Queensland Rural and Remote Maternity Services Planning Framework

A toolkit for collaboration, consultation and co-design

May 2022
Version 2.13

Version Control

Version	Date	Notes
1	August 2019	Draft version for trial sites
2	April 2021	Updated based on feedback
2.13	May 2022	Hyperlinks and references reviewed and updated

Review date: April 2026

Disclaimer:

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About this Framework

The *Queensland Rural and Remote Maternity Services Planning Framework, a tool for collaboration, consultation and co-design* is a resource to support Hospital and Health Services (HHSs) provide comprehensive, woman-centred approaches to maternity service planning. Its purpose is to help with the review, assessment and co-design of maternity services.

Whilst the focus is on rural and remote maternity services, the framework can be used in the review and planning of any maternity service irrespective of population size.

The Framework was initially developed by the Queensland Rural Maternity Taskforce.[1] It is informed by evidence review, analysis of maternity services data, and consultation with rural and remote women, communities and service providers. Feedback from multiple stakeholders including HHSs and divisions within the Department of Health have been incorporated to produce the final version.

The Framework is intended to complement existing organisational and workforce-specific policies and guidelines such as the health service planning tools, workforce planning tools, and the Maternity Services Decision Making Framework (DMF).

It is recommended the Framework is read in conjunction with the Rural Maternity Taskforce Report, as it provides information on the factors that affect access to and safety of maternity services, and an overview of the issues, concerns, and expectations of stakeholders in rural and remote communities.

For ease of reading, the term 'rural' is used throughout the Framework to encompass rural, remote locations and discrete Indigenous communities [2, i]

Why do we need a Framework?

The purpose of planning is to ensure maternity services meet the needs of women and are safe and sustainable.

Maternity care encompasses the following stages:

- preconception
- antenatal (from conception to before onset of labour)
- intrapartum (from onset of labour through to birth of the placenta)
- postnatal care (generally up to six weeks after birth) for women and babies.[ii]

It is recognised that high quality maternity care is provided in many rural communities, however many women who live in rural and remote areas have difficulty accessing their preferred models of care. This is especially so for those women who live a great distance from urban centres.

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[i] A discrete Indigenous community refers to a geographic location, bounded by physical or cadastral (legal) boundaries, and inhabited or intended to be inhabited by predominantly Indigenous people, with housing or infrastructure that is either owned or managed on a community basis.(Australian Institute of Health and Welfare)

[ii] Postnatal care can extend beyond six weeks for women and babies with ongoing postnatal care needs.

The issues of providing maternity services in rural and remote areas of Queensland include[iii,1]:

- Women in rural areas are less likely to receive antenatal and postnatal care.

- Women in rural areas are more likely to have health risks in pregnancy that increase the likelihood of complications.

- People whose care needs are more complex need to access appropriate care, with larger centres providing specialty services.

- Rural health services do not have specialist workforce or equipment required to provide more complex care.

- First Nations maternity care complexities, such as intergenerational trauma, family disruption and loss of culture through colonisation and the Stolen Generation.

- Women who need to travel greater than an hour for the birth of their baby may have increased risk of giving birth before they arrive at the birthing facility. This is referred to as 'born before arrival' (BBA).

The challenge for maternity service planners is to support the delivery of maternity care as close to home as possible, while having in place robust systems to enable access to specialised maternity care for those women who need it.

A shared approach to planning

The Framework proposes a flexible, collaborative approach to rural maternity services planning for women and other stakeholders. All stakeholders are engaged from the beginning of the planning process and throughout review, assessment and service design phases.

This Framework describes an approach to the two phases of the planning process:

Phase 1: Reviewing existing rural maternity services.

Phase 2: Designing (or re-designing) rural maternity services to better meet women's needs.

A Gantt chart is provided in Appendix 4 Appendix 4 – Templates and examples that outlines the suggested activities and approximate timeframes for the review and planning process.

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iii For more information see *Rural Maternity Taskforce Report* (2019), Section 6.2 'Comparison of perinatal outcomes in Queensland for women who live in rural and remote areas with those in urban areas' https://clinicalexcellence.qld.gov.au/priority-areas/patient-experience/maternity-service-improvement/rural-maternity

Planning maternity services

Assessing, reviewing and planning maternity services is vital to ensure that the services are safe, sustainable and meet the needs of the women who use them, regardless of where they live. Good maternity service design starts with reviewing and assessing current maternity services in partnership with stakeholders, including past, present and future users of the health services.

Assessing maternity services requires a thorough review of how adequately women's needs are being met by both:

- individual services
- the service network[iv] as a whole.

Assessment also enables planners to predict changes in demographics and workforce that are likely to impact maternity service availability and scope.

Robust planning processes for maternity services will ensure continued excellent maternity outcomes for women, their babies and their families.

Good maternity services are co-designed in a process that engages **women, their partners, families, communities and local clinicians** from the start of the process. The process involves stakeholders in analysing needs and resource information, generating solutions, working in partnership with management during implementation, monitoring and evaluation, and communicating back to stakeholders.

The following aim, objectives and principles underpin good maternity services planning by HHSs in Queensland.

Aim

- To provide high-quality, woman-centred maternity care.

Objectives

1. Women know their maternity care options and how to access their preferred options.
2. Women access maternity care that meets the cultural needs for themselves, their partners, families and communities.
3. Women access comprehensive care, from preconception to postnatal phases[v].
4. Women access care from a well-trained, well-supported workforce.
5. Women who travel to receive some or all of their maternity care access clinical, social, emotional and financial support for themselves and their partners and families.
6. All public hospitals are equipped and supported to care for women whose birth is unplanned or imminent.

[iv] Service networks will vary depending on a number of factors, which include the types of services and models of care available and location. They can be within the HHS or include other HHSs or external organisations e.g. private care providers or non-government organisations.

[v] Including maternal and early child health needs

Principles

High-quality safe, collaborative, respectful and equitable maternity care incorporates the design principles of the woman having access to:

- continuity of carer
- individualised, woman-centred care
- evidence-based care
- planned births as close to home as possible.

Detailed information on the values and principles that apply to maternity services in Australia is available in '*Woman-centred care. Strategic directions for Australian maternity services*' (Australian Government 2019).[3]

Planning maternity care for First Nations communities

This framework provides a foundation for planning maternity services for First Nations communities. However, there are unique geographical and cultural considerations when delivering maternity care in First Nations communities, particularly in remote communities that require additional consideration by planners.

Resources are available which are designed to support health professionals in developing services that are responsive to the cultural needs of First Nations Queenslanders.[4,5]

Give special consideration to how you will tailor your planning approach for First Nations communities. Draw upon the expertise of community members and local service providers who understand local cultural values.

Models of maternity care

There are broadly 11 models of maternity care that have been defined for the Australian health system[6] (Appendix 1). These definitions do not reflect all the ways in which maternity care is delivered in rural communities but are useful for planning.

Women want to know about their maternity service options and how to access them, even though their preferred option may not be available in their local community. The 11 models of maternity care provide a basis to compare what services are currently available locally with what services could be made available.

Comprehensive maternity service planning should consider during the consultation phase how women can access the models of care they desire, even if they are not available locally. Rural and remote maternity services and Aboriginal and Torres Strait Islander Community-Controlled Health Organisations (A&TSICCHO) may include features of one or more of the 11 models of maternity care to deliver services.

Linkages and communication between services

Health services usually configure their maternity services as a network of providers, from least specialised to most specialised.

You may want to design or redesign maternity services in one community. However, you need to understand your whole HHS maternity services network to do this.

That is because linkages between services are important. To be successful, service networks rely on effective communication and information sharing, protocols and clinical pathways, and inter-professional relationships.

These linkages should have a mutual exchange of information in all communication, including feedback of advice or transfer processes that involve the woman or her baby. This should include information from both the primary and specialised maternity sites' experiences.

Frequency of review and assessment

Rural maternity service planning is an iterative process so reviews should be planned and regular. There is no set frequency with which rural maternity services should be reviewed.

However, HHS planners may need to review maternity service configuration and scope in rural settings more frequently than in urban settings because small changes in workforce availability can have major impacts on service continuity.

Phase 1:
Reviewing current rural maternity services

Before undertaking the review of a maternity service there are three key activities that need to occur. These are:

1. **Determine scope, process, approach, expectations**
2. **Establish governance and appoint a steering committee**
3. **Develop a stakeholder engagement and consultation plan**

Appendix 3 provides links to project management resources that can support this process and Appendix 4 provides templates and draft documents e.g. Terms of reference.

1.1. Determine scope, process, approach, expectations

First and foremost, establish the scope of the review and planning process. Confirm with the HHS executive their expectations and discuss the process, approach and level of support required. Refer to the HHS service plan, HHS strategic plan and inform the Hospital and Health Board the review is being undertaken.

1.2. Establish governance and steering committee

Establish the governance of the steering committee, with a clear executive sponsor and a clear decision-making pathway.

Identify steering committee members. They will guide the approach to overseeing the review and planning of the maternity service. The membership may likely comprise, but is not limited to, representation of:

- Consumer with recent lived experience of the local services e.g. within the past two years
- First Nations representation, e.g. consumer and/or healthcare worker
  - □ For cultural safety, it may be preferable to have a sub-committee of First Nations stakeholders with a representative reporting to the steering committee
- Community (including Elders, A&TSICCHOs, community leaders, women's groups or men's groups - to be determined by that community[7], and representation of any specific cultural groups identified in the local population)
- Clinicians e.g. midwife, General Practitioner (GP) obstetrician
- HHS executive
- Facility management
- HHS planning officer
- Primary Healthcare Network (PHN).

The frequency of meetings will be determined by the activities being progressed e.g. the steering committee may need to meet fortnightly during the review process.

1.3. Engagement with stakeholders

The health service must engage with stakeholders from the beginning of the planning process (Figure 1[8]). Stakeholders will guide the design of maternity services, review relevant data and information, and provide feedback and evidence as the planning progresses.
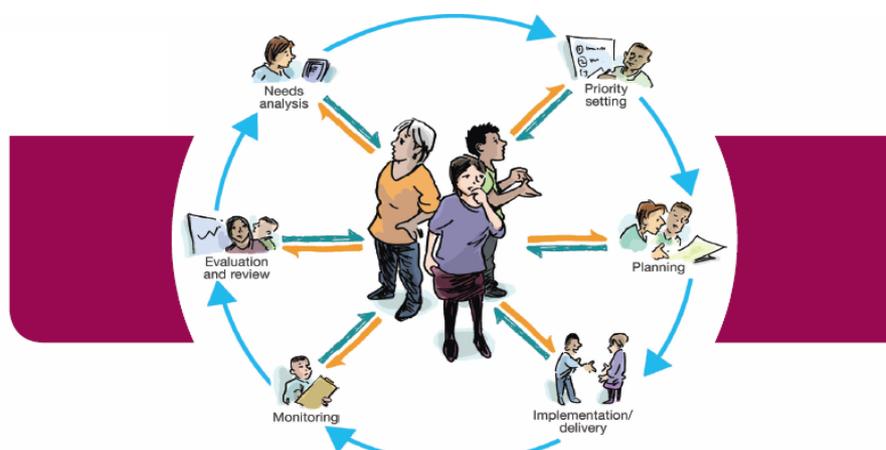
Figure 1. When do we engage?[8]

The engagement and consultation plan that is developed may include strategies for both Phase 1 (review and assessment) and Phase 2 (design or re-design of services). This can provide reassurance to stakeholders that engagement and consultation will continue throughout the entire process and provide clarity regarding how their contributions will be heard and progressed. Appendix 3 provides links to resources to assist in the engagement, consultation, and co-design processes.

1.3.1 Identify the stakeholders

Maternity service consumers and community members are essential to the stakeholder engagement process. **Consumer engagement** refers to the activities and processes through which past, present and future consumers and their communities can partner with health organisations in the design, delivery, evaluation and monitoring of their services.

Other stakeholders to engage with should include:

- clinicians who deliver maternity services (midwives, doctors credentialled in obstetrics)
- clinicians who support them within the HHS (e.g. doctors, nurses, allied health providers, pathology, medical imaging)
- GPs and private practicing midwives
- Aboriginal and Torres Strait Islander Community-Controlled Health Organisations
- ambulance and air retrieval services
- primary health networks
- higher level services and retrieval services to whom rural maternity services refer.

1.3.2 Develop an engagement and consultation plan

Formal mechanisms for engaging stakeholders can be established or used. This includes consumer representation on HHS governance bodies, local reference groups or committees, and involvement from consumer organisations.

Informal mechanisms of engagement will also be required to ensure consumers and clinicians participate in the planning process. These can include but are not limited to workshops with stakeholder groups, online surveys, and yarning circles.

The Hospital and Health Board and Executive should be actively engaged and informed at key steps of the planning process of maternity services planning. Other stakeholders to consider engaging with in addition to those listed in the previous section include:

- local government e.g. town council / local council or the state representative

- professional healthcare bodies and associations

- health service funders.

Consumer and community engagement considerations

The _National Safety and Quality Health Service (NSQHS) Standard 2: Partnering with consumers_ articulates that the HHS must engage with consumers and demonstrate partnerships with consumers in service planning, designing care and service measurement and evaluation.[9]

It is important to understand and differentiate between consumer and community engagement. Both levels of engagement provide useful information.[10]

Engaging with consumers

Consumers must have meaningful roles in maternity services decision-making. It is important to engage or partner as early as possible and throughout the planning process (e.g. from needs analysis stage through to evaluation).

Consumers need to be resourced and supported to enable their engagement in maternity services planning. Consider flexible approaches to engaging with consumers. Practical strategies to meaningfully engage with consumers are described within Health Consumers Queensland's (HCQ) _A Guide for Health Staff: Partnering with Consumers (2018)_.[8]

The HCQ _Consumer and Community Engagement Framework for Health Organisations and Consumers_[10] (Engagement Framework) has documented good principles of consumer engagement. The Engagement Framework outlines the building blocks for partnerships between staff in organisations and their consumer representatives.

There are four elements of this Engagement Framework we can use to enable and guide partnerships with consumer representatives:

1. Where partnering can happen
2. When to partner
3. The engagement spectrum
4. The engagement principles.

The relationship between these elements is represented in the framework diagram (Figure 3).[8]
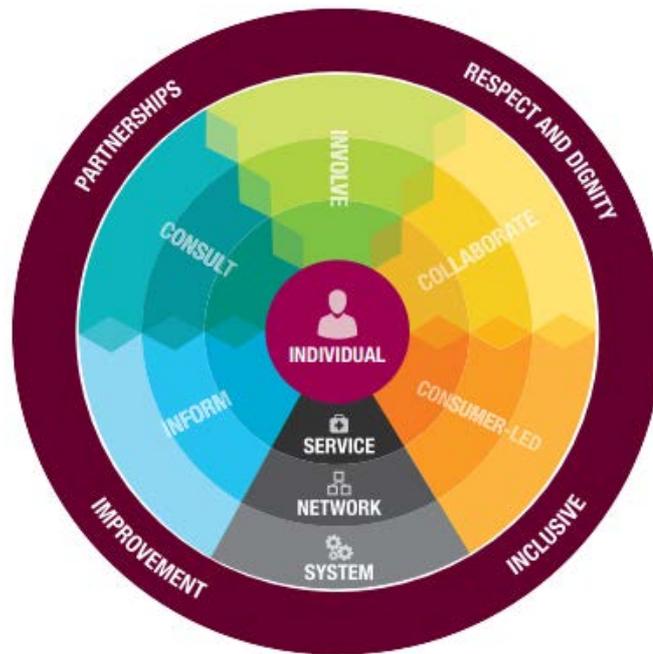
Figure 2. The Consumer and Community Engagement Framework[8]

The key to effective and successful consumer partnerships is to keep consumers at the centre of all planning, design, delivery and evaluation. This means formally and informally partnering with consumers across varying levels of influence and from informing, consulting, involving, collaborating through to consumer led (as indicated in Figure 3).

The HHS must be open to an increasing level of consumer influence as an opportunity to deliver better outcomes. We must ensure that all our partnership activities are underpinned by the four principles of consumer partnerships (outer circle of Figure 3) so that the consumer voice and lived experience guides the development and re-design (where required) of maternity services that are being planned.

Engaging with communities

Community engagement takes place with broader groups of consumers and community members. It is more likely to feed into broader strategies, while consumer engagement is health organisations partnering with consumers who have lived experiences of the services.

It is important to ensure that the diversity within the community is well represented throughout the consultation process. This active partnering ensures that health policy, planning, service delivery and evaluation are informed by community and consumer experience. When reviewing or planning maternity services, it is important to do both levels of engagement.

Engaging with Aboriginal and Torres Strait Islander peoples

Authentic and effective engagement means investing time and building relationships.[11] Good consumer engagement relies on effective engagement with Aboriginal and Torres Strait Islander people living in local communities.

Engagement between HHS and Aboriginal and Torres Strait Islander people about maternity services is essential to understanding how well maternity services meet local needs.

First Nations Australians continue to have poorer maternal and child health outcomes than non-Indigenous Australians. While progress has been made in some health areas, maternity and other health services are still not as accessible and appropriate for Aboriginal and Torres Strait Islander populations as for non-Indigenous people.

Aboriginal and Torres Strait Islander communities are very diverse. The culture and practices of Aboriginal people and those of Torres Strait Islander people are quite different. The role of traditional culture in each family's life varies.

Aboriginal and Torres Strait Islander women should be engaged separately as well as part of a broader consumer engagement process to ensure women have the opportunity for their culturally specific care needs to be heard.

Aboriginal and Torres Strait Islander clinicians, health workers, health practitioners and liaison officers, and A&TSICCHOs within your organisation and HHS can provide advice on engagement with Aboriginal and Torres Strait Islander people in your area.

Communicate back to stakeholders

It is vital to communicate back to all stakeholders throughout the process and about outcomes – including consumers, community groups and clinicians. Inform stakeholders of project delays or if expected outcomes were not achieved. Closing the feedback loop about the review ensures that stakeholders are informed of what happened with their time and efforts contributed. This feedback should continue as services are re-oriented or new services implemented.

Figure 3. Feedback loop with stakeholders[8]

Evaluate consumer engagement

Ongoing and continuous improvement are important steps of any service design and delivery. Plan and ensure that consumers are involved at all stages when using this Framework at both a service and HHS level. For further information on evaluating consumer partnering, please refer to HCQ's *A Guide for Health Staff: Partnering with Consumers.*[8]

1.4. How do we review and assess our maternity services?

There are many aspects that need to be taken into consideration when reviewing and assessing maternity services, all are equally important yet cannot be relied upon individually. Maternity service review and assessment broadly comprises the following tasks, all of which should be undertaken collaboratively with the HHS's Executive, Board, clinical and consumer representatives:

- ■ **Analyse relevant data and service information**
- ■ **Assess maternity service system risks**
- ■ **Consult with consumers, clinicians and community members**
- ■ **Review the feedback and information**
- ■ **Report on findings and priority setting**
- ■ **Share the findings with stakeholders**

Findings must inform the design, or re-design, of maternity services to meet the needs of women, their partners, families and rural communities.

1.4.1 Analyse relevant data and service information

The analysis of relevant data and service information should occur in conjunction with the clinician, consumer and community consultation.

Thoroughly analysing the available data and information will provide an understanding of where women in rural communities currently access maternity care. This understanding then informs decisions regarding the maternity service options that the service could potentially make available to women.

Consider the data and information for your maternity services network, not just an individual facility within the network. Analyse where women from different geographical areas within the HHS receive services.

Population size and projected trends will influence the sustainability of some maternity services. Many rural and remote communities have experienced population decline and do not have the population base to support a full range of health services.

The following steps can be followed to effectively analyse data and service information:

a. Review the population size and population projections[vi] for geographical areas[vii] within the HHS catchment. For services near the border with other HHSs or jurisdictions the flow of patients into or out of the catchment may need to be considered.

   Describe the socio-demographic characteristics, chronic disease, and lifestyle risk factor profile of local communities to identify relative socio-economic disadvantage and health risks including:

   - ■ any disparities between Aboriginal and Torres Strait Islander community members compared to non-Aboriginal and Torres Strait Islander community members.

   - ■ impacts of social determinants of health such as homelessness, domestic violence, drug and alcohol use, comorbidities, unemployment, education, rural and remote

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[vi] Including but not limited to current and projected population of women of normal child-bearing age (15-44)
[vii] Geographical areas are usually LGA or SA2. The Australian Rural Birthing Index (ARBI)[14] defines a maternity service catchment area as the area bounded by a 1-hour road travel time in any direction from the facility where the service is provided.

locations, social and emotional wellbeing and mental health services, child safety and early childhood health and wellbeing information, and housing data.

Determine the distance from the local community to the nearest service that provides:

- different Clinical Services Capability Framework (CSCF) levels of maternity and neonatal services

- planned birthing services

- planned birthing services with caesarean section-capability.

Population projections provide information about projected changes in the size of local populations and their age structure. The Queensland Government Statistician's Office Queensland Regional Database provides a spatial and temporal overview of Queensland's current and projected population within regional areas.[12] The Queensland Health Statistical Services Branch can assist with data requests from health services, including service specific birthing data. The Planning Portal, hosted by System Planning Branch, Queensland Health can provide current and historical health needs and service utilisations data. The Department of Aboriginal and Torres Strait Islander Partnerships provides local community profiles that include social determinants of the health of a community e.g. overcrowding and includes population data.

b. **Determine the number of births for women.** You need to know:

- the number of births at each facility

- the number of births for women who live in each geographical area within the HHS, which facility they birth at, how many were referred for antenatal consults or birth at higher level facilities such as maternal fetal medicine or neonatal intensive care services, any associated maternal and perinatal risk factors, and the outcomes for each birth.

The Queensland Health Statistical Services Branch can provide pregnancy and birth data for all births in Queensland including maternal and perinatal risk factors and perinatal outcomes, through the Perinatal Data Collection. Alternatively, the Queensland Regional Database records the number of births each calendar year to women residing within different geographical areas.

c. **Describe the maternity service map within the HHS catchment.**

Identify:

- maternity services that are available (antenatal, intrapartum, postnatal)

- different models of maternity care available within the HHS catchment (refer to the 11 models of maternity care in Appendix 1) and where these are located, including those models that are accessible only outside the HHS catchment

- A&TSICCHOs that deliver aspects of maternity care within the HHS catchment[viii]

- the geographic proximity of each facility in the service network[ix] to the nearest facility that can perform emergency caesarean section.

[viii] Queensland Aboriginal and Islander Health Council (QAIHC) identifies 28 member services, however not all communities have an A&TSICCHO attached https://www.qaihc.com.au/about/our-members
[ix] Service network may include A&TSICHHOs and private providers.

Describe:

- current CSCF level of maternity and support services at each facility[13]

- operating theatre capacity, utilisation and suitability of infrastructure across HHS sites

- transport and accommodation available for women and their partners and families and any costs associated with accessing these, including reimbursement schemes available to women and their partners and families

- current staff accommodation availability for permanent and transient visiting services

- telehealth capability and workforce capacity at both hub and spoke service for antenatal and postnatal clinics

- support services that are available. These can include but are not limited to support for culturally and linguistically diverse people, people with mental health concerns, children, LGBTIQ+ (lesbian, gay, bisexual, transgender, intersex, queer, questioning and other sexuality, sex and gender diverse) families, pregnant teenagers, patients with a physical or intellectual disability, or pregnant women with other complex health needs.

d. Prepare a workforce profile which should describe:

- the available maternity workforce in each discipline

- where the workforce is located

- the credentials and scope of practice of the available workforce

- any maternity recruitment and retention challenges that have been experienced, including data on staff recruitment and retention.

Assessment should include mapping the First Nations workforce that supports maternity services delivery and assessing availability against local Aboriginal and Torres Strait Islander population demographics. Aboriginal and Torres Strait Islander Health Workers, Health Practitioners and Liaison Officers support the delivery of more acceptable, effective, culturally safe care for Aboriginal and Torres Strait Islander people. Identify factors that contribute to workforce recruitment and retention issues.

Additional information on workforce considerations is available in section 1.4.5 Clinician consultation process, section 2.2.2 Service network design and in the *Rural Maternity Taskforce Report* section 3.4 Maternity workforce. Appendix 3 provides links to workforce planning resources.

e. Calculate the Australian Rural Birthing Index for populations between 1,000 and 25,000 people in size.

Clinical Services Capability Framework

The CSCF[13] is a Queensland Health tool that outlines the minimum service and workforce requirements, as well as specific risk considerations required in both public and private health facilities to ensure safe and appropriately supported clinical services. Categorisation is based on the hospital's self-assessment and rating of their maternity service into CSCF levels ranging from Level 1 (lowest) to Level 6 (highest).

The CSCF is intended for a broad audience, including clinical staff, managers and health service planners. It is not intended to replace clinical judgment or service-specific patient safety policies and procedures, but to complement and support the planning and provision of acute and sub-acute health services.

Maternity care does not occur in isolation. A range of support services[x] is needed, including considerations of caring for a well or unexpectedly sick newborn, to enable care to be provided in rural and remote services. Refer to the CSCF for details of support service requirements.

Table 1 provides a summary of the CSCF descriptions of the various levels of maternity service.

Table 1. Levels of maternity service provision, CSCF

Level	Service description
1	Provides community antenatal and postnatal care only. There are no planned births or maternity inpatient services.
2	Provides access to antenatal care and inpatient postnatal stay as well as planned births for women of 37 weeks or greater gestation and with no identified risk factors, however, epidurals are not available to labouring women. If operating theatre on site, may provide elective caesarean sections for women at or beyond 39 weeks gestation with uncomplicated pregnancy
3	Provides community and inpatient care for antenatal and postnatal women without identified risk factors and planned birth care for healthy women with pregnancy of 37 weeks gestation or greater and not expected to have labour or birth complications. May offer women with relatively low-risk pregnancy and favourable Bishop (cervical assessment) score at term, an induction of labour locally. May manage women who present in preterm labour at 35 weeks gestation or greater, with otherwise uncomplicated pregnancy, after consulting with higher level maternity and neonatal service. Can perform elective caesarean section on women at or beyond 39 weeks who have experienced uncomplicated pregnancy.
4	Provides maternity care for low- and moderate-risk women, but cannot care for women with complex, high-risk conditions. May provide high risk antenatal clinics as satellite or outreach from higher level service. Can care for pregnant women at 32 weeks gestation or greater if a continuous positive airway pressure (CPAP) device is accessible on-site for the baby, and the baby is expected to have a birth weight of 1,500 grams or more with no additional risk factors. If a CPAP device not accessible on-site, the service can plan and deliver care for pregnant women at 34 weeks gestation or greater.
5	Can provide planned care for women at 29 weeks gestation or greater with babies expected to have a birth weight of 1,000 grams or more, as well as providing a multidisciplinary service with capacity to manage all unexpected pregnancy and neonatal emergency presentations.
6	Provides all levels of care, including the highest level of complex care for women with serious obstetric and fetal conditions requiring high-level multidisciplinary care.

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[x] Support services can include but is not limited to pathology, medical imaging, allied health, support for people with mental health issues, children, LGBTIQ+ (lesbian, gay, bisexual, transgender, intersex, queer, questioning and other sexuality, sex and gender diverse) families, pregnant teenagers, patients with a physical or intellectual disability, or pregnant women with other complex health needs.

Australian Rural Birthing Index

The [Australian Rural Birthing Index (ARBI)](#) is an important tool that informs this aspect of the planning process. It is an index that can be used to contribute to planning the level of maternity service for a particular rural facility. It helps to estimate the appropriate level of maternity service that should be provided in a location based on the needs of the population.

The ARBI applies to rural maternity services in facilities with catchment populations of 1,000 to 25,000 people. The term 'rural' is used inclusively here to denote locations with Australian Bureau of Statistics (ABS) remoteness area (RA) categories of Inner Regional, Outer Regional, Remote and Very Remote (RA categories 2 to 5). The Australian Government is transitioning to the use of the Modified Monash Model (MMM) of rurality classification. MMM 2 to 7 correlate with the ARBI rural geography classifications.

The index is calculated based on:

- Catchment area of the maternity service
- Population Birth Score (PBS): the number of births in the catchment population
- Social Vulnerability – Adjustment for Population Vulnerability (APV): the relative socio-economic disadvantage of the catchment population compared to the rest of the country
- Isolation Factor (IF): the geographic proximity of the facility to the nearest alternative surgical facility that can perform emergency caesarean section.

The calculation process applied a weighting to each of the above factors to produce a score that estimates the appropriate level of maternity service for its location based on population need.

Detailed instructions on how to calculate the ARBI are available [online](#).[14]

The final ARBI score recommends an appropriate level of service able to be supported in the rural catchment as per Table 2.

Table 2. Australian Rural Birthing Index score

ARBI Score	Suggested Maternity Service Level
Less than 6	Unlikely to have local birthing. May have antenatal and/or postnatal care only.
6–10	Possible to have local birthing but probably without emergency caesarean section capability.
10–18	Likely to have local birthing possibly without emergency caesarean section capability.
Over 18	Generally will have local birthing probably with emergency caesarean section capability.

1.4.2 Assess maternity service system risks

Safety and quality in all Queensland maternity services are of paramount importance—careful risk assessment is vital. Care must not only be clinically safe; it must *feel safe to consumers.*

> *"There will always be an element of risk in birth, whatever the choice of birthplace. However, safety in childbirth is intrinsically related to the mother's emotional, psychological and physical well-being during labour. This, in turn, is influenced by the choices which are made during pregnancy, choices which*

should enable a woman to give birth at ease with her environment, her attendants and herself."[15]

- Review the available safety and quality information for each service within the maternity services network.[xi]
  - Review health outcomes for women and babies (including breastfeeding, physical health and maternal mental health outcomes).
  - Compare the service outcomes against the National Core Maternity Indicators.[16]
- Determine the rates and trends of babies being born before arrival and imminent births at non-birthing services within the network.
- Review summary results of root cause analyses, Coroner's reports and any other service reviews.
- Review referrals and transfers of women and/or babies with time critical care needs between different facilities within the HHS maternity services network and to services outside the network.
  - Review outcomes in cases where women needed transfer for care.

Key considerations for stakeholders in assessing risk

A comprehensive maternity service risk analysis includes considering the following risk areas:

- clinical
- cultural (women and their partners, families and communities)
- social and emotional
- financial
- ethical impacts on rural families, communities and clinicians of how maternity services are delivered.[17]

Clinical risks of closing or reducing services

Clinical risks can arise from the closure and/or reduction of maternity services. These include women avoiding adverse cultural, social, emotional and financial impacts of having to travel for care by:

- not reporting pregnancy
- avoiding antenatal care
- presenting late in pregnancy or labour in a setting neither prepared nor staffed to provide a birthing service.

Evidence shows that Level 2 CSCF maternity services (Table 1) in rural areas demonstrate safe outcomes.[18,19,20,21] These units may provide a valuable birthing option in rural areas for women with low-risk pregnancies who choose this birthing option and who understand the limitations of this service.[22]

[xi] See also clinical governance and workforce information as described in section 1.4.5 Clinician consultation process

The Australian College of Midwives (ACM) *National Midwifery Guidelines for Consultation and Referral* (2021) provide an evidence-based framework for inter-professional collaboration in the maternity care of women. The Framework guides decisions regarding appropriate levels of maternity care for women with different levels of clinical risk.[23]

1.4.3 Share the results with stakeholders

Relevant data and information should be shared with the stakeholders who are engaged in the planning process, ensuring that confidentiality is maintained where required. Stakeholders should consider the findings from the available information. They should also consider if questions that have been raised by this information need to be explored with consumers and clinicians. This will inform the consultation phase of the review and assessment process.

1.4.4 Consumer and community consultation process

There are many benefits to partnering with consumers and the community in the development, planning and delivery of health services. These benefits include:

- improved care processes
- increased consumer satisfaction and engagement
- more effective priority-setting and use of resources.

Key questions to ask consumers

Maternity care must be respectful of women, their cultural heritage, their partners and families. Consumer feedback informs maternity service redesign priorities for the HHS. Planners need feedback from women, their partners and families who have used maternity services across antenatal, intrapartum and postnatal phases to understand:

- *What was the woman's experience of receiving maternity care?*

  Identify where women go to access maternity care, which models they access, and why they choose these options. Describe their care options and identify the service gaps in antenatal care, birthing and postnatal care. Ask about transport and accommodation and women's experience of these.

- *What opportunities are there to enhance services?*

  Discuss perceived and real or actual challenges associated with the current ways in which maternity services are delivered and how these might be addressed.

- *What is working well?*

  Describe the compliments, comments and complaints procedure that enable women to express views about their pregnancy and childbirth experience. Determine how well this meets women's needs and views regarding the effectiveness of the HHS response.

- *What are the health needs of women before they get pregnant, when they are pregnant, when they give birth and after they give birth?*

  Consider the health information and health literacy needs of consumers and how well these are being met. Consider what your HHS is doing to become a health literate organisation.

How to seek consumer feedback

The HHS can seek consumer feedback through informal and formal mechanisms. To gain informal feedback, planners can go to where mothers and babies are within the community. Attending mother-baby groups, playgroups or other groups enables consumers to tell planners about their experiences in an informal setting.

Some consumers may be uncomfortable sharing their personal stories in a group setting. It is important to provide opportunities for individual conversations and written feedback to cater for a broad range of consumers and include partners and other family members. Being flexible is the key.

Formal consumer feedback can be obtained through consumer representatives on HHS governance bodies, local reference groups or committees and from consumer organisations. Try to ensure that the consumers who take part in this formal mechanism have lived experience of the maternity services for whom you are consulting. However, some First Nations, culturally and linguistically diverse (CALD) consumers may be more comfortable with an Elder or Aunty speaking with or for them.

It can be useful to engage independent organisations[xii] and individuals to obtain feedback on behalf of the HHS, however there is great value in the senior leadership being present and listening to feedback firsthand.

Share de-identified consumer feedback and information with stakeholders. Stakeholders should consider the issues raised by consumers and the priorities these might raise for maternity service design or re-design within the HHS.

Feedback on cultural aspects of care

People from diverse cultures and abilities can have differing maternity care needs. Some cultures have a stronger emphasis on family and extended support systems than others. The service must factor in the cultural and health needs of CALD consumers, people with disability, as well as Aboriginal and Torres Strait Islander people.

The spiritual, cultural and social needs of Aboriginal and Torres Strait Islander populations vary across local populations and, therefore, services need to reflect this. The only way to understand these differences is to ensure we engage with the community. The service must hear from the women who access and use the maternity services. This process is aided when partnering with community leaders and women to develop ongoing long-term relationships occurs.

Birthing on-country is culturally important in some Aboriginal and Torres Strait Islander communities, and this importance varies between communities. It is important that the HHS understands this well through the consultation process. The service should seek feedback and input from Aboriginal and Torres Strait Islander clinicians, health workers, health practitioners and liaison officers within the HHS, and from the local A&TSICCHOs, to identify appropriate strategies to receive feedback from Aboriginal and Torres Strait Islander stakeholders.

[xii] E.g. Health Consumers Queensland http://www.hcq.org.au/

1.4.5 Clinician consultation process

The care and safety of rural women throughout the whole of their reproductive journey relies on a rural maternity workforce that delivers both the continuum of care and the continuity of care and carer needed by the women, their babies, partners and families.

Feedback from rural maternity service providers informs an understanding of local service delivery. The service must obtain clinician feedback for answers to the following questions:

- How are maternity services delivered within the local community?

- Which aspects of care can women access locally, and which aspects of care do women have to travel to access? What care could be delivered locally but is not?

- What care needs necessitate women and babies being transferred to a higher-level service? How well do these arrangements work? What could be improved?

Describe the clinical governance

Health services configure their maternity services as a network of providers, from least to most specialised.

- Identify the clinical protocols, procedures and guidelines that support the delivery of maternity care across the clinical network, Including the referral processes for women and babies between different facilities within the maternity services network.

- Identify any gaps in protocols and procedures that link services within the HHS maternity network.

- Ensure reciprocity in all communication during the woman's maternity journey including feedback of advice or transfer processes as it applies to the woman and/or her baby from both the primary and specialised maternity sites' experiences.

  ☐ Where care is transferred, we must recognise that the woman's home site remains the hub of her care, as extending her care to a specialist site is temporary. It necessitates effective two-way communication for continuity of care.

Maternity services require governance and leadership at an individual service level, as well as across the network. The HHS should work with clinician stakeholders to identify and describe clinical governance and leadership arrangements for the delivery of maternity care.

- Each facility will have its own clinical governance. This should be described.

- The maternity network as a whole will also have a system of clinical governance with clear lines of accountability and responsibility for the delivery of safe, high-quality care. This should also be described.

Understand the workforce

The rural and remote maternity workforce deliver maternity care in a challenging environment with fewer resources and specialist supports than larger maternity centres. This workforce has distinctive training, skills development, and maintenance needs in maternity, neonatal, emergency and cultural aspects of care.

The HHS must have systems and processes in place to assure the psychological safety of rural maternity service providers. The review and assessment process should explore:

- How are providers supported to deliver maternity care locally? What could be improved?

- How are workforce training and professional development needs met? What else is required?

- What are the arrangements to ensure the psychological safety of staff working in rural maternity roles? How can arrangements be strengthened?

Both the core maternity workforce (midwives and doctors with obstetric credentials) and the support workforce (other doctors, nurses and allied health professionals in the service) have education and training needs.

Feedback should be sought from the HHS Executive and Board members regarding their maternity service goals and priorities, risk considerations and opportunities for service improvement.

Additional information on maternity workforce considerations is available in section 1.4.1(d) (Prepare a workforce profile), section 2.2.2 Service network design and the *Rural Maternity Taskforce Report* section 3.4 Maternity workforce. Appendix 3 provides links to workforce planning resources.

1.5. Report on findings and priority setting

When the data analysis and stakeholder consultation has been completed a report on the findings and any proposed actions should be provided to the HHS executive for their review and consideration. It is important to note that there may be recommendations that involve a reconfiguration of services utilising existing resources.

Two templates have been developed to assist in this process (provided in Appendix 4):

- A facility assessment template that can be completed for each facility that is assessed

- HHS assessment template that contains a summary of the individual facility assessments, prioritised service issues that have been identified, and proposed options for any service change to address the issues.

Once completed and reviewed by the HHS executive, the HHS assessment report may be used as supporting documents alongside potential business cases which would be subject to normal Departmental review processes.

1.6. Share the findings with stakeholders

The findings and feedback should be shared with the stakeholders who are engaged in the planning process. Stakeholders should consider the issues raised by consumers, clinicians and the community and raise these with the HHS for maternity service design or re-design consideration.

Ensure you close the feedback loop and communicate, in a culturally appropriate way, to all consumers you have partnered with.

Feedback should also be given in regards to what are the next steps, that are the key components of Phase 2: Design or redesign of rural maternity services.

Phase 2:
Design or redesign of rural maternity services

Maternity service design or re-design may include a redesign of the models of care or how and where services are delivered, for example:

- antenatal and postnatal services provided in community and primary care settings could be established or expanded to include allied and mental health care services
- it may encompass the development of a new birthing service.

The process of maternity service design or re-design comprises the following tasks, all of which should be undertaken collaboratively with the service's Executive, Board, clinical and consumer representatives, using co-design principles and strategies:

1. Develop plan for co-design of maternity services
   a. Identify workforce and stakeholders to lead the planning and co-design of the service.
   b. Review steering committee membership and update if required.
   c. Create/update stakeholder engagement and communication plan.
2. Design the service
   a. Engage with stakeholders to develop options
   b. Complete the Maternity Services DMF process
   c. Feedback to stakeholders on assessment and prioritisation of options
   d. Finalise plan for maternity services
3. Follow HHS and, if required, Department of Health approval process to implement planned changes

2.1 Planning for co-designed maternity services

Good maternity services are co-designed in a shared process that engages **women, their communities and local clinicians** from the start of the review and throughout the planning and co-design process. These groups will be involved in analysing needs and resource information and generating solutions. They should also work in partnership with HHS management during the stages of implementation, monitoring and evaluation, and communicating back to stakeholders.

The HHS and maternity service providers, in collaboration with the women in their community, should consider the spiritual, social, cultural and health needs identified through the stakeholder engagement processes in Phase 1 and how these can be addressed through maternity service design or re-design within the HHS.

It is important to have a steering committee to oversee the design process, with membership consisting of consumers, community representatives, management, clinicians, union representations, PHN representatives, GPs, and other significant stakeholders. The steering

committee established for Phase 1 (review of current services) can be used but may need to be reviewed and updated for Phase 2.

The stakeholder engagement and consultation plan developed for Phase 1[xiii] should be reviewed and if required, adapted to include a co-design plan. The co-design plan should build on relationships developed through the initial review phase. This will support the continued engagement of stakeholders throughout the process.

Consider the activities you will undertake to engage with women, communities and clinicians through the design phase. Consider what worked well in Phase 1 and replicate where appropriate. This may include:

- externally facilitated workshops with all stakeholders
- morning tea, kitchen table conversations and yarning circles with consumers.
- surveys.

2.2 Designing a maternity service

The findings from the review and assessment process (Phase 1) will inform service design or re-design of existing maternity services.

The Maternity Services DMF[24] and associated Library Toolkit is available, along with a library of resources (as an adjunct to this guide, listed in Appendix 4) to assist in the review, redesign and transition to continuity of care and carer models. Additional resources to support the design, re-design and planning of maternity services are provided in Appendix 3.

Aspects that need to be considered when designing a maternity service are outlined in the following sections.

2.2.1 Service design considerations

- Engage stakeholders early who are likely to be affected by any service design solutions. This will support more informed service decision-making.
- The cultural needs of women are a central consideration of how services are designed. It is essential to enable women with culturally specific care needs to participate in this process.
- Good maternity care relies upon interdisciplinary collaboration within facilities and between different maternity services in the network. Involve clinicians across disciplines and affected facilities within the network.[25]
- Communities should be well informed about:
  - ☐ the maternity care available locally
  - ☐ how service availability might vary (for example, on weekends and when various staff may be unavailable)
  - ☐ how service delivery is supported at regional and tertiary levels
  - ☐ the potential limitations on local services if unexpected complications arise during pregnancy
  - ☐ referral and transfer arrangements if unexpected complications arise.

[xiii] See section 1.3 Engagement with stakeholders

- Care for pregnant women in rural and remote Australia is provided by midwives, doctors, nurses and allied health providers, including the First Nations workforce, that work together to support local maternity services.

  - Care arrangements between providers and services within the maternity services network should be guided by locally agreed protocols and referral guidelines.

- Women in rural communities should have access to pre-pregnancy counselling.

  - Individual risk assessment and counselling, particularly with respect to early pregnancy screening tests, are important in helping women to make well-informed decisions about their care.

- Communities and clinicians need to be informed and supported through any major changes in models of maternity service delivery.

- Innovative models of care can enable services to remain in the community when there are external adverse events that may cause restrictions to travel or service access e.g. extreme weather event, a pandemic.

Antenatal care

All women in rural communities should have access to comprehensive antenatal care. Antenatal care should:

- maintain and improve health and general wellbeing

- emphasise the importance of a healthy diet and exercise

- provide advice to avoid smoking, alcohol and illicit drugs

- provide for the mental health, social and emotional wellbeing needs of women

- address domestic and family violence and link women into social support services

- screen for managing pregnancy complications through detailed history, clinical examination and appropriate investigations throughout the pregnancy

- manage any pregnancy complications as they arise.

Work with stakeholders to identify options for women to address gaps in antenatal care (identified in the service review and assessment phase).

Determine and document referral pathways to inform service providers of how pregnant women who require additional care will be managed and treated by the appropriate specialist teams if problems are identified.

Rural communities should have access to comprehensive programs of education for birth and parenthood for women and their partners and families, taking care to include information about:

- the course of an uncomplicated pregnancy

- the possible need for obstetric treatment

- the common obstetric procedures

- options for pain relief in labour, both pharmacological and non-pharmacological

- transition to parenthood (services and peer support)

- other topics (mental health, social and emotional wellbeing, diet, exercise, breastfeeding, domestic and family violence).

Identify and describe how this will be provided.

Planned births and neonatal care

Planned births are provided across the HHS's network of maternity service providers. The network will include providers of differing clinical service capabilities and specialisation. Identify where planned births will occur within the maternity services network.

Work with stakeholders to agree on CSCF levels for maternity and neonatal services of facilities within the HHS.

Engage with the community to determine their needs with regards to cultural practice in birthing, such as traditional birthing practices, placenta removal, kinship considerations, culturally safe and welcoming environments.

Linkages between services are important. Service networks rely on effective communication and information sharing, protocols and clinical pathways, and inter-professional relationships to be effective. Work with stakeholders to identify and address service linkage requirements in obstetric and neonatal care.

Work with stakeholders to plan for transitioning the facilities where CSCF role is changing – plan community engagement, clinician engagement, referral and transfer arrangements and workforce support needs.

Unplanned births

All facilities need to be resourced and supported to manage women who present with care needs associated with imminent birth. Emergency and non-emergency transport systems should be clearly documented.

Facilities without planned birthing should be supported to ensure workforce education and training needs, facility resources and equipment needs are addressed to enable the facility to manage imminent births.[xiv]

Postnatal care

The postnatal period is defined as the period after the birth of the baby, usually the first six weeks after birth. All women in rural communities should have access to comprehensive postnatal care. The primary aims are to provide:

- recuperation from the birthing process
- breastfeeding education and support
- parenting education and support
- clinical care to promote the physical and psychological health and wellbeing of the woman and her baby.

Care includes routine clinical examination and observation of the woman and her baby and routine baby and mother screening to detect additional support needs, including sexual and reproductive health, pelvic and continence, mental health care needs, and social and emotional wellbeing.

[xiv] Office of Rural and Remote Health Clinical Support Unit https://qheps.health.qld.gov.au/orrh/csu/education-training/maternity-and-neonatal

Postnatal care provided by midwives and obstetricians can be supported by a range of health professionals, including nurses, GPs and Aboriginal and Torres Strait Islander health workers.

Postnatal care should be evidence-based and woman-centred to enable women to make informed decisions regarding their own care and the care of their baby. This care should be culturally appropriate and culturally safe.

- Work with stakeholders to identify options for women to address gaps in postnatal care (identified in the service review and assessment phase).

- Identify and document the responsibilities of health services and community-based providers in caring for mother and baby.

- Ensure any postnatal care arrangements promote continuity of care for women and babies across the full range of services involved in their care.

- Ensure that robust systems for communication and information sharing between providers are in place such as timely sharing of discharge summaries.

- Determine and document referral pathways to inform service providers of how women who require additional postnatal care can be managed and treated by the appropriate specialist teams if problems are identified.

Health services need to collect and report accurate data on women's and babies' access to postnatal care. Work with stakeholders to agree what data will be collected and how this will be shared with stakeholders.

2.2.2 Service network design

Clinical governance

Clinical governance refers to the systems and processes to support the delivery of safe, high-quality maternity care across the HHS network.

The HHS should work with stakeholders to determine and document the clinical governance arrangements to:

- provide clinical leadership of the maternity service network

- implement and monitor the safety and quality of maternity and neonatal care in accordance with the National Safety and Quality Health Service (NSQHS) Standards (second edition).

- foster clinical excellence and ongoing improvement of standards

- foster a culture of psychological safety for clinicians

- provide clear accountability for all team members.[26]

All health professionals must have a clear understanding of the concept and process of risk assessment and management to improve the quality of care and safety for mothers and babies, while reducing preventable adverse clinical incidents.

Where an incident has occurred, every unit should follow a clear mechanism for managing the situation including investigation, learning and communication and, where necessary, implementing changes to existing systems, training or staffing levels.

There should be a strong system of reflective practice which ensures that good practice is recognised, supporting staff when poor outcomes occur and facilitating review of incidents when things go wrong.

Work with stakeholders to ensure transparent processes are in place whereby clinicians and other stakeholders can see how identified clinical quality issues are dealt with. Describe how clinicians are supported appropriately during a performance review.

Clinical protocols, procedures and guidelines

Rural maternity services should comply with evidence-based guidelines for the provision of high-quality clinical care. Queensland Health provides a suite of maternity and neonatal best practice clinical guidelines.[27]

Each birth setting must have clinical protocols, procedures and guidelines[xv] to assist in the delivery of maternity care. Work with stakeholders to describe the clinical protocols, procedures and guidelines that support the delivery of maternity care across the proposed HHS maternity network.

Ensure protocols, procedures and guidelines are in place that document processes for the referral and transfer of women and babies with time-critical care needs, both to facilities within the proposed maternity services network and specialist facilities outside the network.

Some women will choose to decline recommended maternity care. Describe procedures, including documentation, for when women decline recommended care and also for clinicians or services that decline to provide the woman's preferred or requested care. Ensure staff are trained and/or have an understanding of these, with review of why variations in receiving or providing care is occurring.

The ACM *National Midwifery Guidelines for Consultation and Referral* (2021) provide an evidence-based framework for inter-professional collaboration in the maternity care of women. The Framework guides decisions regarding appropriate levels of maternity care for women with different levels of clinical risk.[28]

Equipment and resources

Facilities in birth settings should be equipped and maintained at an appropriate standard.

Work with stakeholders to identify the equipment and resources needed for each rural facility within the HHS so that they can meet their assigned CSCF role for the delivery of services. Address gaps in equipment, resources, and infrastructure including Information and Communication Technology and telehealth resources.

Consider how telehealth and augmented reality technologies can support the delivery of more support services locally.

Emergency and non-emergency transport options should be defined and documented.

Maternity workforce

High-quality rural maternity services rely on an appropriate workforce with leadership, skills mix and experience to provide excellent care. The HHS must ensure all maternity service providers across the maternity service network participate in continuing professional

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[xv] Wherever possible statewide guideline should be used. If adaptation to address local situations is required, the development of conflicting or contrary guidelines should be avoided.

development and maintain knowledge and skills relevant to their clinical work, as well as improving and updating their skills as required.

- Work with clinician stakeholders to identify the CSCF specified workforce required to deliver maternity care for each rural setting in the service network.
  - ☐ Describe workforce recruitment and retention issues – work with stakeholders to develop strategies for how these will be addressed, with a strategic focus on workforce planning through consideration of long-term strategies (e.g. Grow-Your-Own).[xvi]
  - ☐ Identify workforce skills requirements – work with stakeholders to describe:
    - o requirements for maternity service providers continuing professional development, and knowledge and skills maintenance relevant to their setting of work and professional role
    - o how the workforce will be supported to maintain their skills across the network
    - o how to sustain delivery of the Neonatal resuscitation, Neonatal stabilisation for retrieval, and Imminent birth education programs to assist rural facilities.
  - ☐ Describe arrangements for networking professionals across settings in the maternity service network to facilitate inter-professional engagement and learning.
  - ☐ Determine mechanisms for clinicians to participate in regular multidisciplinary clinical audit and reviews of clinical services, including outcomes.
- Determine the cultural competency and safety requirements of the service and workforce
  - ☐ All healthcare providers must recognise and respect the diversity of ethnic, religious, social and cultural values and beliefs of the women for whom they care. Cultural competency should underpin the maternity service that we provide.
  - ☐ A culturally competent workforce and culturally safe maternity service is vital to improving health outcomes. For Aboriginal and Torres Strait Islander women, their partners and families, cultural competence directly influences the engagement of women in maternity care. These, in turn, directly influence the health and wellbeing outcomes of Aboriginal and Torres Strait Islander women and newborns/babies.
- Describe how the education and training needs of the maternity workforce to support the delivery of culturally competent care will be addressed.
- Determine the systems and processes that will assure the psychological safety of the rural maternity workforce across the proposed network. Describe systems of reflective practice and professional supervision encompassing all professional disciplines involved in delivery of maternity care.

[xvi] https://www.health.qld.gov.au/system-governance/strategic-direction/health-workforce-information-gateway/workforce-supply

Maternity workforce roles

Provision of maternity services is based on different health disciplines participating in providing quality care that is tailored to meet each woman's maternity needs. The aim is to provide continuity of antenatal, intrapartum and postnatal care.[29] The majority of women will be provided primary care by midwives, supported by medical professionals according to their health needs, preferred model of care and local pathways, during their pregnancy. Communication and information sharing between team members is vital for delivering high quality care.

1. The role of Aboriginal and Torres Strait Islander health workers is crucial to improving the health outcomes of Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander health workers and Aboriginal and Torres Strait Islander medical services are critical to the provision of safe and culturally appropriate maternity care to Aboriginal and Torres Strait Islander women.

   Work with Aboriginal and Torres Strait Islander stakeholders, including women, their communities, the First Nations workforce and A&TSICCHOs to determine and develop First Nations workforce roles that can support the delivery of culturally tailored maternity care. Plan for how these can be introduced and maintained within the maternity services network.

2. All rural maternity service networks should have a designated lead midwife. Rural maternity services should aim to develop the capacity for women to receive continuity of midwifery care during pregnancy, birth and transition to parenthood. Each midwife will collaborate with the supporting obstetric medical team. For women who are not suitable for, or choose not to access, continuity of midwifery care, it is essential they have access to midwives who provide antenatal, intrapartum and postnatal care.

3. Registered nurses support the delivery of maternity care across antenatal, intrapartum and postnatal phases. Registered nurses work with midwives, doctors, retrieval and emergency transport personnel and the broader healthcare team to support the delivery of local operating theatre, ward based and emergency care in many rural facilities. Rural maternity service networks will designate responsibility for organising and managing operating theatres to registered nurses.

4. All rural maternity service networks should have a designated lead medical practitioner credentialled in obstetrics. Each medical practitioner providing maternity care will collaborate with the supporting midwifery team. Women with risks that may impact their pregnancies, including where complications associated with birth are anticipated, should receive care in collaboration with an obstetrician and follow the ACM *National Midwifery Guidelines for Consultation and Referral* (2021), and include an agreed care pathway.

5. Rural maternity service networks may have a designated lead anaesthetist (specialist or GP) with responsibility for organising and managing the obstetric anaesthetic service.[xvii,30,31]

6. Rural maternity service networks may have a designated lead medical practitioner with responsibility for organising and managing neonatal services, including for ensuring guidelines for accessing neonatal retrieval services are in place in all rural facilities and clinical staff are familiar with their use.

[xvii] The Joint RANZCOG/ANZCA Position statement on the provision of Obstetric Anaesthesia and Analgesia Services (WPI 14) and the ANZCA guidelines PS03 Guidelines for the Management of Major Regional Analgesia provide further specific information relating to anaesthesia.

7. General Practitioners (GPs) have a pivotal role in the care of women and their partners and families.

- **Pre-pregnancy care.** Regardless of whether the GP has a special interest in obstetrics, he or she will mostly be responsible for delivering pre-pregnancy care, including family planning and pre-pregnancy planning.

- **The first pregnancy consultation.** For most women, the first consultation in pregnancy is with the woman's GP. Given the increasing complexities of first-trimester care, particularly with respect to genetic counselling, this emphasises the considerable responsibility that all GPs have in the care of pregnant women. The GP should discuss maternity service models and how to access these and arrange for timely access to the woman's chosen model.

  As most GPs are not employed by the HHS, the HHS should consider mechanisms to ensure the role of the GP in maternity care is supported and credentialled for maternity care with the HHS. Education and training, resources such as clinical pathways and referral templates can enable this role.

- **Ongoing care.** GPs provide continuity of care for the woman and her family, especially in rural communities.

- For Aboriginal and Torres Strait Islander women, their Aboriginal and Torres Strait Islander Medical Service may provide initial and ongoing support. Their initial contact may be with an Aboriginal and Torres Strait Islander health worker or Aboriginal and Torres Strait Islander Health Practitioner rather than a GP.

Additional information on maternity workforce considerations is available in section 1.4.1(d) (Prepare a workforce profile), section 1.4.5 Clinical consultation process and the *Rural Maternity Taskforce Report* section 3.4 Maternity workforce. Appendix 3 provides links to workforce planning resources.

Next steps

Once the service plan has been developed and agreed upon by the HHS and Department of Health, an implementation plan, including time frames, will need to be developed for consideration by the HHS Executive and Board. If the service changes requested are considerable and require funding and/or infrastructure changes, a business case may need to be developed. Online resources and templates are provided in Appendix 3 to assist in this process.

See also the HHS service agreements[32] regarding commencement of a new service (section 12) or cessation of service delivery (section 11).

Follow the HHS and Department of Health (if appropriate) approval processes to implement the planned changes to the service. This may require the implementation plan and business case to be reviewed by relevant departmental areas such as Healthcare Purchasing and System Performance Division, and possible endorsement at a system level e.g. System Management Committee, or Rural and Remote Health Advisory Committee prior to implementing.

Engagement, collaboration and communication with stakeholders should continue throughout this process to ensure the service being developed and delivered meets the identified needs of the women, their partners, families, community and clinicians.

Evaluation

Once the service changes have been implemented there should be monitoring, evaluation and review as noted in the Guide to Health Service Planning.[33] This is to evaluate whether the process and impact of the service change continue to achieve the effects and outcomes they were designed to accomplish. The assessment, review and planning of maternity services should be an ongoing process to ensure the services continue to meet stakeholder needs and service conditions, which can both change over time.

Appendix 1 – Models of maternity care

There are 11 models of maternity care that have been defined for the Australian health system.[6] These definitions do not reflect all of the ways in which maternity care is delivered in rural communities but are useful for planning.

Aboriginal and Torres Strait Islander health workers may support the delivery of maternity care to First Nations people in any of these models.

Model	Description
1. **Combined care**	■ Antenatal care is provided by a private maternity service provider (doctor or midwife) in the community. ■ Intrapartum and early postnatal care is provided in the public hospital by hospital midwives and doctors. ■ Postnatal care may continue in the home or community by hospital midwives.
2. **GP obstetrician care**	■ Antenatal care is provided by a GP obstetrician. ■ Intrapartum care is provided in either a private or public hospital by the GP obstetrician and hospital midwives in collaboration. ■ Postnatal care is usually provided in the hospital by the GP obstetrician and hospital midwives and may continue in the home or community.
3. **Midwifery Group Practice caseload care**	■ Antenatal, intrapartum and postnatal care is provided within a publicly funded caseload model by a known primary midwife with secondary backup midwife/midwives providing cover and assistance, with collaboration with doctors in the event of identified risk factors. ■ Antenatal and postnatal care is usually provided in the hospital, community or home with intrapartum care in a hospital, birth centre or home.
4. **Private midwifery care**	■ Antenatal, intrapartum and postnatal care is provided by a private midwife or group of midwives in collaboration with doctors in the event of identified risk factors. ■ Antenatal, intrapartum and postnatal care could be provided in a range of locations including the home.
5. **Private obstetrician (specialist) care**	■ Antenatal care is provided by a private specialist obstetrician. ■ Intrapartum care is provided in either a private or public hospital by the private specialist obstetrician and hospital midwives in collaboration. ■ Postnatal care is usually provided in the hospital by the private specialist obstetrician and hospital midwives and may continue in the home, hotel or hostel.
6. **Private obstetrician and privately practising midwife joint care**	■ Antenatal, intrapartum and postnatal care is provided by a privately practicing obstetrician and midwife from the same collaborative private practice. ■ Intrapartum care is usually provided in either a private or public hospital by the privately practicing midwife or private specialist obstetrician in collaboration with hospital midwifery staff. ■ Postnatal care is usually provided in the hospital and may continue in the home, hotel or hostel by the privately practicing midwife.
7. **Public hospital high risk maternity care**	■ Antenatal care is provided to women with medical high risk/complex pregnancies by maternity care providers (specialist obstetricians and/or maternal-fetal medicine subspecialists in collaboration with midwives) with an interest in high risk maternity care in a public hospital. ■ Intrapartum and postnatal care is provided in the hospital by midwives and doctors in collaboration. ■ Postnatal care may continue in the home or community by hospital midwives.
8. **Public hospital maternity care**	■ Antenatal care is provided in hospital outpatient clinics (either onsite or outreach) by midwives or doctors. Care could also be provided by a multidisciplinary team. ■ Intrapartum and postnatal care is provided in the hospital by midwives and doctors in collaboration. ■ Postnatal care may continue in the home or community by hospital midwives.

Model	Description
9. Remote area maternity care	■ Antenatal and postnatal care is provided in remote communities by a remote area midwife (or a remote area nurse) or group of midwives sometimes in collaboration with a remote area nurse or doctor. ■ Antenatal and postnatal care, including high- and low-risk pregnancies, as well as consultations for the management of gestational diabetes may be provided via telehealth. Alternatively, fly-in-fly-out models can support clinicians in an outreach setting. ■ Intrapartum and early postnatal care is provided in a regional or metropolitan hospital (involving temporary relocation prior to labour) by hospital midwives and doctors.
10. Shared care	■ Antenatal care is provided by a community maternity service provider (doctor or midwife) in collaboration with hospital medical or midwifery staff under an established agreement and can occur both in the community and in hospital outpatient clinics. ■ Intrapartum and early postnatal care usually takes place in the hospital by hospital midwives and doctors, often in conjunction with the community doctor or midwife (particularly in rural settings).
11. Team midwifery care	■ Antenatal, intrapartum and postnatal care is provided by a small team of rostered midwives (no more than eight) in collaboration with doctors in the event of identified risk factors. ■ Intrapartum care is usually provided in a hospital or birth centre. ■ Postnatal care may continue in the home or community by the team midwives.

Appendix 2 – Data requirements summary and sources

Data required	Suggested data source
Population size and population projections for geographical areas within the HHS catchment.	• Queensland Government Statistician's Office Queensland Regional Database • Statistical Services Branch
Socio-demographic characteristics, chronic disease and lifestyle risk factor profile of local communities to identify relative socio-economic disadvantage and health risks Disparities between Aboriginal and Torres Strait Islander community members compared to non-Aboriginal and Torres Strait Islander community members Social determinants of health such as homelessness, domestic violence, drug and alcohol use, comorbidities, unemployment, education, rural and remote locations, social and emotional wellbeing and mental health services, child safety and early childhood information, and housing data	• Health service and system planning – Planning Portal • Department of Aboriginal and Torres Strait Islander Partnerships – local community profiles
Distance from local community to nearest service that provides: • different CSCF levels of maternity and neonatal services • planned birthing services • planned birthing services with caesarean section-capability	• online maps
Number of births: • at each facility • for women who live in each geographical area within the HHS, and which facility they birthed at, how many were referred for antenatal consults or birth at higher level facilities such as maternal fetal medicine or neonatal intensive care services, any associated maternal and perinatal risk factors, and the outcomes for each birth.	• Queensland Regional Database • Statistical Services Branch – Perinatal Data Collection • Health service and system planning – Planning Portal
Maternity service map within HHS catchment: • Maternity services available (antenatal, intrapartum, postnatal) • Models of maternity care available within the HHS catchment (the 11 maternity models) and where these are located, including models that are accessible only outside the HHS catchment • A&TSICCHOs that deliver aspects of maternity care within the HHS catchment • Geographic proximity of each facility in the service network to the nearest facility that can perform emergency caesarean section. • Name and location of maternity and neonatal tertiary service for annual upskilling of rural remote maternity staff, • Operating theatre capacity, utilisation and suitability of infrastructure across HHS sites. • Transport and accommodation available for women and their partners and families and any costs associated with accessing these, including reimbursement schemes available to women and their partners and families.	• HHS collate information from local service providers

Data required	Suggested data source
- Current staff accommodation availability for permanent and transient visiting services - Telehealth capability and workforce capacity at both hub and spoke service for antenatal and postnatal clinics - Support services that are available. These can include but are not limited to support for culturally and linguistically diverse people, people with mental health concerns, children, LGBTIQ+ (lesbian, gay, bisexual, transgender, intersex, queer, questioning and other sexuality, sex and gender diverse) families, pregnant teenagers, patients with a physical or intellectual disability, or pregnant women with other complex health needs	
Current CSCF level of maternity and support services at each facility	Clinical Services Capability Framework[13]
Workforce profile: - Available maternity workforce in each discipline - Where workforce is located - Credentials and scope of practice of available workforce - Any maternity recruitment and retention challenges that have been experienced, including data on staff recruitment and retention - Map First Nations workforce that supports maternity services delivery and assess availability against local Aboriginal and Torres Strait Islander population demographics - Identify factors that contribute to workforce recruitment and retention issues	Health Workforce Information Gateway (HeWI)
Calculate Australian Rural Birthing Index for populations between 1000 and 25,000 people in size.	Australian Rural Birthing Index Toolkit[14] (University Centre for Rural Health)
Assess maternity service system risks:	
Review available safety and quality information for each service within the maternity services network.	RiskMan Local safety and quality reporting systems (if available) Inform my care – Statewide public reporting website
Review health outcomes for women and babies (including breastfeeding, physical health and maternal mental health outcomes).	Statistical Services Branch
Compare the service outcomes against the National Core Maternity Indicators.[xviii]	Statistical Services Branch Data Dashboards
Determine rates and trends of babies being born before arrival and imminent births at non-birthing services within the network.	Perinatal Data Collection Statistical Services Branch
Review summary results of root cause analyses, Coroner's reports and any other service reviews.	RiskMan Local safety and quality reporting systems (if available) Coroners court – Findings Coronial Inquest Findings Register

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xviii Australian Institute of Health and Welfare (AIHW). National Core Maternity Indicators. Available at:
https://www.aihw.gov.au/reports/mothers-babies/ncmi-data-visualisations/contents/summary

Data required	Suggested data source
• Review referrals and transfers of women and / or babies with time critical care needs between different facilities within the HHS maternity services network and to tertiary services outside the network.	HHS case review
• Review numbers, trend, outcomes of women /newborn babies who need transfer to higher level services for care.	HHS case review

Appendix 3 – Supporting documents and resources

Consumer and community engagement and co-design

Co-design: how to increase CALD consumer participation and input[xix] (QLD Government)	https://www.dsdsatsip.qld.gov.au/resources/dsdsatsip/disability/ndis/cald/op-co-design-participation.pdf
Community engagement resources (QLD Health)	https://www.forgov.qld.gov.au/community-engagement
Experience based co-design toolkit (Australian Healthcare and Hospitals Association / Consumers Health Forum of Australia)	https://ahha.asn.au/experience-based-co-design-toolkit https://chf.org.au/experience-based-co-design-toolkit
Health Consumers Queensland	http://www.hcq.org.au/
• Consumer and community engagement framework for health organisations and consumers	http://www.hcq.org.au/wp-content/uploads/2017/03/HCQ-CCE-Framework-2017.pdf
• A guide for consumers: Partnering with health organisations	http://www.hcq.org.au/wp-content/uploads/2018/06/HCQ_ConsumerGuide.pdf
• A guide for health staff: Partnering with consumers	http://www.hcq.org.au/wp-content/uploads/2018/06/HCQ_StaffGuide.pdf
Multicultural engagement guide (QLD Health) (Currently under review)	https://www.health.qld.gov.au/multicultural/support_tools/engage-guide
Multicultural health (QLD Health)	https://qheps.health.qld.gov.au/multicultural
National Safety and Quality Health Service Standards (NSQHS) Standard 2: Partnering with consumers (Australian Commission on Safety and Quality in Health Care)	https://www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard
Patient experience and consumer engagement (Agency for Clinical Innovation, New South Wales Government)	https://www.aci.health.nsw.gov.au/make-it-happen/peace
Place-based approaches (QLD Government)	https://www.chde.qld.gov.au/about/initiatives/place-based-approaches

Aboriginal and Torres Strait Islander peoples' engagement

Aboriginal and Torres Strait Islander cultural capability framework 2010–2033 (QLD Health)	https://www.health.qld.gov.au/__data/assets/pdf_file/0014/156200/cultural_capability.pdf
Aboriginal and Torres Strait Islander patient care guideline (QLD Health)	https://www.health.qld.gov.au/__data/assets/pdf_file/0022/157333/patient_care_guidelines.pdf
AIATSIS code of ethics for Aboriginal and Torres Strait Islander research (Australian Institute of Aboriginal and Torres Strait Islander Studies)	https://aiatsis.gov.au/sites/default/files/2020-10/aiatsis-code-ethics.pdf *(see p.14 – Engagement and Collaboration)*
Australian Institute of Health and Welfare (AIHW) National guidelines for collection of Indigenous status in health data sets (Australian Institute of Health and Welfare 2010)	https://www.aihw.gov.au/reports/indigenous-australians/national-guidelines-collecting-health-data-sets/contents/table-of-contents
Growing Deadly Families: Aboriginal and Torres Strait Islander Materiality Services Strategy 2019–2025. (QLD Health 2019)	https://www.health.qld.gov.au/public-health/groups/atsihealth/health-priorities/maternity-services

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[xix] This resource is part of a suite of resources developed to assist organisations build capacity to provide culturally appropriate support options for culturally and linguistically diverse communities under the NDIS. The resources can have a wider application in healthcare. The full suite is available at: https://www.dsdsatsip.qld.gov.au/our-work/disability-services/disability-connect-queensland/national-disability-insurance-scheme/ndis-market-information-resources/cultural-linguistically-diverse-resources

Improving the identification of Aboriginal and Torres Strait Islander people in health care (QLD Health 2015)	https://www.health.qld.gov.au/__data/assets/pdf_file/0032/146795/ii_guide.pdf
My life My Lead. Opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health. Report on the national consultations (Commonwealth of Australia 2017)	https://www.health.gov.au/resources/publications/my-life-my-lead-report-on-the-national-consultations
National Aboriginal and Torres Strait Islander Health Plan 2021–2031 (Commonwealth of Australia 2021)	https://www.health.gov.au/health-topics/aboriginal-and-torres-strait-islander-health/how-we-support-health/health-plan https://www.health.gov.au/resources/publications/national-aboriginal-and-torres-strait-islander-health-plan-2021-2031
Local Thriving Communities (Department of Aboriginal and Torres Strait Islander Partnerships)	https://www.dsdsatsip.qld.gov.au/our-work/aboriginal-torres-strait-islander-partnerships/reconciliation-tracks-treaty/tracks-treaty/local-thriving-communities
Queensland Aboriginal and Islander Health Council (QAIHC)	https://www.qaihc.com.au/about/our-members
The characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander women (Australian Government 2012)	https://www1.health.gov.au/internet/main/publishing.nsf/Content/maternity-pubs-cultur
NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health (Australian Commission on Safety and Quality in Health Care 2017)	https://www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-user-guide-aboriginal-and-torres-strait-islander-health

Data collection and analysis

Aboriginal and Torres Strait Islander community profiles: Know Your Community (Department of Aboriginal and Torres Strait Islander Partnerships)	https://statistics.qgso.qld.gov.au/know-your-community/profiles
Australian Rural Birthing Index Toolkit (University Centre for Rural Health)	https://ucrh.edu.au/the-australian-rural-birthing-index-toolkit/
Queensland Mothers and Babies reports (Queensland Maternal and Perinatal Quality Council)	https://clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/queensland-maternal-and-perinatal-quality-council/resources-and
Queensland Regional tools and statistics (QLD Government Statistician's Office)	https://www.qgso.qld.gov.au/statistics/QLD-regions/regional-tools-statistics
Perinatal reports and information (QLD Health)	https://www.health.qld.gov.au/hsu/peri#annual
Perinatal data collection (QLD Health)	https://www.health.qld.gov.au/hsu/collections/pdc
Health Service and system planning – Planning Portal (QLD Health)	https://www.health.qld.gov.au/system-governance/strategic-direction/plans/health-service
Statistical Services Branch, QLD Health	https://www.health.qld.gov.au/hsu
• Data Dashboards	https://qheps.health.qld.gov.au/hsu/dashboards/dbhome
• Health Indicator sets	https://www.health.qld.gov.au/hsu/healthindicators/healthindicators
• InfoBank	https://qheps.health.qld.gov.au/hsu/infobank/infobank

Benchmarking/assessing maternity service system risks

Aboriginal and Torres Strait Islander Health – Performance Indicators (QLD Health)	https://qheps.health.qld.gov.au/hsu/qhpi-at

Health Roundtable	https://www.healthroundtable.org/Join-Us/Improvement-Groups/Maternity
National Core Maternity Indicators (Australian Institute of Health and Welfare)	https://www.aihw.gov.au/reports/mothers-babies/ncmi-data-visualisations/contents/summary
Patient Experience Surveys (QLD Health) ● Maternity ● Maternity Outpatient Clinics	https://qheps.health.qld.gov.au/psu/patient-experience
Patient Reported Experience and Outcome Measures (QLD Health)	https://qheps.health.qld.gov.au/psu/premsproms
Variable Life Adjustment Display (VLAD)	https://qheps.health.qld.gov.au/psu/vlads
Women's Healthcare Australasia	https://women.wcha.asn.au/benchmarking

Maternity services design and planning

Business Planning Framework (*for midwifery workload management*) (QLD Health)	https://qheps.health.qld.gov.au/nmoq/workforce-sustainability/bpf
Decision Making Framework (*for transitions to maternity continuity of carer models*) (QLD Health)	https://qheps.health.qld.gov.au/nmoq/maternity/decision-making-framework
Maternity Care in Australia. A framework for a healthy new generation of Australians (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists).	https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/About/Maternity-Care-in-Australia-Web.pdf
Midwifery Continuity of Carer Cost Modelling Tool (QLD Health)	https://qheps.health.qld.gov.au/nmoq/maternity/midwifery-continuity-of-carer-cost-modelling-tool
National Safety and Quality Health Service (NSQHS) Standard 1: Clinical Governance Standard	https://www.safetyandquality.gov.au/our-work/clinical-governance/clinical-governance-standard
Nomenclature for models of maternity care: literature review (Australian Institute of Health and Welfare)	https://www.aihw.gov.au/reports/mothers-babies/nomenclature-for-models-of-maternity-care/contents/table-of-contents
Obstetric and gynaecology services in rural and remote communities in Australia (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists)	https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/O-G-services-in-remote-and-rural-communities-in-Australia-(C-Obs-34).pdf?ext=.pdf
Woman-centred care: Strategic directions for Australian maternity services (Australian Government)	https://www.health.gov.au/resources/publications/woman-centred-care-strategic-directions-for-australian-maternity-services

Health Service planning

Clinical Services Capability Framework (QLD Health)	https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/modules
Data Guide (QLD Health)	https://qheps.health.qld.gov.au/__data/assets/pdf_file/0023/417083/gdl206_data_guide.pdf
Guide to health service planning (QLD Health)	https://qheps.health.qld.gov.au/__data/assets/pdf_file/0016/418300/gdl201_guide_to_hsp.pdf
Health information supplement (QLD Health)	https://qheps.health.qld.gov.au/__data/assets/pdf_file/0028/416836/gdl205_info_supp.pdf
Health service and system planning (QLD Health)	https://www.health.qld.gov.au/system-governance/strategic-direction/plans/health-service
Health service planning tools (QLD Health)	https://qheps.health.qld.gov.au/spb/html/ppb_hsp_tools

| Investment Management Framework (QLD Health) | https://qheps.health.qld.gov.au/csd/business/property-projects/infrastructure-strategy/investment-management-framework |
| Methods for reporting population health status (QLD Health) | https://www.health.qld.gov.au/research-reports/population-health/methods |

Workforce planning

Hospital Facility Integrated Strategic Workforce Planning, Considerations and Interdependencies (QLD Health)	https://qheps.health.qld.gov.au/__data/assets/pdf_file/0028/2530828/2a.-Planning,-Considerations-and-Interdependencies-v2.pdf
Strategic health workforce planning framework (QLD Health)	https://www.health.qld.gov.au/system-governance/strategic-direction/plans/health-workforce-strategy/strategic-health-workforce-planning-framework
Workforce Planning (QLD Health)	https://qheps.health.qld.gov.au/hr/workforce-planning
Workforce Strategy Branch (QLD Health)	https://qheps.health.qld.gov.au/wsb

Project Management

| Project Management Framework (QLD Health) | https://qheps.health.qld.gov.au/clinical-excellence/project-management-framework |
| Project Management Resources (QLD Health) | https://healthqld.sharepoint.com/teams/CEQ-PaM/SitePages/Resources.aspx |

Rural and remote health services

Better Health for the Bush. A plan for safe, applicable healthcare for rural and remote Queensland (QLD Health)	https://www.health.qld.gov.au/__data/assets/pdf_file/0027/436815/better-health-bush.pdf
Rural and Remote Clinical Network (QLD Health)	https://www.health.qld.gov.au/clinical-practice/engagement/networks/rural-remote
Rural and remote health service framework (QLD Health)	https://qheps.health.qld.gov.au/__data/assets/pdf_file/0029/421976/randr_hsp_framework.pdf
Rural and remote health service planning process (QLD Health)	https://qheps.health.qld.gov.au/__data/assets/pdf_file/0019/413137/randr_hsp_process.pdf
Rural and remote training and development (QLD Health)	https://www.health.qld.gov.au/employment/professional-development/rural-remote
Rural Maternity Taskforce Report (QLD Health)	https://clinicalexcellence.qld.gov.au/priority-areas/patient-experience/maternity-service-improvement/rural-maternity

Clinical Guidelines

Clinical Practice Guidelines: Pregnancy Care (Australian Government)	https://www.health.gov.au/resources/pregnancy-care-guidelines?utm_source=health.gov.au&utm_medium=redirect&utm_campaign=digital_transformation&utm_content=antenatal
Maternity and Neonatal Clinical Guidelines (QLD Health).	https://www.health.qld.gov.au/qcg/publications
National Midwifery Guidelines for Consultation and Referral. 4th Edition. (Australian College of Midwives)	https://www.midwives.org.au/Web/About-ACM/Midwifery-Guidelines-and-Standards/Web/About-ACM/Guideline-Statements.aspx?hkey=1ac129e0-1241-4894-9efe-4edb089f31ec

Partnering with a woman who declines recommended maternity care. (QLD Health)	https://www.health.qld.gov.au/consent/html/pwdrmc
Primary Clinical Care Manual. 10th edition (QLD Health 2019)	https://www.health.qld.gov.au/rrcsu/html/PCCM

Appendix 4 – Templates and examples

The following templates and examples are provided in an attachment as stand-alone documents for ease of use:

- Assessment template – Facility *(Available on request from System Planning Branch via email: Statewide_Planning@health.qld.gov.au)*

- Assessment template – HHS *(Available on request from System Planning Branch via email: Statewide_Planning@health.qld.gov.au)*

- Gantt chart with proposed timeframes (EXCEL)

- Steering committee
    - Terms of reference – draft
    - Phone script and letter content for inviting consumers onto steering committee

- Example – data and information summary graphic (PDF)

- Survey questions

- Stakeholder forums:
    - Phone script and letter content for inviting consumers who have recently had a baby to attend stakeholder forums
    - Forum information sheet (for attendees)
    - Forum Schedules
        - Example 1 – Hub and rural site
        - Example 2 – Hub and outreach site
        - Example 3 – Rural town + hub
        - Example 4 – Rural site

Table 3. Gantt chart for rural and remote maternity service review, assessment and planning process

Ref	Activity	Lead	Start	End	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
1	**Review current service**		1	11																										
1.1	**Determine scope, process, approach, expectations.**		1	1	█																									
1.1.1	Confirm with HHS Executive and/or Board, expectations, discuss process, approach, and level of support required.		1	1	█																									
1.1.2	Identify resource to lead review and assessment		1	1	█																									
1.2	**Establish governance and steering committee**		1	1	█																									
1.2.1	Hold steering committee meetings fortnightly		2	26		█		█		█		█		█		█		█		█		█		█		█		█		█
1.3	**Create stakeholder engagement and consultation plan**				█																									
1.4	**Collect and analyse data and service information**		2	6			█	█	█	█																				
	• Describe current maternity service map • Prepare workforce profile • Assess Maternity service system risks • Calculate Australian Rural Birthing Index (ARBI) if appropriate • Prepare summary report																													
1.5	**Engagement and consultation with stakeholders**		3	8			█	█	█	█	█	█																		
1.5.1	Prepare consultation material		3	6			█	█	█																					
1.5.2	Consumer and community consultation		7	9							█	█	█																	
1.5.3	Clinician consultation		7	9							█	█	█																	
1.6	**Report on findings**		9	16									█	█	█	█	█	█	█	█										
1.6.1	Compile report		9	12									█	█	█	█														
1.6.2	Deliver report and recommendations to HHS Executive for approval		13	14													█	█												
1.6.3	Progress through governance process for approval to change scope/enhance service as required		15	16															█	█										
1.6.4	Feedback findings to all stakeholders		17	18																	█	█								
2	**Plan (re)design of maternity service**		18	26																		█	█	█	█	█	█	█	█
2.1	**Develop plan for co-designing maternity services** • Identify resource to lead planning and co-design project • Review steering committee membership and update if required • Review and update stakeholder engagement and communication plan		18	20																		█	█	█						

Ref	Activity	Lead	Start	End	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
2.2	**Design maternity service**		20	26																				■	■	■	■	■	■	■
2.2.1	Engage with stakeholders to develop options		20	23																				■	■					
2.2.2	Complete Maternity Services DMF process		20	21																				■	■	■				
2.2.3	Feedback to stakeholders on assessment and prioritisation of options		24	25																								■	■	
2.2.4	Finalise plan for maternity services		24	26																								■		■
3	**Follow HHS and Department (if appropriate) approval processes to implement planned changes to service**		26	?																										▶

Acronyms and Abbreviations

Acronym	Definition
ABS	Australian Bureau of Statistics
ACM	Australian College of Midwives
A&TSICCHOs	Aboriginal and Torres Strait Islander Community-Controlled Health Organisations
AIHW	Australian Institute of Health and Welfare
ANZCA	Australian and New Zealand College of Anaesthetists
APV	Adjustment for Population Vulnerability
ARBI	Australian Rural Birthing Index
CALD	Culturally and linguistically diverse
CPAP	Continuous positive airway pressure
CSCF	Clinical Services Capability Framework
DMF	Decision Making Framework
GP	General Practitioner
HCQ	Health Consumers Queensland
HHS	Hospital and Health Service
IF	Isolation Factor
MMM	Modified Monash Model of rurality classification
NSQHS	National Safety and Quality Health Service
PBS	Population Birth Score
PHN	Primary Health Networks
QLD	Queensland
RA	Remoteness Area
RANZCOG	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

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