Report 29050

Case	Birth date	Planned or unplanned	Handled according to policy*
16	23.5.04	Planned	S1–S3 not met S5 & S6 no S7 yes S8–N/A S9 met S10 N/A S11 met S12 N/A S13 AIMS report not completed

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Case	Birth date	Planned or unplanned	Handled according to policy*
17	9.4.04	Discussed place of birth. Wants to stay at home—is aware of TCH policy. Planned by woman and probably midwife too.	S1 met S2–S3 not met S4–S7 yes S8 N/A S9 yes S10 N/A S11 yes S12 N/A S13 no

Case	Birth date	Planned or unplanned	Handled according to policy*
18	26.0304		S1–S3 not met S4–S5 yes S7 yes S8 N/A S9 yes S10 N/A S11 yes S12 N/A S13 no

Case	Birth date	Planned or unplanned	Handled according to policy*
19	13.3.04	Woman's planned HB but very fast after RM arrived. Clearly did not want a VE, etc.—RM kept away until labour well established	S1–S3 met S4–S5 yes S6 not met S7 met S8 N/A S9 yes S10 N/A S11 met S12 N/A S13 no

Case	Birth date	Planned or unplanned	Handled according to policy*
20	26.2.04	Seems to be planned homebirth	S1–S6 not met S7 yes S8 N/A S9 yes S10 N/A S11 yes S12 N/A S13 no

Note: Cases 2, 8, 12, 13—inadequate documentation available

* NB: In terms of assessing whether or not the pregnancy and birth was handled according to the policy in place at the time, the only 2 policies that have been used as reference are July 2001 File 820 Canberra Midwifery Program: unplanned homebirth and November 14 2005 File 8.9 Canberra Midwifery Program: Homebirth. The Policy dated February 2005 file 8.9 Midwifery Program: unplanned homebirth has not been used as a comparator because it is headed Draft Only: