Report on Inquiry into Maternity Services in the ACT

Standing Committee on Health, Ageing and Community Services

June 2020

Report 10

# 

# The Committee

Committee membership

Ms Bec Cody MLA Chair from 26 September 2018

Mrs Vicki Dunne MLA Deputy Chair from 14 December 2016

Member from 13 December 2016

Ms Caroline Le Couteur MLA Member from 13 December 2016

Former Members

Mr Chris Steel MLA Chair from 14 December 2016 to 23 August 2018

Mrs Elizabeth Kikkert MLA Deputy Chair from 14 December 2016 to 20 September 2018

Mr Michael Pettersson MLA Chair from 4 to 20 September 2018

Member from 13 December 2016 to 3 September 2018

Secretariat

Dr Andréa Cullen FGIA FCIS Secretary [from 21 August 2019]

Mr Andrew Snedden Acting Secretary [from 10 July 2019 to 20 August 2019]

Mrs Josephine Moa Secretary [from July 2018 to 9 July 2019]

Ms Alice Houghton Assistance with preliminary research on ACT maternal and perinatal data

Ms Frieda Scott Assistance with summarising six written submissions

Ms Lydia Chung Administrative assistance

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Resolution of appointment

The Australian Capital Territory (ACT) Legislative Assembly appointed the Standing Committee on Health, Ageing and Community Services on 13 December 2016.

Specifically, the resolution of 13 December 2016 establishing the Standing Committees of the 9thAssembly as it relates to the Standing Committee on Health, Ageing and Community Services states:

That:

(1) The following general purpose standing committees be established and each committee inquire into and report on matters referred to it by the Assembly or matters that are considered by the committee to be of concern to the community:

(b) a Standing Committee on Health, Ageing and Community Services to examine matters related to hospitals, community and public health, mental health, health promotion and disease prevention, disability matters, drug and substance misuse, targeted health programs and community services, including services for older persons and women, families, housing, poverty, and multicultural and indigenous affairs;[[1]](#footnote-1)

(6) Each committee shall have power to consider and make use of the evidence and records of the relevant standing committee during the previous Assembly.

(7) Each committee be provided with necessary staff, facilities and resources.

(8) The foregoing provisions of this resolution, so far as they are inconsistent with the standing orders, have effect notwithstanding anything contained in the standing orders.[[2]](#footnote-2)

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Preface

*I think we have tripped into a space where we deliver services that meet the needs of the services rather than putting the woman in the centre and asking what is right, what does the woman need and what does the woman want. Mostly people want what is best for them.*[[3]](#footnote-3)

Ms Mary Kirk—Executive Officer, Canberra Mothercraft Society

The Committee emphasises that the provision of maternity services in the ACT should be woman-centred rather than service-centred. Overwhelmingly evidence received to this inquiry was of the view that maternity services and models of care should be woman-centred.

Maternity care that is woman-centred ‘focuses on a woman’s unique needs, expectations and aspirations; recognises her right to self-determination in terms of choice, control and continuity of care; and addresses her social, emotional, physical, psychological, spiritual and cultural needs and expectations. Woman-centred care also acknowledges that a woman and her unborn baby do not exist independently of the woman’s social and emotional environment and incorporates this understanding in assessment and provision of health care’.[[4]](#footnote-4)

In seeking to respond to the many issues raised in evidence to this inquiry—the Committee has been forward looking in setting out its recommendations using an overarching ethos that maternity services and models of care should at all times be woman-centred. The Committee further emphasises that the benefits of woman-centred care for both women and care providers are well established.

The Committee acknowledges the professional staff—midwives, doctors, nurses, allied health and other clinicians—who deliver maternity services in and across the maternity care continuum in the ACT and the vast array of non-clinical staff (including significant numbers of volunteers) who support the professionals in the delivery of these services. The Committee also acknowledges that maternity services and care is delivered in the ACT—24 hours a day, 7 days a week, 52 weeks a year, often under significant pressure and increasing demand.

The Committee wishes to thank all of those who have contributed to its inquiry, by making submissions and/or appearing before it to give evidence. The Committee recognises the significant commitment of time and resources, and for many the emotional heartache and distress, required to participate in an inquiry of this nature and is grateful that it was able to draw on a broad range of expertise and experience in its deliberations. In its report, the Committee has based many of its recommendations on suggestions by inquiry participants.

Standing Committee on Health, Ageing and Community Services

## 

Acronyms/Glossary

|  |  |
| --- | --- |
| Term | Definition |
| ABA | Australian Breastfeeding Association |
| ACT | Australian Capital Territory |
| ACTIA | Australian Capital Territory Insurance Authority |
| AHPRA | Australian Health Practitioner Regulatory Agency |
| AIHW | Australian Institute for Health and Welfare |
| ANMF | Australian Nursing Midwifery Federation |
| ATSI | Aboriginal and Torres Strait Islander |
| AusHFG | Australasian Health Facility Guidelines |
| BFCI | Baby Friendly Community Initiative |
| BFHI | Baby-Friendly Health Initiative |
| BMI | Body Mass Index |
| CatCH | Continuity at the Centenary Hospital |
| CALD | Culturally and linguistically diverse |
| CHS | Canberra Health Services |
| CHWC | Centenary Hospital for Women and Children |
| COAG | Council of Australian Governments |
| COPE | Centre of Perinatal Excellence |
| CPHB | Calvary Public Hospital Bruce |
| CMP | Canberra Midwifery Program |
| CMS | Canberra Mothercraft Society |
| GP | General Practitioner |
| HCCA | Health Care Consumers’ Association |
| HCE | Health Complaints Entity |
| HPH | Health Promoting Hospital |
| LC | Lactation Consultant |
| LGBTQI+ | Lesbian, Gay, Bisexual, Transgender, Queer or Intersex |
| LMC | Lead Maternity Carer |
| MACH | Maternal and Child Health |
| MaCC | Maternity Care Classification System |
| MACW | Ministerial Advisory Committee on Women |
| MBS | Medicare Benefits Schedule |
| NHMRC | National Health and Medical Research Council |
| NGOS | Non-government organisations |
| NSW | New South Wales |
| NICU | Neonatal Intensive Care Unit |
| NZ | New Zealand |
| OECD | Organisation for Economic Co-operation and Development |
| PANDSI | ACT Post and Ante Natal Depression Support and Information organisation (now the Perinatal Wellbeing Centre) |
| PEP | Parenting Enhancement Program |
| PTSD | Post-traumatic stress disorder |
| Queen Elizabeth II Family Centre | A residential 4-night, 5-day inpatient service for families experiencing significant parenting challenges that require intensive intervention and strategies to promote family health and wellbeing. |
| RANZCOG | Royal Australian and New Zealand College of Obstetrics and Gynaecology |
| SCN | Special Care Nursery |
| Sands Australia | Miscarriage, stillbirth and newborn death support |
| TCH | The Canberra Hospital |
| T of R | Terms of Reference |
| UNSW | University of New South Wales |
| WHO | World Health Organization |

Recommendations

[Recommendation 1](#_Toc45628730)

[5.12 The Committee recommends that the ACT Government ensure that the planning, design and delivery of maternity services in the ACT is woman- and baby-centred.](#_Toc45628731)

[Recommendation 2](#_Toc45628732)

[5.13 The Committee recommends that the ACT Government report to the ACT Legislative Assembly by the last sitting day in August 2020 on the implementation of the National Strategy—*Woman-centred care: Strategic directions for Australian maternity services*. This should include: (i) detail on the implementation plan and phases; and (ii) an assessment of the broad changes needed to the planning, design and delivery of maternity services in the ACT to provide for woman-centred care pursuant to the National Strategy.](#_Toc45628733)

[Recommendation 3](#_Toc45628734)

[5.14 The Committee recommends that the ACT Government report to the ACT Legislative Assembly by the last sitting day in August 2020 on the implementation of *Canberra Maternity Options* and its effectiveness in making it easier for women to learn about and access Canberra’s public maternity system. This should include: (i) detail on the implementation plan and phases; and (ii) the design of an evaluation framework that encompasses process, impact and outcome evaluation parameters.](#_Toc45628735)

[Recommendation 4](#_Toc45628736)

[5.25 The Committee recommends that the ACT Government in partnership with Tresillian Family Care Centres conduct a trial of a ‘First 2000 Days’ pilot program to address the needs of families and to support vulnerable and disadvantaged families in the ACT.](#_Toc45628737)

[Recommendation 5](#_Toc45628738)

[5.26 The Committee recommends that the ACT Government in partnership with Canberra Mothercraft Society and Relationships Australia ACT and Region trial the wider availability of the evidence-based parenting program ‘Relaxing into Parenting + Baby Makes Three’.](#_Toc45628739)

[Recommendation 6](#_Toc45628740)

[5.27 The Committee recommends that the ACT Government ensure that ACT maternity care clinical practices and referral pathways—in particular those concerned with post-natal depression are inclusive of fathers and partners to support timely identification and treatment.](#_Toc45628741)

[Recommendation 7](#_Toc45628742)

[5.28 The Committee recommends that the ACT Government ensure infrastructure planning responds to women’s preference for partners and/or support people to remain with them during and after labour.](#_Toc45628743)

[Recommendation 8](#_Toc45628744)

[5.29 The Committee recommends that the ACT Government—in partnership with its Council of Australian Government (COAG) colleagues—advocate for changes to the *Australasian Health Facility Guidelines* (AusHFG) to support women’s preference for partners and/or support people to remain with them during and after labour.](#_Toc45628745)

[Recommendation 9](#_Toc45628746)

[5.42 The Committee recommends that the ACT Government should prioritise improving the availability of woman-centred midwife-led continuity of care throughout the ACT.](#_Toc45628747)

[Recommendation 10](#_Toc45628748)

[5.43 The Committee recommends that the ACT Government should prioritise dismantling the barriers that prevent the availability of and access to woman-centred midwife-led continuity of care. This includes but is not limited to: (i) extending midwife visiting rights to ACT hospitals; (ii) expanding birth centre and home birth places and options; and (iii) establishing avenues for providing women and families with independent evidence-based information on the benefits of midwife-led continuity of care.](#_Toc45628749)

[Recommendation 11](#_Toc45628750)

[5.51 The Committee recommends that the ACT Government should expand the availability of continuity of care and carer models to enable women’s choices to be met and supported.](#_Toc45628751)

[Recommendation 12](#_Toc45628752)

[5.52 The Committee recommends that the ACT Government ensure that the planning, design and delivery of maternity services in the ACT is underpinned by the concept of continuity of care and carer. This should include the incorporation of the three dimensions of continuity of care—relational/personal; information; and management—in and across all available models of maternity care.](#_Toc45628753)

[Recommendation 13](#_Toc45628754)

[5.53 The Committee recommends that the ACT Government should ensure that funding models for maternity services in the ACT recognise the need to include not only women but also their babies—to ensure adequate services and staffing and reasonable workloads to meet continuity of care needs of both mothers and their babies.](#_Toc45628755)

[Recommendation 14](#_Toc45628756)

[5.54 The Committee recommends that the ACT Government—in partnership with its Council of Australian Government (COAG) colleagues—advocate for the development of funding models to support access to continuity of care and continuity of carer models in all jurisdictions.](#_Toc45628757)

[Recommendation 15](#_Toc45628758)

[5.62 The Committee recommends that the ACT Government revisit the accreditation of its hospitals and health services as World Health Organization (WHO) health promoting hospitals and health services.](#_Toc45628759)

[Recommendation 16](#_Toc45628760)

[5.63 The Committee recommends that the ACT Government investigate the feasibility of accrediting the Centenary Hospital for Women and Children as a World Health Organization (WHO) health promoting hospital.](#_Toc45628761)

[Recommendation 17](#_Toc45628762)

[6.16 The Committee recommends that the ACT Government should: (i) publicly release key indicators of maternity safety, quality and health outcomes at regular intervals; and (ii) where quality and safety data indicate that services are performing below the National average in any area—a plan to improve care, involving women in the governance of these initiatives, should be developed and implemented. The Committee further recommends that the Government consider publishing this information in the *ACT Public Health Services Quarterly Performance Report.*](#_Toc45628763)

[Recommendation 18](#_Toc45628764)

[6.17 The Committee recommends that the ACT Government should develop measurable targets for increasing women’s access to continuity of care services, and access to psychological support and services across the maternity continuum.](#_Toc45628765)

[Recommendation 19](#_Toc45628766)

[6.18 The Committee recommends that the ACT Government consider developing a consumer feedback tool and process that elicits at six months post birth a woman’s maternity experience—physical, social, cultural, emotional, psychological and spiritual safety—in accordance with the Australian Commission on Safety and Quality in Health Care Partnering with Consumer Standard.](#_Toc45628767)

[Recommendation 20](#_Toc45628768)

[6.26 The Committee recommends that the ACT Government prioritise how lessons can be learned and future risks mitigated in relation to service complaints that are settled on a confidential basis and are not reported to the Health Practitioner Regulation Agency (AHPRA) or the ACT Health Complaints Entity (HCE).](#_Toc45628769)

[Recommendation 21](#_Toc45628770)

[6.27 The Committee recommends that pursuant to the ACT *Civil Law (Wrongs) Act 2002* that the ACT Government provide flexibility for maternity care claimants seeking low financial compensation to be conciliated outside formal court processes under the ACT *Human Rights Commission Act 2005*.](#_Toc45628771)

[Recommendation 22](#_Toc45628772)

[6.38 The Committee recommends that the ACT Government should implement the Australian Nursing and Midwifery Federation’s Mandated Minimum Nurse/Midwife to Patient Ratios Framework for the safe management of maternity workloads across publicly funded maternity services.](#_Toc45628773)

[Recommendation 23](#_Toc45628774)

[6.46 The Committee recommends that the ACT Government establishes a Ministerial Advisory Council on Maternal Health comprising consumer and community representatives to advise the Minister on the policy direction for maternity services and models of care with a view to developing a comprehensive model of woman-centred care that encompasses a care continuum for the mother baby family unit from conception to early childhood.](#_Toc45628775)

[Recommendation 24](#_Toc45628776)

[6.47 The Committee recommends that the ACT Government should ensure that woman-reported outcomes, well-being and experiences are collected (for example, using patient reported experience(s) and outcome measures) and reported as a core part of quality assessment of maternity services.](#_Toc45628777)

[Recommendation 25](#_Toc45628778)

[6.48 The Committee recommends that the ACT Government strengthen the current consumer involvement process to ensure that it represents the needs of the people accessing maternity care.](#_Toc45628779)

[Recommendation 26](#_Toc45628780)

[6.49 The Committee recommends that the ACT Government ensure that maternity consumers are represented and included in ACT Maternity Services planning and monitoring committees.](#_Toc45628781)

[Recommendation 27](#_Toc45628782)

[6.55 The Committee recommends that in light of the feedback provided by the Canberra Mothercraft Society on *the ACT Health Territory-Wide Health Services Framework 2017–27* (the Framework), the ACT Government review the Framework and make any necessary adjustments.](#_Toc45628783)

[Recommendation 28](#_Toc45628784)

[6.59 The Committee recommends that the ACT Government remind all health professionals working within the delivery of ACT publicly funded maternity services of their responsibilities and obligations: (i) regarding adequate and contemporaneous clinical record keeping; and (ii) that any disclosure of patient clinical records should be in accordance with legislative requirements for managing the privacy of health records.](#_Toc45628785)

[Recommendation 29](#_Toc45628786)

[7.14 The Committee recommends that the ACT Government update its *Canberra Maternity Options* with accessible evidence-based information about the: (i) options, outcomes, and implications of choices regarding models of care; and (ii) benefits for women, their babies and families and health professionals of planning, designing and delivering maternity services that are underpinned by the concept of continuity of care and continuity of carer.](#_Toc45628787)

[Recommendation 30](#_Toc45628788)

[7.22 The Committee recommends that the ACT Government mandate that birth debriefings with a qualified health professional be offered to and accessed by women and their husbands or partners within 72 hours after birthing.](#_Toc45628789)

[Recommendation 31](#_Toc45628790)

[7.24 The Committee recommends that the ACT Government prioritise a feasibility study to examine the establishment of a perinatal hospice facility to provide perinatal services and care to relevant women, their babies and families.](#_Toc45628791)

[Recommendation 32](#_Toc45628792)

[7.25 The Committee recommends that the ACT Government—in partnership with its Council of Australian Government (COAG) colleagues—advocate for changes to the *Australasian Health Facility Guidelines* (AusHFG) to include inpatient requirements for perinatal hospice facilities, services and care.](#_Toc45628793)

[Recommendation 33](#_Toc45628794)

[7.26 The Committee recommends that the ACT Government in the planning, design and delivery of maternity services and models of care adopt the Sands *Australian Principles of Bereavement Care—Miscarriage, Stillbirth and Newborn Death.*](#_Toc45628795)

[Recommendation 34](#_Toc45628796)

[7.27 The Committee recommends that the ACT Government provide bereavement training—informed by the Sands *Australian Principles of Bereavement Care—Miscarriage, Stillbirth and Newborn Death—*to all health professionals working in and across the maternity care continuum in the ACT.](#_Toc45628797)

[Recommendation 35](#_Toc45628798)

[7.28 The Committee recommends that the ACT Government—in partnership with Sands Australia, Red Nose Australia, Perinatal Wellbeing Centre and other organisations working to support women and families experiencing perinatal loss—implement strategies to strengthen comprehensive bereavement care and information and emotional support for bereaved parents in their transition from hospital to home and the months following.](#_Toc45628799)

[Recommendation 36](#_Toc45628800)

[7.35 The Committee recommends that the ACT Government ensure that the planning, design and delivery of maternity services and models of care reflect and support the competencies detailed in the *Characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander women report*.](#_Toc45628801)

[Recommendation 37](#_Toc45628802)

[7.36 The Committee recommends that the ACT Government continue and expand support for community-based maternal, child and family health services delivered by community-controlled, Aboriginal health services.](#_Toc45628803)

[Recommendation 38](#_Toc45628804)

[7.37 The Committee recommends that the ACT Government support the implementation of strategies identified in the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023*.](#_Toc45628805)

[Recommendation 39](#_Toc45628806)

[7.38 The Committee recommends that the ACT Government support the development of an Aboriginal and Torres Strait Islander maternity services workforce.](#_Toc45628807)

[Recommendation 40](#_Toc45628808)

[7.39 The Committee recommends that the ACT Government enhance continuity of care for Indigenous women in the ACT—in particular, in regard to transfers between community-based and hospital settings.](#_Toc45628809)

[Recommendation 41](#_Toc45628810)

[7.42 The Committee recommends that the ACT Government expand the continuity of midwifery care program to be accessible and culturally appropriate.](#_Toc45628811)

[Recommendation 42](#_Toc45628812)

[7.43 The Committee recommends that the ACT Government ensure that the planning, design and delivery of maternity services and models of care reflect and support the competencies detailed in the *Competency Standards Framework for Clinicians—Culturally responsive clinical practice: Working with people from migrant and refugee backgrounds*.](#_Toc45628813)

[Recommendation 43](#_Toc45628814)

[7.44 The Committee recommends that the ACT Government ensure that the planning, design and delivery of maternity services and models of care support all health professionals providing services and care to people who need to use a language other than English to access information and/or communicate effectively when accessing maternity services and care. This should include: (i) the development of strategies to improve training in working with interpreters and bicultural workers; (ii) women who require interpreting services having access to these services at every appointment; (iii) improved accessibility of language services and bilingual and bicultural workers; and (iv) accessible language services should also be extended to women who are deaf or hard of hearing and require the use of Auslan or Deaf interpreters.](#_Toc45628815)

[Recommendation 44](#_Toc45628816)

[7.60 The Committee recommends that the ACT Government ensure that the planning, design and delivery of maternity services and models of care supports the delivery of care, especially face-to-face delivery, in places and in ways that are accessible for women with a range of disabilities.](#_Toc45628817)

[Recommendation 45](#_Toc45628818)

[7.61 The Committee recommends that the ACT Government identify and implement strategies to better support women who are the subject of a child protection notification during their pregnancy.](#_Toc45628819)

[Recommendation 46](#_Toc45628820)

[7.62 The Committee recommends that the ACT Government in its planning, design and delivery of maternity services and models of care strengthen strategies to better identify and respond to women at increased risk of intimate partner violence during pregnancy and trauma informed care is used to ensure safety is prioritised.](#_Toc45628821)

[Recommendation 47](#_Toc45628822)

[7.63 The Committee recommends that the ACT Government extend the continuity of the maternity care model for women under the Parenting Enhancement Program (PEP) to include postpartum support.](#_Toc45628823)

[Recommendation 48](#_Toc45628824)

[7.66 The Committee recommends that—for women and their families who are the subject of child protection notification in pregnancy and who are at risk of having their child removed from their care—the ACT Government: (a) strengthen and enhance pre and postnatal family and decision making support; and (b) proactively address child protection and health care practices that reflect the assumption that removal of a child in these circumstances is inevitable.](#_Toc45628825)

[Recommendation 49](#_Toc45628826)

[7.77 The Committee recommends that the ACT Government—in partnership with all stakeholders that work in and across the integrated network of public, private and voluntary health services that deliver maternity services to the ACT community—develop a *Fit for the Future Territory-Wide Maternity Workforce Plan*. The Plan should address the drivers of supply and retention including, but not limited to, higher education, recruitment and working conditions, targeted ongoing learning, positive cultures, effective leadership, and well-articulated and supported transition to practice programs.](#_Toc45628827)

[Recommendation 50](#_Toc45628828)

[7.78 The Committee recommends that the ACT Government strengthen and support the development and maintenance of skills (including clinical reflection and supervision) of health professionals working in maternity services—with regard to: (i) cultural competency; (ii) trauma-informed care; (iii) open disclosure; (iv) shared decision-making; (v) mental health and well-being competency; (vi) disability sensitivity; (vii) bereavement care; and (viii) working with vulnerable, marginalised and disadvantaged women.](#_Toc45628829)

[Recommendation 51](#_Toc45628830)

[8.7 The Committee recommends that the ACT Government ensure that the planning, design and delivery of maternity services and models of care adopt and uphold the 10 principles outlined in the Global Respectful Maternity Care Council’s *Respectful Maternity Care Charter: Universal Rights of Mothers and Newborns.*](#_Toc45628831)

[Recommendation 52](#_Toc45628832)

[9.14 The Committee recommends that the ACT Government take appropriate steps to ensure that the *Canberra Maternity Options* Program can focus on individual women’s needs or choices when they choose where to birth.](#_Toc45628833)

[Recommendation 53](#_Toc45628834)

[9.18 The Committee recommends that the ACT Government strengthen the structure of antenatal education to be inclusive of all the potential risks as well as the positive aspects of pregnancy, the birthing experience and parenting. This should include: (i) coverage of where birthing events may not progress as planned; and (ii) planning for unanticipated complications, necessary precautions and redress measures.](#_Toc45628835)

[Recommendation 54](#_Toc45628836)

[10.14 The Committee recommends that the ACT Government: (i) adopt the Maternity Care Classification System (MaCCS) and use it when referring to models of care available in the ACT in the information provided to women and their families; and (ii) use the MaCCS to evaluate the effectiveness of all single-models of maternity care available to pregnant and birthing women in the ACT and surrounding region and publicly report this information at regular intervals.](#_Toc45628837)

[Recommendation 55](#_Toc45628838)

[10.15 The Committee recommends that the ACT Government—in partnership with key advocacy and consumer stakeholders—develop and facilitate access to specialised models of maternity care for women who have a high risk of poorer outcomes.](#_Toc45628839)

[Recommendation 56](#_Toc45628840)

[10.19 The Committee recommends that the ACT Government establish eligibility criteria for the Birth Centre at the Centenary Hospital for Women and Children in accordance with evidence-based guidelines such as the *National Midwifery Guidelines for Consultation and Referral*.](#_Toc45628841)

[Recommendation 57](#_Toc45628842)

[10.20 The Committee recommends that the ACT Government expand the capacity of the Birth Centre Unit at the Centenary Hospital for Women and Children to address unmet demand for this major model category of maternity care.](#_Toc45628843)

[Recommendation 58](#_Toc45628844)

[10.31 The Committee recommends that the ACT Government establish planned home birth as an ongoing birth option (model of care) for women in the ACT.](#_Toc45628845)

[Recommendation 59](#_Toc45628846)

[10.32 The Committee recommends that the ACT Government establish eligibility criteria for planned home birth models of care in accordance with evidence-based guidelines such as the *National Midwifery Guidelines for Consultation and Referral*.](#_Toc45628847)

[Recommendation 60](#_Toc45628848)

[10.35 The Committee recommends that the ACT Government dismantle barriers for private midwives to exercise visiting and rights of private practice to care for women who may need to be admitted in unforeseen circumstances in public hospitals.](#_Toc45628849)

[Recommendation 61](#_Toc45628850)

[10.36 The Committee recommends that the ACT Government—in partnership with its Council of Australian Government (COAG) colleagues—advocate for changes to address Medicare Benefits Schedule (MBS) arrangements and indemnity insurance which limit access to private home birth for women and their families.](#_Toc45628851)

[Recommendation 62](#_Toc45628852)

[10.47 The Committee recommends that the ACT Government, pursuant to the *ACT Breastfeeding Strategic Framework 2010–2015,* ensure the provision of effective, consistent, up to date and evidence-based breastfeeding information and services for mothers and babies in hospital and community settings.](#_Toc45628853)

[Recommendation 63](#_Toc45628854)

[10.48 The Committee recommends that the ACT Government collect annual statistics on breastfeeding outcomes 0–24 months for hospitals and clinics, and publish annual ACT breastmilk production, performance of ACT hospitals and health services on breastfeeding outcomes performance, especially for at-risk groups. The Committee further recommends that the Government consider publishing this information in the *ACT Public Health Services Quarterly Performance Report*.](#_Toc45628855)

[Recommendation 64](#_Toc45628856)

[10.49 The Committee recommends that the ACT Government strengthen the promotion of and support for breastfeeding across the maternity continuum—including by: (i) making Baby-Friendly Health Initiative (BFHI) accreditation mandatory in all health facilities where babies are born; (ii) creating supportive breastfeeding services in all communities by adopting the Baby Friendly Community Initiative (BFCI); (iii) facilitating compulsory and adequate breastfeeding education for all health professionals who may encounter women of reproductive age, both during their initial training and when undertaking ongoing professional development; (iv) promoting Australian Breastfeeding Association (ABA) health professional seminars—annual health professional education (seminars) as well as workshops and study modules; (v) ensuring well-informed referral by health professionals to breastfeeding support organisations, including the ABA, and informing mothers adequately about the work of breastfeeding-support groups in the community, such as the provision of Breastfeeding Education Classes for expectant parents and local peer support groups (not just handing them a brochure or placement of a sticker on their baby book); and (vi) ensuring all health professionals who encounter mothers and their breastfed babies understand and follow the evidence-based *National Health and Medical Research Council (NHMRC) Australian Infant Feeding Guidelines*.](#_Toc45628857)

[Recommendation 65](#_Toc45628858)

[10.51 The Committee recommends that the ACT Government explore the feasibility of establishing a day stay lactation clinic for the ACT.](#_Toc45628859)

[Recommendation 66](#_Toc45628860)

[10.52 The Committee recommends that the ACT Government—in partnership with its Council of Australian Government (COAG) colleagues—advocate for a Medicare rebate for professional lactation consulting services.](#_Toc45628861)

[Recommendation 67](#_Toc45628862)

[10.57 The Committee recommends that the ACT Government establish an official milk bank in the Australian Capital Territory (ACT) to: (a) give ACT and region women an opportunity to donate; and (b) supply breast milk to babies in and out of a hospital setting.](#_Toc45628863)

[Recommendation 68](#_Toc45628864)

[10.65 The Committee recommends that the ACT Government—in partnership with its Council of Australian Government (COAG) colleagues—advocate for the development and implementation of national evidence-based guidelines for postnatal care.](#_Toc45628865)

[Recommendation 69](#_Toc45628866)

[10.73 The Committee recommends that the ACT Government ensure that women and their families accessing maternity services are educated about the availability of resources such as the Centre of Perinatal Excellence (COPE)—*Ready to COPE e-guide to pregnancy*.](#_Toc45628867)

[Recommendation 70](#_Toc45628868)

[10.74 The Committee recommends that the ACT Government ensure that perinatal mental health is included in health professional training and the existing maternity care workforce accesses professional development in perinatal mental health (such as the Centre of Perinatal Excellence online training package).](#_Toc45628869)

[Recommendation 71](#_Toc45628870)

[10.75 The Committee recommends that the ACT Government in the planning, design and delivery of maternity services and models of care adopt the *Australian Practice Guidelines for the Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*.](#_Toc45628871)

[Recommendation 72](#_Toc45628872)

[10.76 The Committee recommends that the ACT Government—in partnership with its Council of Australian Government (COAG) colleagues—advocate for changes to the *Australasian Health Facility Guidelines* (AusHFG) to include inpatient requirements for perinatal mental health services for the mother-baby family unit, including the establishment of mother baby family units in all jurisdictions.](#_Toc45628873)

[Recommendation 73](#_Toc45628874)

[10.77 The Committee recommends that the ACT Government in the planning, design and delivery of maternity services and models of care ensure that expectant mothers are screened to assess the likelihood of developing and/or experiencing mental health problems in pregnancy and the first year following birth.](#_Toc45628875)

[Recommendation 74](#_Toc45628876)

[10.78 The Committee recommends that the ACT Government establish a dedicated unit in Canberra for mothers requiring residential mental health care for the mother baby family unit to access both antenatally, and where possible, with their baby after the birth.](#_Toc45628877)

# Introduction and conduct of inquiry

* 1. Inquiry referral

Under the ACT Legislative Assembly’s Standing Orders[[5]](#footnote-5), the Standing Committee on Health, Ageing and Community Services (the Committee) has the power to self-refer inquiries.

The Committee resolved on 11 September 2018 to conduct such an inquiry into maternity services in the ACT.

The Committee informed the ACT Legislative Assembly on 18 September 2018, that pursuant to Standing Order 216, it had resolved to inquire into maternity services in the ACT.[[6]](#footnote-6)

* 1. Inquiry terms of reference

The Committee also informed the Assembly on 18 September 2018 of its terms of reference (T of R) for its inquiry. Specifically, the T of R are to inquire into and report on the operation of maternity services in the ACT—with particular reference to:

1. models of care for all maternity services offered at the Centenary Hospital for Women and Children (CHWC) and Calvary Public Hospital (CPH), including, but not limited to, the Birth Centre, the Canberra Midwifery Program, and the Home Birth Trial and whether there are any gaps in care;
2. provision of private maternity services including centre and non-centre services;
3. management of patient flow, including, but not limited to, wait lists, booking services, and capacity constraints;
4. management of patient birthing preferences, including, but not limited to, professional advice offered to patients, and the practices associated with birthing emergencies;
5. interaction between the CHWC and CPH with other service areas, including, but not limited to, emergency departments, and operating theatres;
6. the efficiency and efficacy of maternity services;
7. the impact on maternity services on regional participants;
8. patient satisfaction with the services;
9. the impact on staff including, but not limited to, rostering policies and practices, staff-to-patient ratios, optimum staffing levels, and skills mix;
10. the impact of technological advances and innovations;
11. relevant experiences and learnings from other jurisdictions; and
12. any related matters.

In considering the Inquiry T of R—the Committee’s overarching focus is concerned with the operation of maternity services in the ACT; the adequacy and effectiveness of policy approaches and responses for the provision of maternity services; a focus on outcomes (as opposed to outputs and activities); evaluating and measuring effectiveness; the evidence base for different types of models of care and associated interventions; and the funding and agenda/policy setting regime/framework for maternity services.

* 1. Conduct of the inquiry
     + 1. Field visits and briefings

As part of its inquiry, the Committee held three field visits to gather information. The locations and dates of these visits are as follows:

* + Centenary Hospital for Women and Children (CHWC)—26 February 2019;
  + Tresillian Queen Elizabeth II Family Centre—29 October 2019; and
  + Calvary Public Hospital—Bruce (CPHB)—19 November 2019.

The Committee thanks those individuals and organisations for making time available to meet with it. The Committee acknowledges that hosting visits of this nature in 24-hour service delivery environments providing important frontline services is an additional ask to an already busy working environment.

The Committee also met via videoconference with Dr Sue Calvert, Chief Executive and Registrar, New Zealand (NZ) Midwifery Council on Tuesday 28 April 2020. The Committee discussed with Dr Calvert the NZ midwifery-led model of maternity care. NZ introduced its midwifery-led model of care almost 25 years ago. The model is a choice-based model of primary maternity care with a Lead Maternity Carer (LMC) service in which each woman has a LMC to coordinate care throughout their pregnancy. The Committee also thanks Dr Calvert for making time available to assist it.

* + - 1. Submissions

The Committee invited written submissions from the public for its inquiry on 18 September 2018. The Committee widely advertised its call for submissions using a range of communication channels—including, via a media invite and release; an announcement in the ACT Legislative Assembly; advertising in the *Canberra Times;* via the ACT Legislative Assembly website; and via social media communication channels. The Committee also directly invited key stakeholders, interest groups and organisations with an interest in the Inquiry to make written submissions.

The Australian healthcare system is second to none. The ACT is fortunate to be part of such a system and contribute to it. However, any healthcare system needs constant monitoring and revision to ensure that it stays up to date and addresses the needs and expectations of the public, patients and the doctors, nurses, midwives and ancillary staff who maintain it. This inquiry is about looking at the delivery of maternity services and care in the ACT.

At the time the Committee announced its inquiry and called for submissions it emphasised that the inquiry was important—pregnancy, childbirth and early parenting are an important and significant time for mothers, fathers and their families. It is vital that the services that support this significant time and the experiences that accompany pregnancy and childbirth should, in our community, be of the highest quality. The Committee also welcomed hearing from the community, as well as the health sector, and other interested stakeholders, about what was working well in the delivery of maternity services in the ACT, together with what may need to be improved.

The original deadline for receipt of submissions was 7 December 2018, however the Committee extended the deadline on a number of occasions. Also, in response to direct contact from interested individuals and organisations, the Committee also considered requests for, and accepted, late submissions to the inquiry.

The Committee agreed on 8 October 2019 to provide a final opportunity for late submissions to the inquiry to be received by COB 30 October 2019.

The individuals and organisations who lodged written submissions are listed at **Appendix A**. Copies of authorised submissions can be downloaded from the Committee inquiry homepage.[[7]](#footnote-7) Further detail on submissions received is set out in Chapter three.

The Committee acknowledges that many participants to its inquiry have shared deeply personal experiences and that contemplating and preparing these submissions would not have been easy. The Committee sincerely thanks all inquiry participants for taking the time and personal energy to contribute to an inquiry of this nature.

* + - 1. Support services for witnesses

Given the sensitive nature of many of the submissions received by the inquiry, support services were offered to witnesses. This included support services on the day and following appearance at a hearing.

* + - 1. Public hearings

The Committee held public hearings on 9 and 11 July 2019; 6 August 2019; and 15 October 2019. The Committee also held an *in-camera* hearing on 8 October 2019.

A list of witnesses who appeared at the public hearings is at **Appendix B**. Full transcripts of public hearings are available on the Legislative Assembly website.[[8]](#footnote-8) Further detail on evidence received at these hearings is set out in Chapter three.

* + - 1. Questions

A number of witnesses undertook to provide further information, or took questions on notice at public hearings. The Committee acknowledges that taking questions on notice means that a considered and accurate answer can be provided.

Responses to these questions can be accessed from the inquiry homepage.[[9]](#footnote-9)

The Committee thanks all witnesses for their assistance with the provision of responses and additional information. This information assisted the Committee in its understanding of the many issues it considered during the inquiry.

* + - 1. Report adoption

The Committee met on 19 and 27 May 2020; and 3 June 2020 to consider the Chair’s draft report and the report, as amended, was adopted by the Committee on 3 June 2020.

* 1. Structure of the Committee’s report

The Committee’s report is divided into three parts, comprising a total of 11 chapters, covering the following main topics:

*Part 1—Context to the Inquiry*

* Chapter 1—Introduction and conduct of the Inquiry
* Chapter 2—Inquiry context [subject matter and local context]

*Part 2—Views from submitters and witnesses*

* Chapter 3—Views of submitters and witnesses

*Part 3—Views of the Committee*

* Chapter 4—Guiding principles informing and underpinning the inquiry
* Chapter 5—Overarching strategic focus for maternity services in the ACT
* Chapter 6—Governance framework for maternity services in the ACT
* Chapter 7—Maternity care—Safety
* Chapter 8—Maternity care—Respect
* Chapter 9—Maternity care—Choice
* Chapter 10—Maternity care—Access
* Chapter 11—Conclusion

At Chapter 1, information on the context for the inquiry—including referral and T of R are summarised.

At Chapter 2, information is provided on the national and local context for the funding and provision of maternity services in Australia; a statistical snapshot of selected maternity data in the ACT; maternity services in the ACT including available models of care; and *Canberra Maternity Options*—for accessing maternity care in Canberra’s public health system.

At Chapter 3, evidence analytics together with a summary of views (individuals and organisations/groups) on the inquiry terms of reference—as expressed in written submissions and by witnesses at public hearings—are considered and summarised.

At Chapter 4, the Committee sets out the guiding principles informing the inquiry. These principles are informed by views of contributors to the inquiry and the body of theory and practice as it concerns the delivery of maternity services. Many of the contributors, either in full or in-part, referred to the concepts underpinning the guiding principles.

At Chapters 5 through to 10—the Committee sets out its consideration of the many issues raised in evidence across its inquiry T of R—organised across the following parameters: (i) overarching strategic focus—for maternity services in the ACT; (ii) governance framework for maternity services in the ACT; and (iii) system and service values—safety, respect, choice and access.

* 1. Acknowledgements

The Committee thanks the Ministers for Health and directorate and agency officials who assisted the Committee in the course of its inquiry by appearing before it and/or providing additional information.

The Committee acknowledges and thanks key interest and stakeholder groups and organisations who made written submissions and those who appeared as witnesses and provided information at its public hearings.

The Committee also acknowledges and thanks all individuals who made written submissions and those who appeared as witnesses and provided information at its public hearings.

The Committee recognises the significant commitment of time, personal energy and resources, and for many the emotional heartache and distress, required to participate in an inquiry of this nature and is grateful that it was able to draw on a broad range of expertise and experience in its deliberations. The Committee has based many of its recommendations on suggestions by inquiry participants.

# Inquiry context

Maternity care in Australia encompasses a continuum of care—antenatal, intrapartum and postnatal care for women and their babies up to six weeks after birth. This care is provided in a variety of public and private settings by a range of health professionals. The continuum of care is underpinned by service capability frameworks, workforce, funding, information and data, and technological infrastructure.[[10]](#footnote-10)

The term ‘maternity care’ refers to the continuum of care given by health care providers to women and their babies during pregnancy, birth and the postnatal period.[[11]](#footnote-11)

It is widely acknowledged that the following are positive features of maternity services in Australia:

* + universal (free) antenatal and birthing care is provided to everyone regardless of socio-economic status;
  + gross perinatal and maternal mortality outcomes are comparable to those of other Organisation for Economic Co-operation and Development (OECD) countries[[12]](#footnote-12); and
  + a committed maternity workforce provides a level of personal care that makes a positive difference to many women (their babies and families) and their transition to becoming mothers.[[13]](#footnote-13)

With regard to how Australia’s infant and maternal outcomes compare with other OECD countries, according to the Australian Institute of Health and Welfare (AIHW) 2018 International health data comparisons, in 2017 (or based on the latest year of data):

* + Australia experienced the 5th lowest rate of infant mortality (with no minimum threshold of gestation period or birthweight) among OECD countries, at 3.1 deaths per 1,000 live births. Turkey experienced the highest rate of infant mortality (10 deaths per 1,000 live births); and
  + the rate of maternal mortality in Mexico was almost 10 times that in Australia, at 36.7 compared with 3.9 deaths per 100,000 live births (OECD average 7.0 deaths per 100,000 live births).[[14]](#footnote-14)
  1. Provision of maternity services

Maternity services in Australia are delivered through a mix of public and private services with planning and delivery predominantly undertaken by the states and territories through publicly funded programs. The Australian government is responsible for providing national direction and supporting efforts to improve care and outcomes.[[15]](#footnote-15)

A nation-wide plan, the Australian National Maternity Services Plan was introduced in 2010.[[16]](#footnote-16)  More recently, parties to the Council of Australian Governments (COAG) endorsed the National Strategy—*Woman-centred care: Strategic directions for Australian maternity services* in November 2019.[[17]](#footnote-17) This document provides overarching national strategic directions to support Australia’s maternity care system and to facilitate improvements in line with contemporary practice, evidence and international developments.

State and territory governments, together with public and private health services, plan for and provide maternity services to meet the needs of their respective communities.

* 1. Funding of maternity services

The Australian government funds health services via agreements with its eight state and territory jurisdictions.

Access to maternity care, in the main, is determined by Australia’s health system’s structure and funding arrangements. This includes: Medicare, specialist and general practice, private health insurance and other Australian, state and territory government health funding models, including for public hospitals.

Medicare—a universal health insurance scheme funded by the Australian government—provides access to certain types of medical care and hospital services. For maternity services—Medicare can provide coverage for some or all expenses incurred during pregnancy and the birth of a baby.[[18]](#footnote-18)

Private obstetric care, private midwifery care, private health insurance, Medical Benefits Schedule [MBS] items and broader workforce issues also influence the cost of provision of maternity care in Australia.

* 1. Models of care

According to the Australian Institute of Health and Welfare (AIHW)—the term ‘model of care’ is often used in the healthcare system—in particular in relation to maternity care.[[19]](#footnote-19)

When applied to maternity care—it highlights that:

There are several ways to look after the health and well-being of women and babies during pregnancy, birth and afterwards – these ways are called ‘models of care’. Sometimes, an obstetrician or another doctor is the lead healthcare professional and at other times it is a midwife. Sometimes, the responsibility is shared between obstetricians and midwives.[[20]](#footnote-20)

An important consideration concerning maternity models of care is the overarching ethos of the system in which the available models are embedded. This can range from a primary healthcare-led system (often referred to as a midwifery-led system) to a medically-led system with varying degrees/levels of midwifery input. Internationally, the typical overarching system is a medically-led system with varying degrees/levels of midwifery input. Australia has such a system. There are many countries though—such as NZ and many Scandinavian countries—that have an overarching system that is primary healthcare-led.

Maternity care models currently in operation in Australia fall into eleven major categories.[[21]](#footnote-21) A summary of these major model categories are at **Attachment C**. Importantly, whilst eleven major model categories have been identified in Australia it does not mean that these are available in every jurisdiction. Local contextual factors—such as the needs of communities, location, availability and attitudes of the workforce, and geography of a region—play a role in determining the models of care that may be available and accessible to women within their community.[[22]](#footnote-22) Further, ‘[d]ifferences in the experience, preferences and views of health professionals’ can also play a role in determining the models of care that may be available and accessible to women in their communities.[[23]](#footnote-23)

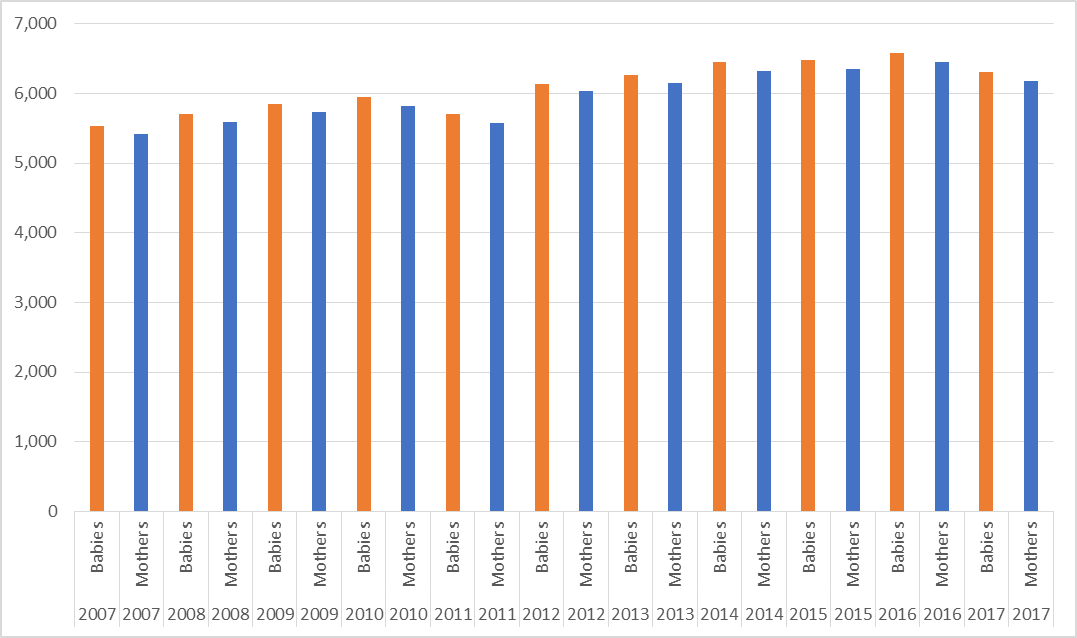
Essentially, models of care become the organising framework underpinning the delivery of maternity services in the jurisdictions:

A model of care has both tangible components (such as roles, structure, methods, location) and those that are less so (such as philosophy, culture, values). A model of care can be thought of as a ‘recipe’ for how care is provided; it describes the systematic and standardised way that health care (in this case, maternity care) is provided, including who the health-care professionals are, their roles, where care is provided and the care ‘pathway’ that the health-care consumer will follow. The benefit of describing health-care delivery in terms of models is that it ensures that all staff working together in a particular area or unit work in a similar way, within a similar framework and guided by a common set of goals (Davidson et al. 2006). Further, by defining a model in a systematic way, care can be evaluated on a common basis. Through randomised controlled trials and systematic reviews, an increasing evidence base is being developed on the different outcomes for women and babies under different models of maternity care.[[24]](#footnote-24)

* 1. Statistical snapshot of selected maternity data in the ACT
     + - 1. Snapshot—Mother and Baby numbers in the ACT

The data from the ACT Government Maternal Perinatal Data Collection[[25]](#footnote-25)—Mother and Baby Numbers—include figures for both ACT and non-ACT resident mothers from 2007–2017. The data shows that the numbers of mothers and babies are generally increasing in the ACT, despite experiencing a small decline in 2011. Figure 2.1 sets out mother and baby numbers in the ACT from 2007 to 2017.

Figure 2.1: Mother and baby numbers in the ACT, 2007–2017

* + - * 1. 
        2. Snapshot—Place of birth in the ACT

In the ACT, the vast majority of mothers gave birth in a hospital. Over 90 per cent of births took place in hospitals, with 5–8 per cent of births taking place at birth centres. The percentage of hospital births has marginally declined, whilst the percentage of birth centre births has marginally increased, from 5.5 per cent in 2010 to 8 per cent in 2018.[[26]](#footnote-26) Table 2.1 sets out birth numbers by place of birth in the ACT from 2010 to 2018.

Table 2.1: Birth numbers (and %) by place of birth in the ACT, 2010–2018

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Place of birth | 2010 (No.) | 2011 (No.) | 2012 (No.) | 2013 (No.) | 2014 (No.) | 2015 (No.) | 2016 (No.) | 2017 (No.) | 2018 (No.) |
| Hospital | 5475  (94%) | 5204  (93.2%) | 5618  (93.1%) | 5673  (92.3%) | 5769  (91.2%) | 5775  (91%) | 5913  (91.6%) | 5671  (91.7%) | 5409  (91.2%) |
| Birth Centre | 320  (5.5%) | 343  (6.1%) | 375  (6.2%) | 433  (7%) | 507  (8%) | NP | 503  (7.8%) | 467  (7.6%) | 477  (8.0%) |
| Home | 6  (0.1%) | 9  (0.2%) | 7  (0.1%) | NP\* | 7  (0.1%) | NP | NP | 12  (0.2%) | 15  (0.3%) |
| Other^ | 25  (0.4%) | 27  (0.5%) | 35  (0.6%) | NP | 42  (0.7%) | 45  (0.7%) | NP | 35  (0.6%) | 28  (0.5%) |
| Total | 5826 | 5583 | 6035 | 6106 | 6325 | 5820 | 6416 | 6185 | 5929 |

Notes:

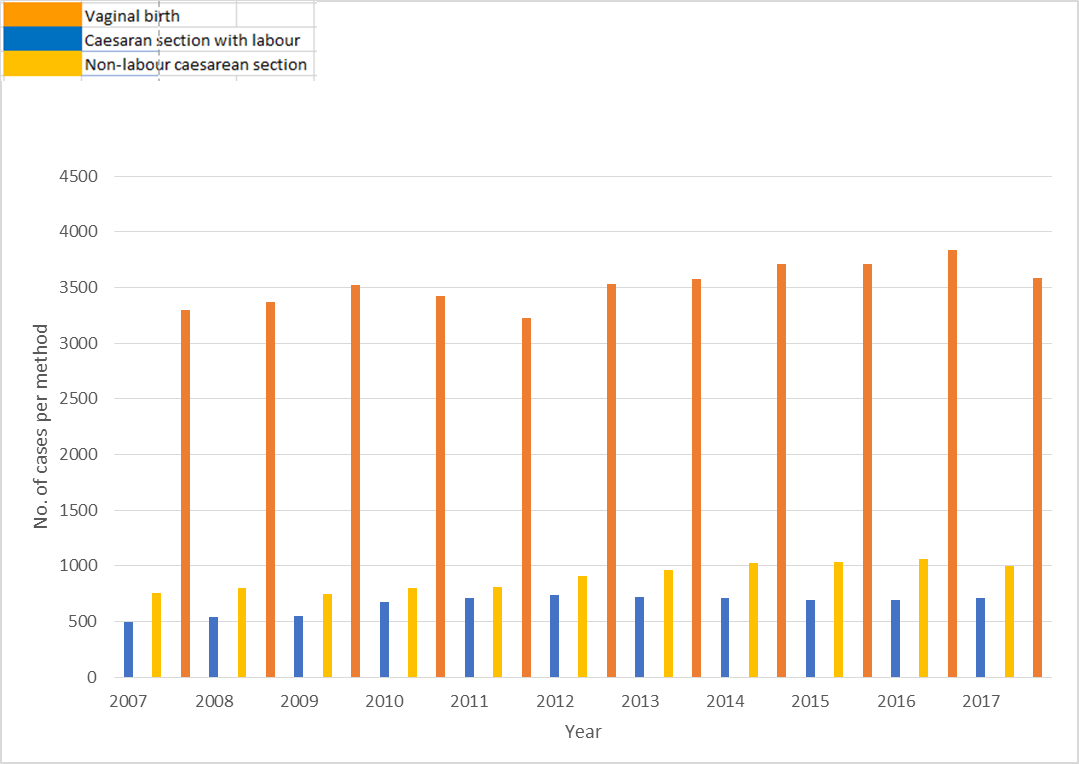
^'Other'—place of birth includes births that occur at a home other than that intended (unplanned home births); home births without a midwife or other medical professional in attendance (free births); births at a community health centre or babies born before arrival at hospital.

\*‘NP’—not publishable due to small numbers, confidentiality or for reliability reasons.

* + - * 1. Snapshot—births by mode of birth and type of caesarean section in the ACT

More women are having caesarean sections without labour than with in the ACT. In 2017, 18.8 per cent of all births were caesarean sections without labour, 13.4 per cent were caesarean sections with labour and 67.7 per cent were all types of vaginal births.[[27]](#footnote-27)

In comparing data for the period 2007 to 2017—the percentage and total number of non-labour caesarean sections has slightly increased during the time period. The percentage of vaginal births, after accounting for other methods available at the time, has slightly decreased from 72.5 per cent in 2007 to 67.7 per cent in 2017. Figure 2.2 sets out births by mode of birth and type of caesarean section in the ACT for this period.

Figure 2.2: Births by mode of birth and type of caesarean section in the ACT, 2007–2017

* 1. Maternity care in the ACT
     + - 1. Models of care in the ACT

There are eight models of maternity care available in the ACT. These models are embedded in an overarching medically-led system with varying degrees/levels of midwifery input.[[28]](#footnote-28) A summary of the models of care are set out in Table 2.2.

Table 2.2—Summary of models of maternity care available in the ACT

| **Model** | **Eligibility/lead carer/relationships** | **Model detail and coverage** | **Who offers the service?** |
| --- | --- | --- | --- |
| **GP Shared Care** | +For healthy mothers with an uncomplicated pregnancy.  +Pregnancy care is shared between the hospital and a woman’s GP.  +During pregnancy, most appointments are with a woman’s GP and some with a midwife from the hospital.  +Get to continue or build a relationship with local GP—with ongoing benefits to support the long term needs of a woman and her family.  +Can manage other non-pregnancy related problems. | +Baby will be born in the Birth Suite of either Centenary Hospital or Calvary Hospital under the care of a midwife, with medical staff available if necessary.  +Postnatal care is provided in the postnatal ward for those women and babies requiring a longer stay.  +If residing in the ACT, Queanbeyan or Jerrabomberra, a woman will receive home visits from a midwife following discharge from hospital. | +Calvary Public Hospital in Bruce  +Centenary Hospital for Women and Children in Garran |
| **Continuity of Midwifery Care—Birth Centre**  **(low risk)**  [Previously—Canberra Midwifery Program (CMP)] | +For mothers considering a low intervention, natural and active approach to pregnancy and birth.  +Get to build a relationship with a known midwife or a small team of midwives who will take care of a woman during pregnancy, labour, birth and after having had their baby. | +The allocated midwife, or a midwife from the team, will provide care throughout the pregnancy and is on-call for labour and birth, planning to occur in the Birth Centre.  +Early discharge is encouraged for well women and babies.  +Following discharge from hospital, a midwife will visit mothers at home. | +Calvary Public Hospital in Bruce  +Centenary Hospital for Women and Children in Garran |
| **Continuity of Midwifery Care—Birth Suite or Birth Centre (only at Centenary Hospital) (all risk)**  [Previously Continuity at the Centenary Hospital—CatCH) | +Suitable for all women—including those with complex and high-risk pregnancies, wanting care from a known (primary) midwife.  +A primary midwife will care for a woman throughout pregnancy, labour, birth and after having had their baby.  +If a woman has existing or pregnancy related health concerns they will be referred to medical and allied health appointments as necessary. | +Birthing care is provided in the hospital Birth Suite or Birth Centre (whichever is most appropriate) by the primary midwife working collaboratively with the medical team if needed.  +Postnatal care is provided in the postnatal ward for those women and babies requiring a longer stay.  +The primary midwife will also visit mothers at home after having had their baby. | +Centenary Hospital for Women and Children in Garran |
| **Maternity team care** | +Midwives available to take care of a woman during pregnancy, labour and birth, working collaboratively with medical and allied health staff if required.  +Uncomplicated births are attended by midwives in the Birth Suite and medical staff are available when needed. | +Postnatal care is provided in the postnatal ward for those women and babies requiring a longer stay.  +If mothers live in the ACT, Queanbeyan or Jerrabomberra, they will receive home visits from a midwife following discharge from hospital. | +Calvary Public Hospital in Bruce  +Centenary Hospital for Women and Children in Garran |
| **Fetal Medicine Unit Care** | +Provides care for women with complex or high-risk pregnancies who require specialised care for either them or their baby.  +Only women with identified risk factors in their pregnancy or those who have had complications in a previous pregnancy will be referred to this service. | +Women are cared for by specialist doctors, sonographers and a designated midwife who will provide continuity of care during a woman’s pregnancy.  +During labour and birth, a woman will be cared for by a team of midwives and medical staff within the Birthing Suite.  +If a woman lives in the ACT, Queanbeyan or Jerrabomberra, they will receive home visits from a midwife following discharge from hospital. | +Centenary Hospital for Women and Children in Garran |
| **Specialist Team Care** | +During pregnancy and labour a woman will be cared for by a team of midwives, medical staff and allied health staff in a hospital.  +Labour and birth will occur in the Birth Suite supported by a midwife, working collaboratively with medical staff.  +A woman’s midwife, doctor or GP may refer a woman to this service if necessary. | +If a woman lives in the ACT, Queanbeyan or Jerrabomberra, they will receive home visits from a midwife following discharge from hospital. | +Calvary Public Hospital in Bruce  +Centenary Hospital for Women and Children in Garran |
| **Homebirth**  **(three-year trial)** | +ACT Health is currently running a three-year homebirth trial.  +The trial gives eligible women who reside in the ACT an option to birth in the comfort and familiarity of their own home. | +Women are supported by a primary midwife during pregnancy, birth and after having had their baby.  +The trial is available to women who meet the eligibility criteria[[29]](#footnote-29) and who live within 15 minutes of Centenary Hospital for Women and Children. | +Centenary Hospital for Women and Children in Garran for eligible women |
| **Private maternity services** | +Women may choose to see a private obstetrician for their pregnancy care.  +Women seeking this model of care see their GP to get a referral to see an obstetrician of their choice. |  | +Private midwifery services are available across the ACT.  +For more information refer to *Having a baby in Canberra[[30]](#footnote-30)*. |

* + - * 1. Canberra Maternity Options—accessing Canberra’s public maternity system

*Canberra Maternity Options* was launched on 30 September 2019—as ‘a new system to make it easier for women to learn about and access Canberra’s public maternity system’.[[31]](#footnote-31) The key features of the new system include: (i) a single entry point via one phone number to access Canberra’s public maternity services; (ii) an established process for women to engage with a midwife early in their pregnancy to discuss pregnancy and birthing options through the public system—including personal preferences and health care needs; (iii) the provision of local support before, during and after pregnancy; (iv) the provision of consolidated service information online about the maternity system and what birthing and care options are available; and (v) providing GPs with targeted information about the new system and the birthing and care options that are available.[[32]](#footnote-32)

The new system stemmed from the findings of the Women’s Centre for Health Matters 2016 consultation project exploring women’s experiences of accessing and using maternity services in the ACT and where there may be opportunities for improvement. As detailed in the *Women and Maternal Care in the ACT Consultation Report—*the consultation foundthat there was room for improvement; that what is best care for one woman is not best care for another; and that women wanted consistency in the information they receive to help them make an informed decision about the maternity care options they may seek to access.[[33]](#footnote-33)

Following the Women’s Centre for Health Matters 2016 consultation project—Canberra Health Services and Calvary Public Hospital ‘developed immediate and long term operational strategies to ensure that women are receiving the right care at the right place, as close to home as possible’.[[34]](#footnote-34) The proposed changes[[35]](#footnote-35) were surveyed in targeted consultations with mums-to-be and community organisations[[36]](#footnote-36) in 2018 and in 2019 via an online ‘YourSay’ survey that invited the Canberra community to share their views on the proposed changes.[[37]](#footnote-37)

# Views of Submitters and Witnesses

This chapter considers views arising on the inquiry T of R—as expressed in written submissions and by witnesses at public hearings—and identifies a number of themes. These are expanded on in part 3 of the report. It also presents a summary of the evidence analytics across written submissions and public hearings.

* 1. Summary of evidence analytics
     + 1. Written submissions

The Committee received 77 submissions to its inquiry—64 of these submissions were published and the other 13 submissions were received in-confidence.

As to the submission analytics—public submissions were received from seven key stakeholder groups—individuals, interest groups and organisations, professional associations, academics/policy and research institutes, union group(s); government and civic based stakeholders and private sector providers. A summary of public submissions[[38]](#footnote-38) received across these stakeholder groups is detailed in Table 3.1.

Table 3.1—Summary of public submissions received across stakeholder groups

|  |  |
| --- | --- |
| **Stakeholder group(s)** | **Number of submissions received** |
| Individuals | 45 |
| Government/Civic | 6 |
| Professional associations | 4 |
| Academics/policy and research institutes | 2 |
| Private sector providers | 1 |
| Union(s) | 1 |
| NGOs | 5 |

The individuals and organisations who lodged written submissions are listed at **Appendix A**. Copies of authorised submissions can be downloaded from the Committee inquiry homepage.[[39]](#footnote-39)

* + - 1. Public hearings

The Committee held five public hearings—hearing from 15 witnesses representing several of the key stakeholder groups. A summary of witnesses appearing across stakeholder groups is detailed in Table 3.2.

Table 3.2—Summary of witnesses appearing across stakeholder groups

|  |  |
| --- | --- |
| **Stakeholder group(s)** | **Number of witnesses** |
| Individuals | 6 |
| Government/Civic | 5 |
| Professional associations | 2 |
| NGOs | 2 |

A list of witnesses who appeared at public hearings is at **Appendix B**. Full transcripts of public hearings are available on the Legislative Assembly website.[[40]](#footnote-40)

* 1. Summary of views of submitters and witnesses

The views and themes arising on the inquiry terms of reference from individuals[[41]](#footnote-41) and organisations and groups[[42]](#footnote-42)—as expressed in written submissions and evidence given at public hearings—are summarised as follows:

1. differing views on whether maternity services should reside in a primary (community) focused ethos or in a medical (doctor) focused ethos;
2. maternity services and models of care should be woman-centred and meet the health and well-being needs of mothers, their babies and families;
3. women should be able to choose a place of birth and model of care based on the safest place for them;
4. maternity services and models of care should also protect and respect the human rights of the mother baby family unit throughout their contact with maternity services;
5. women value and want continuity of care and continuity of carer and women should be supported in their choice of care and carer;
6. women should have access to a range of continuity of care and continuity of carer models;
7. funding models to support access to continuity of care and continuity of carer models should be developed;
8. the importance of the family unit throughout the maternity care continuum—in that, it conveys the importance of husbands, partners and the social and/or community family structure during pre-conception, pregnancy and birth;
9. an overreliance on a medicalised way of working which reduces the benefit of sound midwifery input into how maternity services are managed and care is provided;
10. power imbalances exist within the maternity services system—which can lead to interpersonal and structural discrimination and disrespect towards pregnant women and mothers;
11. the maternity service system is under significant pressure—attributable to increased demand, resourcing challenges as it concerns workforce and physical infrastructure in the form of health facilities;
12. calls for additional facilities in geographically convenient locations to provide accessible services to women and their families commensurate to Canberra’s current and future growth;
13. the *ACT Health Territory-wide Health Services Framework 2017–2027*—does not reflect the true integration of maternity services in the ACT. It does not adequately reflect the integrated network of public, private and voluntary health services that deliver maternity services to the ACT community—but instead focuses on the public sector in isolation;
14. the Australian Nursing Midwifery Federation (ANMF) Mandated Minimum Nurse/Midwife to Patient Ratios Framework—addressing both staffing and patient ratios and skill mix, across publicly funded services—should be implemented;
15. a territory-wide plan to develop a sustainable workforce for the delivery of maternity services needs to be undertaken. The plan needs to address the drivers of supply and retention including, but not limited to, higher education, recruitment and working conditions, targeted ongoing learning, positive cultures, effective leadership, and well-articulated and supported transition to practice programs;
16. the maternity system and its models of care should be strengthened to better support Aboriginal and Torres Strait Islander women and women of culturally and linguistically diverse backgrounds to receive culturally appropriate care;
17. the maternity system and its models of care should better support marginalised, disadvantaged and vulnerable groups;
18. women and their families who experience early pregnancy loss, stillbirth, neonatal death or termination after diagnosis of abnormality in the developing foetus need more comprehensive bereavement care and information and emotional support. The sensitivities of the experiences of parents in these situations needs to be better acknowledged and their mental health needs attended to more comprehensively. They should also be provided with support during subsequent pregnancies;
19. the importance of all women being offered a formal birth debriefing with a qualified health professional in the birthing or hospital setting;
20. the mental health and well-being of women and their partners needs to be considered throughout their contact with maternity services. Importantly, maternity services and models of care need to be delivered in ways that do not exacerbate mental health needs but should prioritise these needs in and across the maternity continuum;
21. improve availability of quality evidence-based, easily understood information about choices in care and associated outcomes during the perinatal period;
22. women want publicly available information to assist them in decision-making—this should include readily accessible and up to date information about all locally available maternity services;
23. expand the availability of continuity of care and carer models to enable women’s choices to be met—for example, expand the capacity of the birth centre to meet unmet demand;
24. concerns about the current design of the publicly funded home birth trial—restrictive criteria for access and limitations on the scope of service available under the trial;
25. public home birth should be a model of care available in the ACT;
26. key indicators of maternity safety, quality and health outcomes should be publicly reported at regular intervals;
27. the incorporation of consumer feedback about maternity experiences should be strengthened to ensure a more woman-centred system; and
28. consumer involvement processes need to be expanded to ensure they represent the needs of the people accessing maternity care.

The Committee notes that this is not an exhaustive list.

# Guiding principles informing the inquiry

This chapter sets out the guiding principles informing the inquiry—informed by views of contributors to the inquiry and the body of theory and practice on the subject of the delivery of maternity services. Many of the contributors, either in full or in-part, referred to the concepts underpinning the guiding principles.

The guiding principles informing the inquiry include:

* 1. WHO principles of perinatal care

In 1998, the World Health Organization (WHO) proposed a set of principles of perinatal care—the WHO Principles of perinatal care—that endorse the protection, promotion and support necessary for effective antenatal and postnatal care.[[43]](#footnote-43) The WHO Principles are as follows:

1. **Care for women with a normal pregnancy and birth should be demedicalised**—pregnancy and birth should be viewed as a natural process in life and essential care should be provided to women with the minimum set of interventions necessary.
2. **Care should be based on the use of appropriate technology**—sophisticated or complex technology should not be applied when simpler procedures may suffice or be superior.
3. **Care should be evidence-based**—care should be supported by the best available research, and by randomised controlled trials where possible and appropriate.
4. **Care should be local**—care should be available as close to the woman’s home as possible and based on an efficient system of referral from primary care to tertiary levels of care.
5. **Care should be multidisciplinary**—effective care may involve contributions from a wide range of health professionals, including midwives, general practitioners, obstetricians, neonatologists, nurses, childbirth and parenthood educators.
6. **Care should be holistic**—care should include consideration of the intellectual, emotional, social and cultural needs of women, their babies and families, and not only their physical care.
7. **Care should be woman-centred**—the focus of care should be meeting the needs of the woman and her baby. Each woman should negotiate the way that her partner and significant family or friends are involved.
8. **Care should be culturally appropriate and culturally safe**—care should consider and allow for cultural variations in meeting these expectations.
9. **Care should provide women with information and support so they can make decisions**—women should be given evidence-based information that enables them to make decisions about care.
10. **Care should respect the privacy, dignity and confidentiality of women**—all women have the right to be treated with respect and dignity, have their privacy respected, and be assured that all their health information is confidential.[[44]](#footnote-44)
    1. Evidence-based maternity care

Contemporary best practice for delivery of maternity services and care—evidence should underpin the development, design and provision of maternity services within a culture of continuous quality improvement. Accordingly, as it concerns contemporary best practice—the Committee notes evidenced-based findings as it concerns: (i) continuity of care and carer[[45]](#footnote-45); and (ii) the correlation between the development of postnatal post-traumatic stress and traumatic birthing experiences.[[46]](#footnote-46)

The Committee notes that the Health Care Consumers’ Association of the ACT stated that women are more likely to experience birth trauma when they do not feel that they have been involved in decisions about their care.[[47]](#footnote-47)

* + - * 1. Continuity of care and carer

Overwhelmingly evidence to the inquiry emphasised the importance of maternity services being underpinned by the concept of continuity of care and carer; and the benefits of this concept for both women and care providers.

Continuity of care and carer is an important and distinct aspect of pregnancy and the birthing experience for women and their families across the maternity continuum. Importantly, research suggests that ‘experienced’ continuity of care is a distinctive concept ‘that should not be confused with experienced quality of care or perception of labor and should be considered as a complementary aspect of quality of care’.[[48]](#footnote-48)

Continuity of care[[49]](#footnote-49) has three dimensions:

1. ‘relational continuity’ or ‘personal continuity’—defined as continuous support throughout the maternity continuum from the same maternity care provider. Relational continuity has been associated with positive birthing experiences[[50]](#footnote-50); and supports trust building and familiarity between care provider and the patient. Some studies also suggest that personal continuity of care is related to fewer interventions such as the need for pain relief[[51]](#footnote-51); and to feeling safer during labour[[52]](#footnote-52);
2. ‘information continuity’—where the care provider uses and exchanges information on past events to deliver care that is appropriate to the patient’s current circumstances; and
3. ‘management continuity’—where the care providers connect their care in a coherent way.[[53]](#footnote-53)

Importantly, where there is discontinuity of care (for example, poor integration of care providers across the maternity continuum, referral to another care provider and breakdown in information exchange) research has shown it can lead to unsafe situations due to the need for more handovers and loss of information[[54]](#footnote-54), as well as inconsistency in advice and information from multiple caregivers.[[55]](#footnote-55) Further, the literature suggests that discontinuity of care where women are cared for by multiple care providers can result in women experiencing less satisfaction with their care[[56]](#footnote-56) or less quality of care[[57]](#footnote-57) compared to women who have not had discontinuity in their care.

Whilst research supports the benefits of continuity of care in improving maternal health outcomes for all women, it is also has benefits for women considered to be at high risk and for vulnerable women in which ‘building trust is hard but crucial in their projected maternal care outcome’.[[58]](#footnote-58)

Importantly, the benefits of continuity of care and carer (relationship-care):

…works both ways with the ability for midwives to develop a more vested relationship with their patients. This can lead to improved aspects of care including but definitely not limited to breastfeeding support, postpartum mental health and birth debrief support.[[59]](#footnote-59)

Underpinned by the strength of the relationship that develops between the care giver and patient—continuity of care that encompasses pregnancy through to the postpartum period may also ‘increase overall patient outcome including the success rates of breastfeeding and birth trauma support’.[[60]](#footnote-60) It may also benefit women who experience ‘birth trauma in their subsequent pregnancies’.[[61]](#footnote-61)

The research also observes that whilst ‘experienced continuity of care’ depends on the care context—it is significantly higher for women who are in midwife-led care as compared to obstetrician-led care.[[62]](#footnote-62) Midwife-led continuity models provide care from the same midwife or team of midwives during the pregnancy, birth and the early parenting period, and many women value this. These midwives also involve other care-providers if they are needed. Obstetrician-led or GP-led models are not usually able to provide the same midwife/wives throughout.[[63]](#footnote-63)

Further, research has found that the main benefits for women who received midwife-led continuity of care include: they were less likely to have an epidural; fewer women had episiotomies or instrumental births; women’s chances of a spontaneous vaginal birth were increased; there were no differences in the number of caesarean births; women were less likely to experience preterm birth, and they were also at a lower risk of losing their babies.[[64]](#footnote-64)

* + - * 1. Postnatal post-traumatic stress and traumatic birthing experiences

Submissions to the inquiry recounted adverse/traumatic birth experiences and subsequent diagnoses of post-traumatic stress disorder (PTSD)—for the women experiencing these events together with an associated impact on their husbands or partners. They also highlighted the importance of formalised debriefing after these events by appropriate health professionals and that mental health considerations need to be integral throughout the maternity care continuum.

Research has shown that trauma experienced at or around the time of childbirth may result in a type of post-traumatic stress disorder. A UK study found that experiences of trauma may not only be attributable to procedures (obstetric and gynaecologic) but also to the roles and behaviour of health professionals towards women. This can include: feelings of powerlessness during procedures; women not being consulted or respected; limited choice and control in decisions during labour and birth; amount of information received; the experience of physical pain, unsympathetic attitudes by health professionals; and the need for health professionals to clearly understand a woman’s informed consent.[[65]](#footnote-65)

The development of postnatal post-traumatic stress can lead to negative outcomes for women, infants and families. The results of research[[66]](#footnote-66) examining the relationship between traumatic birth experiences and PTSD suggest the following interventions as potential protective factors: (i) reduce the use of invasive obstetric procedures during labour and birth; (ii) prepare women and their partners realistically for labour and birth—including providing information on the incidence of interventions and the associated risks and benefits; (iii) ensure that preparation for labour and birth includes candid discussions about emergency procedures to reduce the impact of unexpected events and enable women and their partners to better understand and participate in the decision-making process if an emergency may arise during labour; (iv) given that some trauma symptoms have a delayed onset, postpartum care needs to provide ongoing emotional support to women and assess for the presence of trauma symptoms; and (v) women are more likely to experience psychological morbidity in the postpartum period due to adverse birthing experiences—opportunities should be provided for women experiencing adverse birthing experiences to discuss the birth experience. The benefits of debriefing with a health professional can assist a woman to understand the ‘sequence of events during labor and birth and make sense of her feelings’ and assist with better managing trauma symptoms and be better placed to ‘focus on caring for herself and her baby’.[[67]](#footnote-67)

Further, fathers and partners of women may be at risk of secondary traumatic stress during the birthing experience. The potential for this risk results from exposure to, and out of concern for, their wife or partner experiencing primary traumatic stress.[[68]](#footnote-68) The interventions summarised as potential protective factors at paragraph 4.16 would assist with mitigating risks of secondary traumatic stress.

* 1. Woman-centred care

Woman-centred care focuses ‘on the woman’s unique needs, expectations and aspirations; recognises her right to self-determination in terms of choice, control and continuity of care; and addresses her social, emotional, physical, psychological, spiritual and cultural needs and expectations. It also acknowledges that a woman and her unborn baby do not exist independently of the woman’s social and emotional environment and incorporates this understanding in assessment and provision of health care’.[[69]](#footnote-69)

* 1. Human rights considerations

Human rights considerations are of even more importance given the ACT is a human rights jurisdiction. Whilst not specifically identified in the context of human rights considerations—a number of contributors to the inquiry noted the importance of providing respectful maternity care; that the well-being of a woman, her baby and partner are interconnected, and they can be marginalised in the birthing experience and the ensuing months.

Maternity care needs to encompass basic human rights, including the rights to respect, dignity, confidentiality, information and informed consent; the right to the highest attainable standard of health, and freedom from discrimination and from all forms of ill-treatment. A woman’s autonomy should be recognised and respected—including her emotional well-being, choices and preferences.[[70]](#footnote-70)

* 1. Responding to the Inquiry Terms of Reference

The Committee notes that in November 2019, after the commencement of this inquiry, the ACT and the other parties to the COAG Health Council endorsed the National Strategy—*Woman-centred care: Strategic directions for Australian maternity services*. The National Strategy—covering maternity care of women from conception until 12 months after pregnancy or birth—sets out the:

…overarching national strategic directions to support Australia’s high-quality maternity care system and enable improvements in line with contemporary practice, evidence and international developments.[[71]](#footnote-71)

The National Strategy encompasses four values: safety, respect, choice and access.

It is generally accepted that values drive behaviours, which in turn, drive outcomes. Values drive and underpin the implementation of strategy within a respective governance framework.

The inquiry has 12 T of R—many of which interact and overlap. Rather than devote a separate chapter to each T of R—the Committee has determined to organise its consideration of the evidence, and associated recommendations (where applicable) within a forward looking framework that encompasses all T of R and aligns with the National Strategy. This approach provides for an integrated perspective (avoiding fragmentation of strategy and practice) and supports a robust consideration of issues raised (and solutions where required) within a cohesive context.

Accordingly, the Committee has set out its consideration of the many issues raised in evidence across its inquiry T of R—organised across the following parameters:

* Overarching strategic focus—for maternity services in the ACT—considers evidence relating to the overarching strategic focus for the delivery of maternity services in the ACT.
* Governance framework for maternity services in the ACT—considers evidence relating to the objectives, policies, culture, accountabilities, and performance of maternity services in the ACT.
* System and service values—the culture of maternity services in the ACT is the expression of its values in action. Considers evidence relating to the values of—safety; respect; choice; and access.

# Overarching Strategic Focus

This chapter considers evidence (and where applicable, makes recommendations)relating to the overarching strategic focus for the delivery of maternity services in the ACT.

* 1. Woman-centred care

Overwhelmingly, evidence to the inquiry from organisations and groups advocated for woman-centred care—emphasising that women are the decision-makers in their care and that maternity care should reflect their individual needs.[[72]](#footnote-72) The UNSW Public Services Research Group noted:

In over thirty years of maternity services’ reviews (at both state and federal levels), Australian women have consistently called for woman centred maternity care within a wellness paradigm as an alternative to medicalised maternity care options. The key demand is for woman-centred care, where the woman is supported to make her own decisions based on good-quality, unbiased evidence, and those choices are respected by her birth attendants. Woman-centred care is central to the holistic model.[[73]](#footnote-73)

The Canberra Mothercraft Society observed:

I think we have tripped into a space where we deliver services that meet the needs of the services rather than putting the woman in the centre and asking what is right, what does the woman need and what does the woman want. Mostly people want what is best for them.[[74]](#footnote-74)

Safe Motherhood for All Incorporated was of the view that the ‘ACT faces a challenge in achieving high quality, woman-centred maternity care, in a safe respectful environment’[[75]](#footnote-75)—namely:

* Firstly, in providing maternity services that honour the childbearing woman’s human right to respect, autonomy, dignity and the attainment of the highest level of health.
* Secondly, achieving maternity care that does no harm. The World Health Organisation states—In normal birth there should be a valid reason to interfere with the natural process; 85% of births do not require interventions. As caesarean section rates rise towards 10% across a population, the number of maternal and newborn deaths decreases. When the rate goes above 10%, there is no evidence that mortality rates improve, (WHO, 2015).
* Thirdly, in achieving effective, efficient and appropriate use of the funds available, while maximising the health outcomes for society. The financial costs associated with current maternity care practices create a demand for health services that are not clinically indicated and reduce/limit access to clinical interventions for those who really need them.
* Finally reducing the productivity implications of lost work performance due to ongoing ill health following maternity care.[[76]](#footnote-76)

In summary, evidence received from individuals to the inquiry was of the view that maternity services and models of care should be woman-centred and meet the health and well-being needs of mothers, their babies and families. Maternity services and models of care should also protect and respect the human rights of the mother baby family unit throughout their contact with maternity services. Other views expressed either in support of woman-centred care or highlighting its absence included:

* Women should be able to choose a place of birth and model of care based on the safest place for them and this should be respected.
* Women not feeling listened to during their pregnancy, birth and postnatal experience.
* Many women went to the trouble of taking the time and personal energy to share deeply personal, painful and traumatic pregnancy and birthing experiences in the hope and desire that lessons could be learned so that other women would not have to go through what they had experienced.

The WHO principles define woman-centred care as care that focuses on:

…meeting the needs of the woman and her baby. Each woman should negotiate the way that her partner and significant family or friends are involved.[[77]](#footnote-77)

* + - * 1. Committee comment

The Committee emphasises the evidence quoted at paragraph 5.3 from the Canberra Mothercraft Society that the provision of maternity services should be woman-centred rather than service-centred.

The Committee is firmly of the view that the planning, designing and delivery of maternity services and models of care should reflect that women are the decision-makers in their care and that maternity care should reflect their individual needs.

The Committee notes that parties to the COAG Health Council to which the ACT is a party—endorsed in November 2019 the National Strategy—Woman-centred care: Strategic directions for Australian maternity services. The National Strategy—covering maternity care of women from conception until 12 months after pregnancy or birth—sets out the:

…overarching national strategic directions to support Australia’s high-quality maternity care system and enable improvements in line with contemporary practice, evidence and international developments.[[78]](#footnote-78)

The Committee also acknowledges the Government’s recent launch of *Canberra Maternity Options*—a ‘new system to make it easier for women to learn about and access Canberra’s public maternity system’.[[79]](#footnote-79) The launch of the new system stemmed from the findings of the Women’s Centre for Health Matters 2016 consultation project exploring women’s experiences of accessing and using maternity services in the ACT and where there may be opportunities for improvement.[[80]](#footnote-80)

Notwithstanding the aforementioned work being undertaken to plan, design and deliver maternity services and models of care that support a woman-centred approach, the Committee is of the view that the effectiveness of the implementation of the National Strategy and *Canberra Maternity Options* respectively need to be regularly assessed and outcomes publicly reported.

The Committee recommends that the ACT Government ensure that the planning, design and delivery of maternity services in the ACT is woman- and baby-centred.

The Committee recommends that the ACT Government report to the ACT Legislative Assembly by the last sitting day in August 2020 on the implementation of the National Strategy—*Woman-centred care: Strategic directions for Australian maternity services*. This should include: (i) detail on the implementation plan and phases; and (ii) an assessment of the broad changes needed to the planning, design and delivery of maternity services in the ACT to provide for woman-centred care pursuant to the National Strategy.

The Committee recommends that the ACT Government report to the ACT Legislative Assembly by the last sitting day in August 2020 on the implementation of *Canberra Maternity Options* and its effectiveness in making it easier for women to learn about and access Canberra’s public maternity system. This should include: (i) detail on the implementation plan and phases; and (ii) the design of an evaluation framework that encompasses process, impact and outcome evaluation parameters.

* 1. Mother baby family unit

Some evidence to the inquiry highlighted the importance of the family unit throughout the maternity care continuum—in that, it conveys the importance of husbands, partners and the social and/or community family structure during pre-conception, pregnancy and birth.[[81]](#footnote-81) This position emphasises that maternal care activities and systems need to fulfil the needs of the ‘Mother Baby’ family unit to achieve safe and respectful maternity care.[[82]](#footnote-82) Further, evidence observed that the family unit is also paramount to supporting transition to parenthood.[[83]](#footnote-83)

Tresillian Family Care Centres[[84]](#footnote-84) noted feedback received from families accessing the services at QEII over the past 12 years showed that:

…through the delivery of primary health care and working in partnership with families using a wholistic strengths based approach—the QEII Family Centre has made a positive impact on the health and wellbeing of families.[[85]](#footnote-85)

Tresillian Family Care Centres expressed the view that maternity services in the ACT could benefit from the ‘wrap around’[[86]](#footnote-86) services it offers in the ACT and surrounding NSW focused on supporting families from conception and into the early years. It was of the view that some of these services could be further developed or implemented in partnership with the ACT Government.[[87]](#footnote-87)

One service example cited was the First 2000 Days Project—a NSW Ministry of Health Initiative. This project encompasses the period from conception through to the age of five—the first 2000 days of life. Tresillian Family Care Centres commented:

There is a case to be made for the implementation of a First 2000 Days Project…in the ACT, where gaps in service for vulnerable and disadvantaged families are identified.

…It is well-proven that the first 2000 days of life are vital to the positive trajectory of the life course and health outcomes of individuals, their families and communities. With operations aligned to this same preventative approach, Tresillian has the experience and demonstrated capabilities to assist ACT Health in delivering on its commitments to families.[[88]](#footnote-88)

Safe Motherhood for All Incorporated emphasised that:

Maternity Services need to be holistic and work in partnership with families in all their diversity to, improve collaboration across the health and welfare sector. …

The health and wellbeing of infants and children is critically connected to the health and wellbeing of their mother.[[89]](#footnote-89)

The written submission from Dr Garvan emphasised that there was a need for a holistic response to pregnancy and birth with better support for young families and improved links between health and welfare practitioners. In this regard, the submission recommended addressing gaps and strengthening existing initiatives including: (i) expanding and developing the ‘Baby Makes Three’ program—to strengthen core couple relationships during the early years after the birth of an infant—to support and facilitate communication and cooperation; and (ii) noting the limited reach of programs that QEII is currently running[[90]](#footnote-90)\*—the ‘Relaxing into Parenting’ and the ‘Baby Makes Three’ programs—that have been evaluated and found to have positive outcomes. These programs, however, unfortunately only reach a small proportion of families who birth in the ACT each year.[[91]](#footnote-91)

Some evidence also highlighted the importance of father/partner inclusive practice in the perinatal period—in particular during the perinatal period but also in and across the maternity care continuum.[[92]](#footnote-92) This can also extend to the effect of birth trauma on a woman’s partner where adverse birthing experiences occur. Husbands and partners witnessing their partners in pain can become distracted, upset, and scared. Further, they can be at risk of secondary traumatic stress during childbirth ‘because of the emotionally intense nature of the spousal relationship’.[[93]](#footnote-93)

The Perinatal Wellbeing Centre (formerly the ACT Post and Ante Natal Depression Support and Information (PANDSI) organisation[[94]](#footnote-94)) emphasised the need for a greater focus on perinatal mental health, especially during the antenatal period with emphasis on the importance of prevention (including screening), education and focusing on the family unit. The Centre stated:

The perinatal mental health of women and their partners should be recognised as an integral part of the delivery of maternity services in the ACT. The opportunity to prevent development or escalation of issues through awareness raising, opportunistic screening and other mechanisms will improve the wellbeing of local families in addition to providing long term savings to the health system and workforce productivity.[[95]](#footnote-95)

* + - * 1. Committee comment

The Committee recognises the importance of focusing on the family unit throughout the maternity care continuum. It is also acutely aware of the benefits of services and programs that extend from conception through to early childhood as being ‘vital to the positive trajectory of the life course and health outcomes of individuals, their families and communities’.[[96]](#footnote-96)

Further, the Committee acknowledges the economic and social benefits of services and programs supporting children and families that extend from conception through to early childhood—including but not limited to the ‘effectiveness of early intervention in the promotion of schooling, reduction in crime and promotion of adult mental and physical health’.[[97]](#footnote-97)

The Committee recommends that the ACT Government in partnership with Tresillian Family Care Centres conduct a trial of a ‘First 2000 Days’ pilot program to address the needs of families and to support vulnerable and disadvantaged families in the ACT.

The Committee recommends that the ACT Government in partnership with Canberra Mothercraft Society and Relationships Australia ACT and Region trial the wider availability of the evidence-based parenting program ‘Relaxing into Parenting + Baby Makes Three’.

The Committee recommends that the ACT Government ensure that ACT maternity care clinical practices and referral pathways—in particular those concerned with post-natal depression are inclusive of fathers and partners to support timely identification and treatment.

The Committee recommends that the ACT Government ensure infrastructure planning responds to women’s preference for partners and/or support people to remain with them during and after labour.

The Committee recommends that the ACT Government—in partnership with its Council of Australian Government (COAG) colleagues—advocate for changes to the *Australasian Health Facility Guidelines* (AusHFG) to support women’s preference for partners and/or support people to remain with them during and after labour.

* 1. Maternity services and care—overarching ethos

Evidence to the inquiry presented differing views on whether maternity services should reside in a primary care (community) focused overarching ethos or in a medical care (doctor) focused overarching ethos.

Advocates support a primary care ethos on the basis that:

* + pregnancy, labour, birth and breastfeeding are most often normal and healthy physiologic processes that require supportive care and skilled attention; and
  + many pregnancy-related and newborn complications can be prevented or mitigated by primary maternity care and public health measures designed to prevent illness and promote wellness.[[98]](#footnote-98)

Further a primary care focus adopts the social determinants of health approach to maternity services. This provides a framework to support the consideration of the influence of broader societal, economic and political factors on women, their babies and families, including safety issues and also how maternity services and models of care are structured and organised, and how women and their families experience these services.[[99]](#footnote-99)

The Canberra Mothercraft Society called on the ACT Government:

…to show political commitment and leadership to provide governance and policy frameworks that are contemporary and do reflect reliable evidence, adequate funding and equitable allocation of resources, the engagement of the community, models of care, prioritised primary health care in relation to maternity services—rather than “acute” being the priority—engagement with the private and non-government sectors, active engagement, real engagement, respectful engagement, a workforce that is fit for purpose, and an appropriate physical infrastructure for people to do their work in an enabling environment.[[100]](#footnote-100)

Further, Canberra Mothercraft Society was of the view that the maternity care system should be primary care-led with effective consultation referral processes in place for women with high risk pregnancies and underlying medical needs to access medically-led services as required (a truly integrated approach to maternity services).[[101]](#footnote-101) An example of such an approach is in place in NZ . NZ has a midwifery-led model of maternity care that resides in a primary care (community) ethos. NZ introduced its midwifery-led model of care almost 25 years ago. The model is a choice-based model of primary maternity care (LMC). Under this model—each woman has a LMC to coordinate care throughout their pregnancy.

Australia’s overarching maternity care ethos is a medically-led system with varying degrees/levels of midwifery input. Whilst Australia’s maternity care ethos is a medically-led system it does not prevent midwifery-led care *per se*.

As noted in Chapter 4, there are many benefits of midwife-led continuity of care—providing care from the same midwife or team of midwives during the pregnancy, birth and the early parenting period, and many women value this. These midwives also involve other care-providers if they are needed. Obstetrician-led or GP-led models are not usually able to provide the same midwife/wives throughout.[[102]](#footnote-102)

Further, research has found that the main benefits for women who receive midwife-led continuity of care include: they were less likely to have an epidural; fewer women had episiotomies or instrumental births; women’s chances of a spontaneous vaginal birth were increased; there were no differences in the number of caesarean births; women were less likely to experience preterm birth, and they were also at a lower risk of losing their babies.[[103]](#footnote-103)

Notwithstanding, as noted by the UNSW Public Services Research Group, recent written submissions to the Australian Health Ministers Advisory Council Consultation Paper (2018) indicate that midwife-led care ‘remains widely unavailable’ in Australia. One submission estimated that midwife-led continuity of care is available to no more than 8 per cent of women in Australia.[[104]](#footnote-104)

Further, the UNSW Public Services Research Group observed that:

[d]espite offering a range of care models in the ACT however, continuity of carer models that operate within a wellness paradigm remain largely unavailable since a small percentage of births actually take place within midwife-led birth centres and even fewer as planned homebirths.[[105]](#footnote-105)

Some submitters and witnesses were of the view that the availability of midwife-led continuity of care models to women in the ACT should be improved and the ACT Government should ‘act on factors that are in its remit to address’.[[106]](#footnote-106) These include: extending midwife visiting rights to ACT hospitals; expanding birth centre and home birth places and options; and establishing avenues for providing women and families with independent evidence-based information on the benefits of midwife-led continuity of care.[[107]](#footnote-107)

* + - * 1. Committee comment

The Committee acknowledges that the benefits of midwife-led continuity of care are significant for women, their babies and families and they extend across the care continuum. The Committee is of the view that the ACT Government should do more to increase and support the availability of midwife-led continuity of care as a model of care for women in the ACT.

The Committee recommends that the ACT Government should prioritise improving the availability of woman-centred midwife-led continuity of care throughout the ACT.

The Committee recommends that the ACT Government should prioritise dismantling the barriers that prevent the availability of and access to woman-centred midwife-led continuity of care. This includes but is not limited to: (i) extending midwife visiting rights to ACT hospitals; (ii) expanding birth centre and home birth places and options; and (iii) establishing avenues for providing women and families with independent evidence-based information on the benefits of midwife-led continuity of care.

* 1. Continuity of care and carer

Overwhelmingly evidence received from organisations and groups to the inquiry was of the view that:

1. women value and want continuity of care and carer; and
2. women should be supported in their choice of care and carer.[[108]](#footnote-108)

In summary, evidence received from individuals to the inquiry identified that continuity of care remained an important aspect of having a baby, as does women being included in decision making about their bodies and their babies. Other views expressed, either in support of continuity of care and carer or highlighting its absence included:

1. The views identified in 5.44 a) and b).
2. Submissions where women reported being satisfied with care and treatment—elements contributing to this included: receiving adequate and current information, women being listened to and respected within the patient and caregiver relationship, questions being answered and decisions explained—all leading to the development of trust in the care relationships.
3. Submissions where women reported unsatisfactory care and treatment—elements contributing to this related to a lack of, or discontinuity in, continuity of care—where women had to repeat their health information, inaccurate information being provided and barriers to access, such as difficulty in getting appointments.

The Committee also heard that service efficiencies in existing funding models—such as staff-patient ratios—are at odds with the delivery of quality maternity care, in particular, continuity of care and carer.[[109]](#footnote-109)

Sands Australia (a volunteer-based organisation providing miscarriage, stillbirth and newborn death support), for example, acknowledged that continuity of care is difficult to achieve and it impacts on rosters and skill mixes across maternity settings. However, it noted that there are:

…some economies associated with the practice particularly around pregnancies following pregnancy loss or in high risk pregnancies. Bereaved parents have expressed that a significant amount of their time in medical appointments in public health settings is spent repeating their story, creating additional distress and reducing the time available to deliver high quality care.[[110]](#footnote-110)

* + - * 1. Committee comment

The Committee agrees that access to and quality of care across the different stages of the maternity care continuum should be supported. In the literature the benefits of continuity of care and carer models to the mother baby family unit are well established. Further, evidence to the inquiry emphasised that the core principle of continuity of care was fundamental to effective mental health care and this principle should apply to all maternity care and service provision in and across the maternity care continuum.

The Committee is firmly of the view that that the planning, design and delivery of maternity services in the ACT should be underpinned by the concept of continuity of care and carer. The benefits of this concept for women, their babies and families and care providers are well established.

The Committee acknowledges the work recently undertaken by the Government stemming from the findings of the Women’s Centre for Health Matters 2016 consultation project exploring women’s experiences of accessing and using maternity services in the ACT and where there may be opportunities for improvement. This culminated in the launch of *Canberra Maternity Options* on September 2019. While the Committee commends the Government for this initiative, it believes there is more work to be done—in particular, in addressing funding models for maternity services because the delivery of quality maternity care is often at cross purposes with service efficiencies. In short, current funding models appear to support a fragmented approach to maternity care.

The Committee recommends that the ACT Government should expand the availability of continuity of care and carer models to enable women’s choices to be met and supported.

The Committee recommends that the ACT Government ensure that the planning, design and delivery of maternity services in the ACT is underpinned by the concept of continuity of care and carer. This should include the incorporation of the three dimensions of continuity of care—relational/personal; information; and management—in and across all available models of maternity care.

The Committee recommends that the ACT Government should ensure that funding models for maternity services in the ACT recognise the need to include not only women but also their babies—to ensure adequate services and staffing and reasonable workloads to meet continuity of care needs of both mothers and their babies.

The Committee recommends that the ACT Government—in partnership with its Council of Australian Government (COAG) colleagues—advocate for the development of funding models to support access to continuity of care and continuity of carer models in all jurisdictions.

The Committee also recognises that all health professional stakeholders working in and across the maternity care continuum should be supported in visiting and practice rights in public hospitals. This should apply to services provided to both: (a) admitted; and (b) non-admitted patients (other than at an emergency department). The Committee has made comment and recommendations (where applicable) focused on addressing barriers to visiting and practice rights for these professionals in Chapter 10.

* 1. Health promoting hospital and health service

The Canberra Hospital, Calvary Hospital and the former ACT Department of Health and Community Care were previously accredited as World Health Organization (WHO) health promoting hospitals and health services respectively. It is unclear whether this status has lapsed and, if not, whether it extends to the CHWC.

The WHO’s health promoting hospital and service initiative (the HPH Initiative) informed by the WHO’s 1986 Ottawa Charter for Health Promotion is focused on implementing the concept of capacity building into a structured process for health promotion action in specific settings. As applied to the hospital and associated healthcare settings the HPH Initiative:

…incorporates the principles of capacity building and organizational change, as hospitals steer towards the re-orientation of service delivery to promote health [for patients, consumers, staff and the community] within and outside its physical boundaries. This re-orientation is designed to demonstrate the organization’s obligation in meeting the changing needs of society, as the hospital shifts its focus [to not only include] specific acute curative service delivery [but also the] delivery of health services across the whole health and social care continuum.[[111]](#footnote-111)

The HPH Initiative would provide a significant organising and supportive framework for many of the foundation concepts raised in evidence to this inquiry and which are discussed in this report—including: woman-centred care; continuity of care and carer; Baby Friendly Community Initiative; Baby-Friendly Health Initiative; Breastfeeding-Friendly Workplaces; Australian Charter of Healthcare Rights and Safety; the National Quality Healthcare Standard—Partnering with Consumers; Respectful Maternity Care Charter—The Universal Rights of Childbearing Women; and other health promoting health care and workplace concepts.

Further the HPH Initiative would also support a primary care focus or social determinants of health approach to the planning, designing and delivery of maternity services. This provides a framework to support the consideration of the influence of broader societal, economic and political factors on women, their babies and families, and the community—including safety issues and also how maternity services and models of care are structured and organised, how women and their families experience these services and how health professionals deliver these services.

The HPH Initiative is also a powerful organising framework for instituting and supporting cultural change within hospitals and health services.

* + - * 1. Committee comment

The Committee notes the potential benefits of the WHO HPH Initiative in supporting many of the foundation concepts raised in evidence to this inquiry and which are discussed in this report. Further, it is a useful concept for driving and supporting a primary care focus or social determinants of health approach to the planning, design and delivery of maternity services within a tertiary or hospital setting.

The Committee recommends that the ACT Government revisit the accreditation of its hospitals and health services as World Health Organization (WHO) health promoting hospitals and health services.

The Committee recommends that the ACT Government investigate the feasibility of accrediting the Centenary Hospital for Women and Children as a World Health Organization (WHO) health promoting hospital.

# Governance framework

This chapter considers evidence (and where applicable, makes recommendations) relating to the objectives, policies, culture, accountabilities, and performance of maternity services in the ACT.

Evidence received from organisations and groups concerning the governance framework for maternity services in the ACT is organised across the following seven categories: culture; performance measurement and reporting; consumer feedback—complaints and compliments; resourcing—capacity and physical infrastructure; consumer involvement; integration of services and systems; and clinical records management.

* 1. Culture

In summary, evidence[[112]](#footnote-112) to the inquiry identified the following matters relating to the culture of the public maternity services system:

1. An overreliance on a medicalised way of working—which reduces the benefit of midwifery input into how the services are managed and what care is provided.
2. Power imbalances exist within the maternity services system—which can lead to interpersonal and structural discrimination and disrespect towards pregnant women and mothers.
3. The maternity service system is under significant pressure—attributable to increased demand, resourcing challenges as it concerns workforce and physical infrastructure in the form of health facilities.
4. There seems to be a blame culture in ACT Health—in certain situations, in particular maternity emergencies or unexpected outcomes—midwives in the ACT are fearful of management, anticipate not being supported and are concerned that they will be blamed rather than supported in these situations.

On 10 September 2018, shortly before the Committee announced its inquiry into maternity services in the ACT[[113]](#footnote-113), the then Minister for Health and Wellbeing[[114]](#footnote-114) announced an independent review into the workplace culture within ACT public health services. The decision to conduct the review was:

…in response to significant reporting on poor workplace culture across the three arms of the ACT Public Health Services: ACT Health Directorate, Canberra Health Services and Calvary Public Hospital Bruce over an extended period. An independent panel was appointed to undertake the review.[[115]](#footnote-115)

The Independent Panel released its interim report on 1 February 2019, to which the Government provided ‘in principle support for the recommendations’. The final report—*Independent Review into the Workplace Culture within ACT Public Health Services—*presented to the then Minister for Health and Wellbeing on 5 March 2019 was tabled in the ACT Legislative Assembly on 19 March 2019.[[116]](#footnote-116)

The final report made 20 recommendations spread across seven key workplace culture themes identified by the review—namely: there were inappropriate behaviours including bullying and harassment in the workplace; procedures and processes were inefficient, including complaints handling; training was not adequate to deal with inappropriate workplace practices; there was an inability to make timely decisions; leadership and management were poor at many levels throughout the ACT public health system; there were inefficient and inappropriate human resource practices, including recruitment; and greater clinical engagement was needed to ensure the system benefits from specialised expertise and input.[[117]](#footnote-117)

The Government response to the final report of the Independent Review tabled on 16 May 2019 agreed to all 20 recommendations. A three-year timeframe has been designated for work to be undertaken to implement the 20 recommendations.

* + - * 1. Committee comment

The Committee notes that the focus of work in 2019–20 concerning the recommendations of the independent review into the workplace culture within ACT public health services ‘will be to establish solid foundations to approach cultural change and to implement the [R]eview recommendations’.[[118]](#footnote-118)  This includes: (i) developing a strategic systems-wide approach to build a positive workforce culture across the three arms of the public health system; (ii) enhancing linkages by building and strengthening partnerships with internal and external stakeholders; (iii) developing strong communication channels, recognising progress, providing context and information, and seeking feedback from across the health services; (iv) applying an evidenced based approach to address the recommendations from the review and to effect sustainable change; (v) accessing and analysing data to understand challenges and implement alternate strategies; and (vi) developing strong evaluation mechanisms to measure effectiveness and change.’[[119]](#footnote-119)

The Committee is of the view that successful implementation of the recommendations within the three-year timeframe will require a joined-up approach across the health portfolio and will involve multiple stakeholders. Further, the Committee is of the view that regular reporting on implementation outside the requirement specified in the annual report directions is needed to track progress and to enhance transparency.

Accordingly, the Committee as part of its inquiry into 2018–19 annual and financial reports has recommended that the ACT Government table in the ACT Legislative Assembly quarterly progress reports on the implementation of the recommendations of the *Independent Review into the Workplace Culture within ACT Public Health Services*.

* 1. Performance measurement and reporting

In summary, evidence[[120]](#footnote-120) received to the inquiry identified the following matters relating to performance measurement and reporting—namely that:

1. There is insufficient information publicly available on the outcomes of maternity care in the ACT. Key indicators of maternity safety, quality and health outcomes should be publicly released at regular intervals.[[121]](#footnote-121)
2. Where quality and safety data indicate that maternity services are performing below the national average in any area—a plan to improve care, involving women in the governance of these reform initiatives should be developed and implemented.[[122]](#footnote-122)
3. Measurable targets for increasing women’s access to continuity of care services, and access to psychological support and services should be established.[[123]](#footnote-123)
4. The planning, designing and delivery of maternity services and models of care ‘are not informed by consumer voice and shared decision-making model’.[[124]](#footnote-124) Further, a ‘lack of consumer voice can lead to inequality’.[[125]](#footnote-125)

Safe Motherhood for All Incorporated emphasised that:

The public does not have the information to scrutinise health services. There is a lack of information generally on the outcomes of maternity care in the ACT, and limited information is collected on safety and quality, efficiency and cost-effectiveness. Without rigorous data on targeted variables in an established systematic fashion, we cannot answer relevant questions and evaluate outcomes. The aim is to collect quality evidence that translates into data analysis allowing for convincing and credible understanding of the issues so as to inform future investments, to maximise the return on investment, minimise wastage of limited financial resources, to promote accountability, to support a safety and quality framework for maternity and children and monitor the impact of changing models of care effectively.[[126]](#footnote-126)

To address the aforementioned gaps in accountability regarding performance measurement and reporting on maternity care outcomes in the ACT—Safe Motherhood for All Incorporated made the following observations:

Aggregated trended data can be deceptive and therefore not useful. Immediately mandate and implement arrangements for consistent, comprehensive data collection, monitoring and review.

Develop a consumer feedback tool and process that elicits the spectrum of a woman’s maternity experience—physical, social, cultural, emotional, psychological and spiritual safety in line with the Australian Commission for Safety and Quality in Healthcare Partnering with consumer standard. Ask all women at 6 months post birth for their feedback. There is growing evidence that information provided at this time is more reflective of the actual experience.

…

Adopt the Robson Classification System for assessing, monitoring and comparing caesarean section rates within healthcare facilities over time, and between facilities.[[127]](#footnote-127)

* + - * 1. Committee comment

The Committee is of the view there is a need for an accountable and transparent maternity service system that is high quality, evidence-based and better meets the needs of women and their families. Appropriately designed performance measurement and public reporting would assist in achieving this objective. The Committee considers that public reporting should be regular and frequent—such as by way of inclusion in the *ACT Public Health Services Quarterly Performance Report*. As the Committee understands, the Quarterly Performance Report presents a single source of information on the performance and activity of ACT public health services for the applicable quarter.

The Committee is also of the view that there needs to be improvements to the collection and reporting of maternity services data. This should include—for example, collecting women-reported outcomes to measure quality improvement in maternity care.

The Committee recommends that the ACT Government should: (i) publicly release key indicators of maternity safety, quality and health outcomes at regular intervals; and (ii) where quality and safety data indicate that services are performing below the National average in any area—a plan to improve care, involving women in the governance of these initiatives, should be developed and implemented. The Committee further recommends that the Government consider publishing this information in the *ACT Public Health Services Quarterly Performance Report.*

The Committee recommends that the ACT Government should develop measurable targets for increasing women’s access to continuity of care services, and access to psychological support and services across the maternity continuum.

The Committee recommends that the ACT Government consider developing a consumer feedback tool and process that elicits at six months post birth a woman’s maternity experience—physical, social, cultural, emotional, psychological and spiritual safety—in accordance with the Australian Commission on Safety and Quality in Health Care Partnering with Consumer Standard.

* 1. Consumer feedback—complaints and compliments

In its submission, the Government explained that the CHS' Consumer Feedback and Engagement Team meets regularly with senior executives in the Women, Youth and Children Division, with similar arrangements in place at CPHB to consider and respond to all consumer feedback—complaints and compliments. Further, where a complaint is received, maternity units at CHWC and CPHB provide women and their families with an opportunity to meet with senior staff to discuss their concerns.[[128]](#footnote-128)

As to data on complaints and compliments across the 2015 to 2018 period—the Committee was told:

* + In 2016–17 and 2017–18, maternity services at CHWC received 56 consumer feedback complaints, 186 consumer compliments, and during this period had 7154 births.[[129]](#footnote-129)
  + In 2015–18, maternity services at CPHB received 35 consumer feedback complaints and 714 compliments.[[130]](#footnote-130)

The Committee inquired about complaints relating to maternity services in comparison to complaints received relating to other services and was told:

From 1 July 2018 to 30 June 2019 Canberra Health Services received 1749 complaints. 4.9 per cent of those were related to maternity services. In comparison, in the same period Canberra Health Services received 2870 compliments with 12.4 per cent of compliments relating to maternity services.[[131]](#footnote-131)

Some evidence received from organisations and groups to the inquiry identified the following matters relating to complaints:

1. Reports of matters relating to service complaints being settled on a confidential basis with no reporting to the Australian Health Practitioner Regulation Agency (AHPRA) or the ACT Health Complaints Entity (HCE)—in the absence of full disclosure there are barriers to addressing cause(s) and taking remedial steps with the potential flow-on effect of ongoing poor practice.[[132]](#footnote-132)
2. Cases of complainants seeking low financial compensation—could be resolved outside formal court processes—with benefits for complainants and the ACT. Noting that the ACT civil law wrongs legislation specifically acknowledges that claims can be conciliated under the ACT *Human Rights Commission Act 2005*—recognising the value of matters being resolved outside the formal court processes—this could be possible if ACT Health had more flexibility with regard to these complainants.[[133]](#footnote-133)

Some evidence received from individuals to the inquiry identified the following matters relating to consumer feedback:

1. Frustration and disappointment at feeling unable to extract accountability for disrespectful behaviour shown towards them and the actions of health professionals involved in their care.
2. When making a complaint—feeling heard and understood, respected and a willingness to take feedback on board.
   * + - 1. Committee comment

The Committee notes that the evidence to the inquiry—included both very generous compliments about staff and the care received and complaints recounting devastating experiences relating to disrespectful care; the behaviour of staff and the quality of care received. In considering data on the numbers of complaints to ACT Health, the Committee notes the numbers are small in number when compared with overall birthing numbers and compliments received. Notwithstanding, evidence supports the view that many people are discouraged from complaining about a service they have received for fear of repercussions. Further, as in the case of maternity care, they may not have the personal energy to make a complaint at the time but may at some time after the event be in a position to do so.

The Committee also notes the improvements that can be made with regard to the barriers to addressing cause(s) and taking remedial steps relating to service complaints settling on a confidential basis; and the importance of the ACT Health Directorate having more flexibility to respond to complainants seeking low financial compensation outside court processes with benefits for complainants and the ACT Government.

The Committee recommends that the ACT Government prioritise how lessons can be learned and future risks mitigated in relation to service complaints that are settled on a confidential basis and are not reported to the Health Practitioner Regulation Agency (AHPRA) or the ACT Health Complaints Entity (HCE).

The Committee recommends that pursuant to the ACT *Civil Law (Wrongs) Act 2002* that the ACT Government provide flexibility for maternity care claimants seeking low financial compensation to be conciliated outside formal court processes under the ACT *Human Rights Commission Act 2005*.

* 1. Resourcing—capacity and infrastructure

In summary, some evidence received from organisations and groups to the inquiry identified the following matters relating to resourcing—including its capacity and physical infrastructure:

1. Delays in access and service provision—across the maternity care continuum.[[134]](#footnote-134)
2. Staffing levels are based on management needs not the needs of the women or their choices. Decisions in staffing are based on bed status and patient flow. The nature of childbirth and therefore maternity care is unpredictable and does not lend itself easily to the bed status and patient flow staffing model. Management decisions about staffing are not based on what is best for the woman but based on bed availability.[[135]](#footnote-135)
3. Quality maternity care often is at odds with service efficiencies as the service is programmed to focus on staff-patient ratios, outcomes and statistics. The result is that care becomes task focused, itemised and not woman-centred.[[136]](#footnote-136)
4. The ANMF Mandated Minimum Nurse/Midwife to Patient Ratios Framework—addressing both staffing and patient ratios and skill mix, across publicly funded services should be implemented.[[137]](#footnote-137)
5. Funding models for maternity services should recognise the need to include not only women but also their babies to ensure adequate services and staffing and reasonable workloads to meet the care needs of both mothers and their babies.[[138]](#footnote-138)
6. While advances in technology have enhanced maternity care—its use can lead to an over reliance and disregard for the midwifery philosophy of care and expertise and skills associated with this important profession.[[139]](#footnote-139)
7. Areas of maternity care in the ACT experience obstacles to accessing appropriate technology—for example, midwives who work in women’s homes do not have access to appropriate mobile devices, such as laptops, and remote connection with radiology and pathology clinical patient services and online data management.[[140]](#footnote-140)

In summary, some evidence received from individuals to the inquiry identified the following matters relating to resourcing—including its capacity and physical infrastructure:

1. Delays in service provision, including for: induction of labour; suturing post-delivery; provision of pain relief; and discharge checks.
2. Long wait-times for booked clinic appointments and rescheduling of times with limited notice—causing difficulties with absence from employment, childcare, parking fines, and geographic location to home and other commitments.
3. Inductions being cancelled or delayed due to a ‘lack of beds’.
4. Upon childbirth admission—being asked to wait in the waiting room until a bed was available.
5. Bed reallocations during the postpartum period.
6. Being asked to wait in the waiting room with a newborn baby for several hours while a bed was sourced. Some women being discharged reporting their bed was needed prior to their discharge process being completed.
7. Bed reallocations or delay in bed availability due to capital works construction—March 2018.
8. That birth units or other wards were not staffed adequately and/or inexperienced midwives or doctors were left in charge.

The ACT Government advised that maternity services at both CHWC and CPHB are provided by a multidisciplinary team including obstetricians, neonatologists, midwives, nurses and allied health professionals. Access to specific expertise is available to all women dependent on need. Many women also meet anaesthetists during their birthing experiences.[[141]](#footnote-141)

Further, the Government advised that staffing levels at both hospitals take account: (i) of patient acuity and caseloads; and (ii) staff are able to report concerns related to workload through the incident management system as well as escalating to their line managers.[[142]](#footnote-142)

* + - * 1. Committee comment

It is clear to the Committee that the evidence to the inquiry gives powerful insights into a system that is under increased demand and pressure as it concerns resourcing—its workforce capacity and available physical/facility infrastructure.

The Committee makes further comment on matters related to the maternity workforce in Chapter 7. The Committee also notes that it has made recommendations to develop funding models that better reflect the delivery of maternity services and support for continuity of care and carer in Chapter 5.

The Committee is of the view that some of the capacity constraints consistently raised in evidence was that staff were too busy, there were insufficient staff and birth units or other wards were not staffed adequately and/or inexperienced midwives or doctors were left in charge or in the position of having to make clinical decisions without appropriate support and supervision.

The Committee notes evidence that maternity staffing levels are:

…based on management needs not the needs of the women or their choices... Decisions in ACT maternity hospitals are similar to other hospitals around the world where [staffing levels] are based on bed status and patient flow. The nature of childbirth and therefore maternity care is that it is unpredictable meaning that many maternity units/wards experience ebbs and flows of workload with staff on some shifts being ‘run off their feet’ and not able to provide women the care they need to shifts where no women are admitted. Also, since the cost of staffing Australian hospitals increased in the late 1980’s many hospital have chosen to not staff there wards and units to a 100% capacity. This has intensified the staffing issues in maternity when it is busy and there is a 100% capacity.

Although regulations for public hospitals has required a minimum nurse to patient staffing ratio this has been difficult to apply to maternity services. This is because maternity care is so different to acute healthcare services. The Labour and birth component, for example, is often not a planned healthcare activity and as a result staffing a ward is difficult. Another example is that on the postnatal ward a midwife’s workload is only based on the needs of the woman, as her baby is not seen as an admitted patient. This may be regardless that the baby may need care such as Intravenous (IV) antibiotics or frequent taking of vital signs. This results in midwives being busy but management not recognising the intricacies of their workload. Further reports from our membership is that at CHWC, due to the hospital’s busy workload, women are having planned treatments and interventions at night when staffing is at its lowest. For example, a woman may have an Induction of Labour commenced overnight as it was too busy during the day and now that there are a few empty beds on the Birth Unit it is deemed safe for and Induction of Labour to be commenced. These two management decisions about staffing show that they are not based on what is best for the woman but based on bed availability.[[143]](#footnote-143)

The Committee believes that safe and manageable workloads for nurses and midwives working in publicly funded maternity services need to be in place. The Committee acknowledges that the delivery of quality maternity care may not be supported by staffing-patient ratios based on patient acuity and caseloads and that this formula may be contrary to the delivery of woman-centred care and indeed make it challenging to support the concept of maternity continuity of care.

The Committee considers that the Australian Nursing and Midwifery Federation’s (ANMF) mandated minimum Nurse/Midwife to patient ratios for the safe management of maternity workloads should be implemented. As the Committee understands, the minimum ANMF Nurse/Midwife to patient ratios focus on staff, patients and skill mix.

The Committee recommends that the ACT Government should implement the Australian Nursing and Midwifery Federation’s Mandated Minimum Nurse/Midwife to Patient Ratios Framework for the safe management of maternity workloads across publicly funded maternity services.

* 1. Consumer involvement

Evidence received to the inquiry identified the following matters relating to consumer involvement:

1. The routine incorporation of consumer feedback about maternity experiences needs to be strengthened to ensure a more woman-centred system.[[144]](#footnote-144)
2. The current consumer involvement process does not represent the needs of the people accessing maternity care.[[145]](#footnote-145)
3. Work needs to be undertaken with mental health and other service providers, with input from women and consumer groups, to provide better multidisciplinary, coordinated care within and across the maternity care continuum—in particular, the perinatal period.[[146]](#footnote-146)

As to the limitations of the current consumer involvement process not representing the needs of the people accessing maternity care, the Australian College of Midwives—ACT Branch explained:

The current method of consumer involvement is difficult to engage maternity consumers. Childbirth is one aspect of a family’s healthcare and often once the woman and her partner have completed their family, they disengage from the issues pertinent to a maternity system. On the other hand, a consumer who may have knowledge of the acute care health system may not have any experience of childbirth. This results in the current consumer involvement process not representing the needs of the people accessing maternity care. It would be of great benefit if a maternity consumer organisation could provide a consumer directly to ACT Health.[[147]](#footnote-147)

Safe Motherhood for All Incorporated emphasised that maternity models of care need to be informed by ‘consumer voice’ and the ‘shared decision-making model’—adding that:

Consumers, especially pregnant women, are the least powerful contingent in the health-care system, even though their knowledge, attitudes, and actions could be the most important influence on their own health and safety. There is an urgent need to develop models of care based on meaningful engagement with maternity consumers so as to enhance the shaping of maternity services affecting women, and to ensure that future strategies and policies are in fact consumer driven.[[148]](#footnote-148)

To establish a framework to work towards ensuring that maternity models of care are informed by ‘consumer voice’ and the ‘shared decision-making model’—Safe Motherhood for All Incorporated advanced that the *National Safety and Quality Health Service Standard 2: Partnering with Consumers* was instructive. The Standard requires:

…all health services to partner with women and families in designing and delivering health services and provides the model to create an organisation in which there are mutually valuable outcomes by having:

* consumers as partners in planning, design, delivery, measurement and evaluation of systems and services; and
* consumers as partners in their own care, to the extent that they choose.[[149]](#footnote-149)

Safe Motherhood for All highlighted the outcomes that prevail when health services fail to consult, engage and collaborate effectively with consumers—namely: (i) a misdiagnosis of the prevailing conditions and causality; (ii) poorly designed programs and services; and (iii) a breakdown in trust between the different parties.[[150]](#footnote-150)

* + - * 1. Committee comment

The Committee is strongly of the view that the routine incorporation of consumer feedback about maternity experiences needs to be strengthened to ensure a more woman-centred system. The Committee is also of the view that maternity consumers need to be included in maternity services planning and monitoring committees. The Committee considers that enhancing engagement with consumers in this way can also reduce ‘systemic disrespect’.[[151]](#footnote-151)

The Committee also notes that the 5th ACT Legislative Assembly’s Standing Committee on Health in its inquiry on maternity services in the ACT recommended that the Government establish a Ministerial Advisory Council on Maternal Health. The Government did not support this recommendation. In light of evidence to this inquiry, some 16 years later, the Committee believes the merits, or otherwise, of such a recommendation should be reconsidered.

The Committee recommends that the ACT Government establishes a Ministerial Advisory Council on Maternal Health comprising consumer and community representatives to advise the Minister on the policy direction for maternity services and models of care with a view to developing a comprehensive model of woman-centred care that encompasses a care continuum for the mother baby family unit from conception to early childhood.

The Committee recommends that the ACT Government should ensure that woman-reported outcomes, well-being and experiences are collected (for example, using patient reported experience(s) and outcome measures) and reported as a core part of quality assessment of maternity services.

The Committee recommends that the ACT Government strengthen the current consumer involvement process to ensure that it represents the needs of the people accessing maternity care.

The Committee recommends that the ACT Government ensure that maternity consumers are represented and included in ACT Maternity Services planning and monitoring committees.

* 1. Integration of services and systems

Evidence received from organisations and groups to the inquiry submitted that integration across current systems for maternal care in the ACT was poor—for example, the flow of patient information and history between the current systems for maternal care in the ACT is disjointed and is a barrier to continuity of care.[[152]](#footnote-152)

Further, evidence noted that the *ACT Health Territory-Wide Health Services Framework 2017–27*—does not reflect the true integration of maternity services in the ACT. It does not adequately reflect the integrated network of public, private and voluntary health services that deliver maternity services to the ACT community—but instead focuses on the public sector in isolation.[[153]](#footnote-153) The Canberra Mothercraft Society commented that there were gaps in the framework ‘that would prohibit a reliable, evidence-based maternity service for the ACT’.[[154]](#footnote-154) Regarding integrated health care, the Society observed:

When we look at this plan, the true integrated nature of maternity services in the ACT is absent. It looks like it is only about public health services run by the ACT government. We believe that CMS is an example of why the ACT government needs to look closely at its model of integrated care. There is no mention of the importance of other sectors and the fact that they deliver critical maternity services to our community.

At the macro level of senior managers and policymakers, integration truly happens when decisions on policies, financing, regulation and delivery are appropriate. This means bringing together different services but also considers the whole of the network of public, private and voluntary health services rather than looking at the public sector in isolation.[[155]](#footnote-155)

The Society also noted that the *ACT Health Territory-Wide Health Services Framework 2017–27* ‘still had “draft” on it, but it is what is sitting up there as the public document’.[[156]](#footnote-156)

* + - * 1. Committee comment

The Committee considers that the achievement of integrated maternity services in the ACT requires an overarching planning framework to understand and adequately reflect the integrated network of public, private and voluntary health services that deliver maternity services to the ACT community. It should not focus on the public sector in isolation.

Further, the Committee is of the view that understanding and adequately reflecting the integrated network of public, private and voluntary health services that deliver maternity services to the ACT community is critical to achieving woman-centred care that is underpinned by the concepts of continuity of care and continuity of carer.

The Committee recommends that in light of the feedback provided by the Canberra Mothercraft Society on *the ACT Health Territory-Wide Health Services Framework 2017–27* (the Framework), the ACT Government review the Framework and make any necessary adjustments.

* 1. Clinical records management

Some evidence received from individuals to the inquiry identified the following matters relating to the management of clinical records:

1. Details of admissions not accurately reported in discharge summaries resulting in a lack of appropriate follow-up—for example, by specialist clinics or by their GP. Other inaccuracies regarding birthing experience (pre and post) recorded in patient records.
2. Being provided with other women’s clinical records or notes upon discharge.
   * + - 1. Committee comment

The Committee emphasises that adequate and contemporaneous record keeping is a key part of being a skilled and safe health professional and in the provision of quality care. Inadequate or incomplete record keeping may be a sign of wider problems within a healthcare setting and can lead to a variety of problems for patients and health professionals. Further, adequate and contemporaneous clinical records are vital for continuity of care for patients and are a health professional’s best defence should they be in a situation of having to respond to complaints or claims about the care provided to patients.

The disclosure of clinical records should also be consistent with legislative requirements with regard to managing the privacy of health records.

The Committee recommends that the ACT Government remind all health professionals working within the delivery of ACT publicly funded maternity services of their responsibilities and obligations: (i) regarding adequate and contemporaneous clinical record keeping; and (ii) that any disclosure of patient clinical records should be in accordance with legislative requirements for managing the privacy of health records.



# Maternity care—Safety

This chapter considers evidence (and where applicable, makes recommendations) relating to the system and service value of—safety—that underpins the delivery of maternity care in the ACT.

Evidence received from organisations and groups and individuals concerning safety of maternity care is organised across the following six categories: safety and quality in maternity care; evidenced-based care; responses to perinatal loss (stillbirth and maternal and neonatal morbidity); cultural safety; safety of vulnerable, marginalised and disadvantaged groups; and the maternity care workforce.

* 1. Safety and quality in maternity care

In summary, evidence received from individuals to the inquiry identified the following matters relating to safety and quality in maternity care:

1. After experiencing a complication during the birthing process—inadequate, or no, debriefing. Where a complication may result in referral to another service—lack of, or poor, communication between the treating teams.
2. Inconsistencies in information provision and differing clinical decision/views between health professionals involved in the care of pregnant mothers before, during and after birth—with a flow on effect to safety and quality of care received (real and perceived).
3. Reported experiences of fragmented care—resulting in seeing different midwifes and or obstetricians at visits during their pregnancy. Aside from contributing to raising anxiety levels, fragmented care has safety and quality of care implications.

All of the aforementioned issues highlight gaps in current provision of services—that could well be attributable to increasing demand for services with insufficient resources (both staff and facilities) to respond to demand.

The Australian Nursing and Midwifery Federation highlighted that:

Nurses and Midwives working in maternity services locally express concern about the apparent shortage of Midwives, which they state is resulting in ongoing, excessive work demands which is impacting on their well-being and negatively impacting on their ability to ‘be present’ for women and babies. Midwives have reported demand for birth suite services regularly in excess of 85% and often in excess of 100%, leading to a decrease of the level of care, beyond the minimal safe ‘essentials of care’, and earlier than optimal discharge from inpatient services. Some Midwives stated that this has, in some cases, resulted in new-borns and their mothers requiring referral to support services including MACH and the Queen Elizabeth II Family Centre. Nurses and Midwives further claim that some post-natal women have been kept in delivery suites at CHWC due to the unavailability of beds.[[157]](#footnote-157)

As it concerns demand for maternity services in the ACT, the Government observed that maternity services at CHWC have experienced consistently high demand in recent years. It attributed this increase in demand to Canberra families being attracted to the modern facilities available at the CHWC and changes to the Medicare Safety Net in 2010 resulting in increased out-of-pocket expenses for private maternity patients. The Government explained:

The ACT Government Maternity services at CHWC have experienced consistently high demand in recent years. Canberra families have been attracted to the modern facilities, in particular the single room accommodation, and more women are requiring access to the tertiary level care available at CHWC.

Also impacting on demand were the 2010 changes to the Medicare Safety Net. These resulted in increased out of pocket expenses for private maternity patients, with a resulting increase in demand for public hospital maternity services. Birthing events at CHWC have significantly increased, from 2,743 in 2010-11 to 3,561 in 2016-17, an annual growth rate of 4.5 per cent.[[158]](#footnote-158)

* 1. Evidence-based care

Evidence[[159]](#footnote-159) to the inquiry emphasised that provision of care must be based on the latest evidence and that women and families should have access to quality, evidence-based models of maternity care.

Further, evidence highlighted that women want and should be provided with improved availability of quality evidence-based, easily understood information about choices in care and associated outcomes during the perinatal period.

As to the availability of evidence-based information, the Australian College of Midwives—ACT Branch commented:

…the ACT Health website for maternity services needs improving, as it currently provides minimal useful information and is difficult to access. For example, unlike other jurisdiction health services ACT Health has no easily accessible evidence-based information available to pregnant women such as fact sheets/websites.[[160]](#footnote-160)

The Canberra Mothercraft Society emphasised the relationship between informing a community and creating demand. Discussion ensued as follows:

**MRS DUNNE**: Correct me if I am wrong, but you said that we should be creating demand for service. Could you elaborate on that? Is it that sometimes mothers do not know what is available or what they need and you end up in the sausage factory, in a sense?

**Ms Kirk**: Exactly. If we have a community that is not well informed, that does not know what to ask for, there is not the counter-pressure to expect that. We know how important it is for us when we are providing services that we do respond to what people need. I believe we have an obligation to inform them of what is best practice and then have that counter-pressure back. That is okay; we expect it. Why have we not got it? We do not do that, and I believe we should. If we set it up that people expect best practice, we will deliver best practice. That counter-pressure is very important.[[161]](#footnote-161)

* + - * 1. Committee comment

The Committee emphasises that evidenced-based informed maternity care underpinned by the concept of continuity of care and carer not only leads to improved care and outcomes for women and babies during the perinatal period—it also supports an approach to consistency in the delivery of care.

The Committee notes that there is a range of evidence-based information that should be used to inform the planning, design and delivery of consistent, quality and evidenced-based maternity care to women in the ACT. This includes: the *National Pregnancy Care Guidelines*[[162]](#footnote-162)—developed to support the provision of consistent, high-quality, evidence-based antenatal care to Australian women; as detailed in Chapter 4—the well-established evidence-base for the concept of continuity of care and carer—and the benefits of this concept for both women and care providers; and also as detailed at Chapter 4—the growing research on the correlation between the development of postnatal post-traumatic stress and traumatic birthing experiences and potential protective factors that maternity systems should consider.

The Committee also acknowledges the Government’s recent launch of *Canberra Maternity Options*—a ‘new system to make it easier for women to learn about and access Canberra’s public maternity system’.[[163]](#footnote-163) Notwithstanding, the Committee is of the view that more work is needed to support evidenced-based decision making by women and their families in the ACT.

The Committee recommends that the ACT Government update its *Canberra Maternity Options* with accessible evidence-based information about the: (i) options, outcomes, and implications of choices regarding models of care; and (ii) benefits for women, their babies and families and health professionals of planning, designing and delivering maternity services that are underpinned by the concept of continuity of care and continuity of carer.

* 1. Perinatal loss and maternal and neonatal morbidity and mortality

In summary, evidence received from organisations and groups and individuals to the inquiry identified the following elements relating to perinatal loss and maternal and neonatal morbidity and mortality:

1. The importance of all women being offered a formal birth debriefing with a qualified health professional in the birthing or hospital setting.[[164]](#footnote-164)
2. Women and their families who experience early pregnancy loss, stillbirth, neonatal death or termination after diagnosis of abnormality in the developing foetus need more comprehensive bereavement care and information and emotional support. The sensitivities of the experiences of parents in these situations needs to be better acknowledged and their mental health needs to be attended to more comprehensively.[[165]](#footnote-165)
3. Health facility services and accommodation for women and their families who experience early pregnancy loss, stillbirth, neonatal death or termination after diagnosis of abnormality in the developing foetus—the provision of a perinatal hospice to provide care to relevant women and families of the ACT and surrounding regions.[[166]](#footnote-166)
4. Acknowledgement of correlation between adverse/traumatic birth experiences and subsequent diagnoses of PTSD. This highlights the importance of formalised debriefing after these events by appropriate health professionals and that mental health considerations need to be integral throughout the maternity care continuum.[[167]](#footnote-167)

Many submissions from individuals painfully recounted adverse/traumatic birth experiences and subsequent diagnoses of PTSD—for these women—and observed the development of secondary stress symptoms for their husbands or partners. They highlighted the importance of formalised debriefing after these events by appropriate health professionals and that mental health considerations need to be integral throughout the maternity care continuum.

The Women’s Centre for Health Matters in presenting the experiences of women accessing maternal care in the ACT and the views of services working with women post birth in the community—informed by two consultation projects the Centre carried out in 2015 and 2018—advised that:

Women expressed concerns about the lack of debriefing after the birth about the decisions that had been made, why they had been made and talking to women about what had happened to their bodies.[[168]](#footnote-168)

Several women highlighted that even though they had experienced trauma during their birthing experience, they were also given a debriefing session with midwives within 72 hours of the birth and they relayed how that made a real difference to how they were able to reconcile the reality of what had occurred with the ‘ideal’ they had initially taken into the birthing process.[[169]](#footnote-169)

Sands Australia whilst supporting the concept of continuity of care during pregnancy emphasised its distinctive benefits for bereaved parents, in that the development of a trusting relationship—attributable to continuity of care ‘makes a considerable difference when things go wrong or when difficult decisions related to pregnancy need to be made’.[[170]](#footnote-170)

Further, Sands Australia emphasised that continuity of care needs to apply to bereavement support—in that their community of bereaved parents advise that ‘leaving hospital to go home without their babies is the most difficult time they face’. The level of support available for these parents, in general, is minimal and improved support during this time would benefit these parents working through the difficulties of ‘knowing where or how to continue with life’.[[171]](#footnote-171) Sands Australia suggested that its Hospital to Home program[[172]](#footnote-172) may assist with strengthening support for bereaved parents in their transition from hospital to home and the months following.

With regard to bereavement support—Sands Australia noted that whilst bereaved parents report from a clinical point of view they feel generally well looked after, from a bereavement support point of view, they report inconsistencies between staff approaches. Using Federal funding, Sands Australia advised it had developed a set of Bereavement Principles—aimed at providing hospital staff in all roles with an understanding of what bereaved parents would like and should be able to expect whilst in hospital.[[173]](#footnote-173)

* + - * 1. Committee comment

It is clear to the Committee of the importance and value of instituting, after birthing, a formalised birth debriefing opportunity for women and their husbands or partners with a qualified health professional. The Committee is of the view that it needs to be offered and accessed within 72 hours of a birth.

The Committee recommends that the ACT Government mandate that birth debriefings with a qualified health professional be offered to and accessed by women and their husbands or partners within 72 hours after birthing.

The Committee notes the statistics regarding perinatal death in the ACT. The Committee thanks women and their families who shared experiences of their loss of a child in these circumstances. The Committee is firmly of the view that women and their families who experience perinatal loss need more comprehensive bereavement care and information and emotional support. Further, this should extend to exploring the feasibility of the establishment of a designated perinatal hospice facility to provide services and care for relevant women, their babies and their families. The Committee commends the work undertaken by Karen Schlage in this regard.[[174]](#footnote-174) Accordingly, the Committee makes the following recommendations:

The Committee recommends that the ACT Government prioritise a feasibility study to examine the establishment of a perinatal hospice facility to provide perinatal services and care to relevant women, their babies and families.

The Committee recommends that the ACT Government—in partnership with its Council of Australian Government (COAG) colleagues—advocate for changes to the *Australasian Health Facility Guidelines* (AusHFG) to include inpatient requirements for perinatal hospice facilities, services and care.

The Committee recommends that the ACT Government in the planning, design and delivery of maternity services and models of care adopt the Sands *Australian Principles of Bereavement Care—Miscarriage, Stillbirth and Newborn Death.*

The Committee recommends that the ACT Government provide bereavement training—informed by the Sands *Australian Principles of Bereavement Care—Miscarriage, Stillbirth and Newborn Death—*to all health professionals working in and across the maternity care continuum in the ACT.

The Committee recommends that the ACT Government—in partnership with Sands Australia, Red Nose Australia, Perinatal Wellbeing Centre and other organisations working to support women and families experiencing perinatal loss—implement strategies to strengthen comprehensive bereavement care and information and emotional support for bereaved parents in their transition from hospital to home and the months following.

* 1. Cultural safety

In summary, evidence[[175]](#footnote-175) received to the inquiry identified the following elements relating to cultural safety:

1. A maternity system should ensure and support Aboriginal and Torres Strait Islander women and women of culturally and linguistically diverse backgrounds to receive culturally appropriate care.
2. The maternity service system needs to provide culturally competent care, work with community cultural organisations to ensure the system is responsive to women from all backgrounds, and ensure interpreters are funded and provided throughout the system.
3. Cultural competence training should be provided to all health professionals working in and across the maternity care continuum in the ACT.

In its submission the Health Care Consumers’ Association of the ACT made a number of recommendations focused on strengthening culturally safe, evidence-based models of maternity care in partnership with Aboriginal and Torres Strait Islander women and women from culturally and linguistically diverse backgrounds and their communities.[[176]](#footnote-176)

* + - * 1. Committee comment

The Committee is firmly of the view that the planning, design and delivery of maternity systems and models of care should ensure and support Aboriginal and Torres Strait Islander women and women of culturally and linguistically diverse backgrounds to receive culturally appropriate care.

The Committee notes that an evaluation of state-based initiatives seeking to provide culturally appropriate care to Aboriginal and Torres Strait Islander women found improved outcomes were associated with maternity care models that were culturally safe and responsive; provided continuity of care; and involved partnerships with Aboriginal and Torres Strait Islander health staff and services.[[177]](#footnote-177)

The Committee also notes the importance of maternity services being underpinned by the concept of continuity of care and carer; and the benefits of this concept for both women and care providers—in particular, its benefits in building trust in the care-relationship between women and care providers. A trusted care-relationship is paramount in supporting culturally safe and responsive care to Aboriginal and Torres Strait Islander women and women of culturally and linguistically diverse backgrounds.

The Committee is aware that two documents are relevant to guiding and strengthening maternity care for Aboriginal and Torres Strait Islander women—namely, the *Characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander Women* reportpublished in2012[[178]](#footnote-178); and the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* and associated Implementation Plan.

The Committee recommends that the ACT Government ensure that the planning, design and delivery of maternity services and models of care reflect and support the competencies detailed in the *Characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander women report*.

The Committee recommends that the ACT Government continue and expand support for community-based maternal, child and family health services delivered by community-controlled, Aboriginal health services.

The Committee recommends that the ACT Government support the implementation of strategies identified in the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023*.

The Committee recommends that the ACT Government support the development of an Aboriginal and Torres Strait Islander maternity services workforce.

The Committee recommends that the ACT Government enhance continuity of care for Indigenous women in the ACT—in particular, in regard to transfers between community-based and hospital settings.

The Committee notes a 2016 systematic review seeking the views and experiences of women from culturally and linguistically diverse backgrounds on accessing reproductive health care in Australia identified the following barriers: spoken and written language, including issues relating to interpreters; health professionals’ lack of knowledge regarding cultural norms; systemic barriers relating to the healthcare system and difficulty navigating the system; transport difficulties; and cost of services.[[179]](#footnote-179)

The Committee further notes that the Migrant and Refugee Women’s Partnership launched in January 2019—a Competency Standards Framework for Clinicians—*Culturally responsive clinical practice: Working with people from migrant and refugee backgrounds*. The Framework has been endorsed by Australian College of Midwifery; Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) and 17 other medical colleges and organisations. It is a comprehensive guide for midwives, obstetricians, GPs, nurses and all other health professionals providing services and care to people who need to use a language other than English to access information and/or communicate effectively when accessing health care in Australia. A Guide for clinicians working with interpreters in healthcare settings accompanies the Framework. In addition to language interpreters it also includes Auslan and Deaf interpreters for people who are deaf or hard of hearing.

The Committee recommends that the ACT Government expand the continuity of midwifery care program to be accessible and culturally appropriate.

The Committee recommends that the ACT Government ensure that the planning, design and delivery of maternity services and models of care reflect and support the competencies detailed in the *Competency Standards Framework for Clinicians—Culturally responsive clinical practice: Working with people from migrant and refugee backgrounds*.

The Committee recommends that the ACT Government ensure that the planning, design and delivery of maternity services and models of care support all health professionals providing services and care to people who need to use a language other than English to access information and/or communicate effectively when accessing maternity services and care. This should include: (i) the development of strategies to improve training in working with interpreters and bicultural workers; (ii) women who require interpreting services having access to these services at every appointment; (iii) improved accessibility of language services and bilingual and bicultural workers; and (iv) accessible language services should also be extended to women who are deaf or hard of hearing and require the use of Auslan or Deaf interpreters.

* 1. Safety of vulnerable, marginalised and disadvantaged groups

In summary, evidence received from organisations and groups, and individuals to the inquiry identified the following elements relating to the safety of vulnerable, marginalised and disadvantaged groups:

1. There needs to be continued improvement in maternity health care options for vulnerable and disadvantaged women.[[180]](#footnote-180)
2. Strategies need to be identified and implemented to better support women who are the subject of a child protection notification during their pregnancy.[[181]](#footnote-181)
3. Where families are engaged with the care and protection system, pre and postnatal family and decisions making supports should be enhanced, ensuring that child removal only occurs as a last resort as per the *Our Booris Our Way* report.[[182]](#footnote-182)
4. Women are at increased risk of intimate partner violence during pregnancy, and that this violence is also associated with adverse obstetric outcomes and negatively affects infants. There is a need for better identification and response to women and their families during this period to ensure safety is prioritised.[[183]](#footnote-183)

This highlights the need for the use of trauma informed care, that recognises, acknowledges and understands the prevalence of PTSD in patients who have previously or are currently experiencing violence, whether they have disclosed it or not.[[184]](#footnote-184)

1. People with disabilities are increasingly exercising their right to become parents. Maternity models of care in the ACT need to offer appropriate support to facilitate this—there are limitations with the current models of care with regard to supporting people with disabilities.[[185]](#footnote-185)
2. People with disabilities need to be supported to be successful parents, and minimise or eliminate the practice of child removal.[[186]](#footnote-186)
3. There is a need for maternity services to better support those who identify as Lesbian, Gay, Bisexual, Transgender, Queer or Intersex (LGBTQI+).[[187]](#footnote-187)

Women with Disabilities ACT emphasised there needed to be improved:

…support for mothers with intellectual and learning disabilities. ACT maternity services needs to help provide appropriate antenatal and post-partum support for people with intellectual disabilities who are becoming parents to help to minimise and eliminate the practice of child removal. The current high rate of involvement with child protection systems suggests that there is a significant gap in effective services for parents with intellectual disabilities. Research indicates that intellectual disability is not an indicator of parenting performance. Efforts should be made to actively combat this prejudicial assumption in our systems.

In order to fully exercise their right to become parents, people with intellectual disabilities need to be provided with appropriate information and supports, beginning during pregnancy.[[188]](#footnote-188)

Women with Disabilities ACT also noted that mothers with disabilities are experiencing more barriers to choose their care, which is reinforcing poor experiences and medical trauma. To address this, it advocated that the ‘needs of disadvantaged people’ must be ‘considered in the planning and prioritization’ of maternity services, ‘so that they do not become yet another source of that disadvantage’[[189]](#footnote-189). In Women with Disabilities ACT’s view, this can be improved by ‘better communication of patient information, increased capacity of the CATCH program, greater flexibility in procedure, disability awareness training and inclusion of mothers with disability in the planning process’.[[190]](#footnote-190)

As it concerns supporting women with disabilities as parents, the Health Care Consumers’ Association of the ACT noted:

Women with disabilities in the ACT can face specific challenges when using health services, including maternity services. There is an ongoing need for maternity services to ensure that care is accessible and appropriate for women with disabilities. Women with disabilities deserve to receive the same woman-centred care available to others.[[191]](#footnote-191)

With regard to women and children involved in the child protection system, the Committee was told:

ACT health professionals are required by law to make a pre-natal report to ACT child protection authorities if they are concerned that an unborn child is at risk of abuse or neglect after birth. This practice can undermine the trust between a woman and her caregivers during pregnancy, and can lead to women’s disengagement with pre-natal care services. Once a pre-natal report is made about a woman, her pregnancy may end with the removal of her baby from her care at birth. In many instances this outcome could be avoided if appropriate support services were made available to the woman. Given the over-representation of Aboriginal and Torres Strait Islander families and young people in the out-of-home care system, it seems probable that the practice of removal at birth disproportionately affects Aboriginal and Torres Strait Islander mothers, babies and families.[[192]](#footnote-192)

The ACT Health Services Commissioner observed that:

I have had matters brought to my attention where women have been reluctant to access ACT maternity services because of concerns about child concern reports made by staff about women and mothers with a disability and Aboriginal and Torres Strait Islander women. While this information is largely anecdotal we have dealt with a number of enquiries and complaints from Aboriginal and Torres Strait Islander women who believe a child concern report was raised because of race and from women with a disability who have been reported to child protection services because they have a disability and concern. It is a distressing experience for new parents to have to respond to child concern reports in their first days and weeks of parenting a new child.[[193]](#footnote-193)

As part of evidence to its inquiry into child and youth protection services (part 2) and relevant to this inquiry, the Committee discussed with witnesses from the Canberra Restorative Community Network the statutory authority and circumstances where child protection notifications are made during pregnancy; mandatory reporting requirements by midwives and the removal of children from mothers by child protection agencies. Discussion ensued as follows:

**THE ACTING CHAIR** (Mrs Dunne): Could I go to the point of child removal? Dr Northam, you spoke about the taking of children from hospitals. In your experience, how often does that happen in the ACT?

**Dr Northam:** In fact Fiona has done the data.

**Ms Tito Wheatland:** I have not done the data on that because I could not get it. I spoke to the social workers at the hospital. The week that I went there, it had been very unfortunate; there were four babies removed that week. They said that was really unusual. I said, “How many are we talking about?” They were not actually sure of how many, but they said there would be a couple each month, at least, and maybe one a week. As I said I thought that data would be really easy to get hold of, so I did an analysis of the data under––

**THE ACTING CHAIR:** You would have thought it would be, yes. What sort of circumstances would cause a child to be removed?

**Ms Tito Wheatland:** ADACAS talked to us about that. Quite often it is a mother who has an intellectual disability or some other physical disability or mental illness. Often as well––

**THE ACTING CHAIR**: Those people would have come to the attention of medical authorities before they gave birth. Is there ever intervention––

**Ms Tito Wheatland**: A positive intervention? At the moment, no.

**THE ACTING CHAIR**: It is a matter of saying, “We’ll let nature take its course and then we’ll take the baby,” rather than making a decision about how to assess whether this person who is going to give birth is able to manage after the birth.

**Ms Tito Wheatland**: There can be a number of different ways of being notified. You can have what is called a pregnancy at risk, which is actually provided for under the legislation. That can happen from a number of places. It can be from a doctor, from a neighbour or from wherever. Once that occurs, there is another thing, which is a birth alert. They are both unconnected in the sense that a birth alert can be put on, for example, if you have ever had a child removed beforehand and it comes to care and protection’s notice that you are pregnant.

I was recently involved with a woman where those were the exact circumstances. To try to stop that happening I went to them and said, “What do we need to do to demonstrate that in fact this mother is a safe option for this child?” I did that, we presented it and they said, “Okay, we won’t put a birth alert on if she complies with all of those sorts of things.” I worked with her and walked with her on that journey and made sure that that actually happened. But a lot of parents do not have someone who can do that, because there is no program to do that at the moment. There used to be a program so that, if a mum was identified, you had a whole lot of help. But the people in the hospital said that had stopped and there is really nothing there now that happens.

Some of it is quite malicious. There have been a number of court cases that we are aware of where they would tell a family that mum needed to rest, and waited until the advocate or the person who was there with the mother went away. They then called in the security guards and took the child away. Some of it is quite brutal, in my view, particularly in a human rights compliant jurisdiction.[[194]](#footnote-194)

Evidence to the inquiry noted the lack of structural supports—early intervention and support; and coordinated culturally competent, health and social care for women subject to a child protection notification during pregnancy—and that more needed to be done to address these structural circumstances that were beyond the control of women and their families.[[195]](#footnote-195)

Further, as it concerned maternity services and child protection—the ACT Health Services Commissioner suggested that:

…a review of the processes by which these reports occur be undertaken to ensure public confidence in these processes and to ensure parents are provided with referrals, advocacy, support and information appropriate to their circumstances.[[196]](#footnote-196)

The Ministerial Advisory Committee on Women (MACW) was of the view that the continuity in care model which oversees not only the pregnancy but also the birth and postpartum support is ideal, especially for vulnerable women under the Parenting Enhancement Program (PEP). The MACW noted that the current continuity in care model under the PEP only oversees a patient’s pregnancy up until the time of birth and suggested that, consistent with the Birth Centre model, care under the PEP be extended to include postpartum support.[[197]](#footnote-197)

* + - * 1. Committee comment

The Committee is of the view that women and their families should have access to individualised safe and responsive maternity care that seeks to address barriers that may arise for women and their families due to marginalisation, disadvantage, disability and vulnerability.

The Committee reiterates its earlier comment that the benefits of continuity of care models to the mother baby family unit are well established. Further, evidence emphasised that the core principle of continuity of care was fundamental to effective mental health care and this principle should apply to all maternity care and service provision in the perinatal period.

The Committee also reiterates its previous comments about the importance of maternity services being underpinned by the concept of continuity of care and carer; and the benefits of this concept for both women and care providers—in particular, its benefits in building trust in the care-relationship between women and care providers. A trusted care-relationship is paramount in addressing difficulties that may arise for women and their families due to marginalisation, disadvantage, disability and vulnerability but also equally important in ensuring that these women receive individualised safe and responsive maternity care.

The Committee notes that the provision of individualised safe and responsive maternity care in this regard would be consistent with the ACT being a human rights jurisdiction. Accordingly, maternity services and models of care should also protect and respect the human rights of the mother baby family unit throughout their contact with maternity services.

The Committee also notes that continued improvement in health care options for vulnerable women and maternity and birthing options support the objectives of the ACT Government’s Women’s Plan 2016–26.[[198]](#footnote-198)

The Committee recommends that the ACT Government ensure that the planning, design and delivery of maternity services and models of care supports the delivery of care, especially face-to-face delivery, in places and in ways that are accessible for women with a range of disabilities.

The Committee recommends that the ACT Government identify and implement strategies to better support women who are the subject of a child protection notification during their pregnancy.

The Committee recommends that the ACT Government in its planning, design and delivery of maternity services and models of care strengthen strategies to better identify and respond to women at increased risk of intimate partner violence during pregnancy and trauma informed care is used to ensure safety is prioritised.

The Committee recommends that the ACT Government extend the continuity of the maternity care model for women under the Parenting Enhancement Program (PEP) to include postpartum support.

The Committee agrees with the view of the Health Care Consumers’ Association of the ACT that ‘the removal of children by child protection agencies should occur as a last resort’.[[199]](#footnote-199) Further, the Committee notes evidence to its inquiry that ‘there is a lack of early intervention and support for families who have come to the attention of child protection agencies’ coupled with ‘a specific lack of coordinated, culturally competent, health and social care for women who are the subject of child protection notification during pregnancy’.[[200]](#footnote-200) The Committee is firmly of the view that more needs to be done and can be done in this regard to support women and families in these situations.

The Committee notes that evidence to this inquiry and its inquiry into child and youth protection services (part 2) strongly emphasised that opportunities exist for the Government and maternity services to provide better care for women and families who are the subject of child protection notification in pregnancy and who are at risk of having their child removed from their care. The Health Care Consumers’ Association of the ACT advanced that the work undertaken as part of the *Our Booris Our Way* review has suggested a number of ways to improve care in this regard.[[201]](#footnote-201) This includes—for example: (a) enhancing pre and postnatal family and decision making support; and (b) removing child protection and health care practices that reflect the assumption that removal is inevitable.[[202]](#footnote-202)

The Committee recommends that—for women and their families who are the subject of child protection notification in pregnancy and who are at risk of having their child removed from their care—the ACT Government: (a) strengthen and enhance pre and postnatal family and decision making support; and (b) proactively address child protection and health care practices that reflect the assumption that removal of a child in these circumstances is inevitable.

* 1. The Maternity care workforce

In summary, evidence received from organisations and groups to the inquiry identified the following elements relating to the maternity care workforce:

1. Recruitment and retention of staff—in particular at CHWC has been a challenge for a number of years. Retention of staff can be related to a positive culture.[[203]](#footnote-203)
2. Maternity staff should be trained in cultural competency, trauma-informed care, open disclosure and shared decision-making.[[204]](#footnote-204)
3. Cultural competency, trauma-informed care, open disclosure and shared decision-making in quality improvement and staff development should be prioritised.[[205]](#footnote-205)
4. A more targeted approach to ensuring the maternity services workforce is equipped with the skills required to support the mental health and well-being of all women and their families.[[206]](#footnote-206)
5. A territory wide plan to develop a sustainable workforce for the future needs to be undertaken. The plan needs to address the drivers of supply and retention including, but not limited to, higher education, recruitment and working conditions, targeted ongoing learning, positive cultures, effective leadership, and well-articulated and supported transition to practice programs.[[207]](#footnote-207)

In summary, evidence received from individuals to the inquiry identified the following elements relating to the maternity care workforce:

1. Varied reports about the practice, service and attitudes of health professionals—some were positive and highlighted that the patience and time of these health professionals was critical in helping women develop confidence and feel supported.
2. Other women reported they felt rushed, that their questions were not answered and that they needed more information and support from health professionals during this time.
3. Inexperienced health professional staff carrying responsibilities that they should not have had to carry.
4. Staff members were often too busy.

The Canberra Mothercraft Society proposed ‘that the health workforce is central to attaining, sustaining and accelerating progress on evidence-based ACT maternity services for women’[[208]](#footnote-208) and suggested three guiding questions for decision-makers around maternity services—namely:

* + What health workforce is required to ensure effective coverage of an agreed schedule of maternity services for the ACT?
  + What health workforce is required to progressively expand the coverage of options of care, based on reliable evidence, to all women over time?
  + How does the ACT produce, deploy and sustain a maternity services health workforce that is both fit for purpose and fit to practise in support of accessible, acceptable, affordable and quality care that is close to where women live?[[209]](#footnote-209)

To answer these questions—Canberra Mothercraft Society noted the WHO’s statement ‘that health services are only as effective as the persons responsible for delivering them’ and proposed a ‘conceptual framework that speaks to the key principles of both the right to health and social protection floors—that is, the availability, accessibility, acceptability and quality of health services’.[[210]](#footnote-210) The Society went on to explain:

* + By availability—Canberra Mothercraft Society means ‘the availability of quality maternity services which are based upon reliable evidence and the sufficient supply and stock of appropriately skilled and qualified maternity service providers with the relevant competencies that correspond to the health needs of birthing women and their families’.
  + By accessibility—Canberra Mothercraft Society defines it as relating to ‘the equitable access to maternity services in terms of location, transport, opening hours, the corresponding maternity service health workforce attendance and whether the infrastructure is friendly to women’.
  + By acceptability—Canberra Mothercraft Society defines it as relating ‘to the characteristics of the maternity service environment and the ability of the workforce to treat every woman and her family with dignity, create trust and enable or promote demand for services—demand for services is important—and provide a quality and enabling environment with the requisite facilities, equipment and clinical governance to provide respectful maternity care based upon reliable evidence by maternity health care providers with the required competencies, skills, knowledge and behaviour’.[[211]](#footnote-211)

The Australian College of Midwives—ACT Branch observed that:

Recruitment and retention of staff at CHWC has been an issue for some years now.

...Retention of staff is linked to a healthy functioning culture. When midwives are confident, educated, up-to-date, woman centred and respected to advocate for women and midwife-led care they take pride in their work and want to stay. This influences them to interact proactively with the women and families in their care and makes for a safer healthcare service because they take on the responsibility for their decisions and the care being provided.[[212]](#footnote-212)

Further, the Australian College of Midwives emphasised that:

There must be an emphasis on recruitment and retention strategies that encourages skilled and competent midwives to apply. When midwives are competent and skilled, they provide an organisation with another level of ‘checks and balances’. With their skills and experience they will know that what seems a standard intervention for one woman may not be the best choice for another. Such candour from a midwife in a system that seems to prioritise a medical opinion over that of a midwife’s can be confronting but at times is necessary. Valuing a midwife’s role in maternity care enhances safety and enables a woman to have her needs/choices met.[[213]](#footnote-213)

The Australian Nursing and Midwifery Federation whilst acknowledging that the ‘availability of Midwives is a national issue’—it contended that the ACT was well placed to ‘grow and retain our own’ midwives and nurses to work across the range of ‘maternal services with the right strategic plan’.[[214]](#footnote-214)

The Federation commended the work being undertaken by CHWC to address its workforce issues but was of the view that there needs to be a:

…Territory wide plan to develop a sustainable workforce for the future. Such a plan needs to address the drivers of supply and retention including, but not limited to, higher education, recruitment and working conditions, targeted ongoing learning, positive cultures, effective leadership, and well-articulated and supported transition to practice programs.[[215]](#footnote-215)

* + - * 1. Committee comment

The Committee agrees with the Canberra Mothercraft Society that ‘the health workforce is central to attaining, sustaining and accelerating progress on evidence-based ACT maternity services for women’.[[216]](#footnote-216) Accordingly, the Committee supports the view of the Australian Nursing and Midwifery Federation that the ACT is well placed to grow and retain its own maternity care workforce to work across the maternity care continuum ‘with the right strategic plan’.[[217]](#footnote-217)

Further, the Committee is of the view that any such workforce strategy must, as the Australian College of Midwives has observed, support recruitment and retention strategies that encourage skilled and competent midwives to apply and offer a professional and valued working environment and associated conditions to be retained.

The Committee recommends that the ACT Government—in partnership with all stakeholders that work in and across the integrated network of public, private and voluntary health services that deliver maternity services to the ACT community—develop a *Fit for the Future Territory-Wide Maternity Workforce Plan*. The Plan should address the drivers of supply and retention including, but not limited to, higher education, recruitment and working conditions, targeted ongoing learning, positive cultures, effective leadership, and well-articulated and supported transition to practice programs.

The Committee recommends that the ACT Government strengthen and support the development and maintenance of skills (including clinical reflection and supervision) of health professionals working in maternity services—with regard to: (i) cultural competency; (ii) trauma-informed care; (iii) open disclosure; (iv) shared decision-making; (v) mental health and well-being competency; (vi) disability sensitivity; (vii) bereavement care; and (viii) working with vulnerable, marginalised and disadvantaged women.

# Maternity care—Respect

This chapter considers evidence (and where applicable, makes recommendations) relating to the system and service value of—respect—that underpins the delivery of maternity care in the ACT.

* 1. Respectful and holistic care

In summary, evidence received from individuals to the inquiry identified the following elements relating to respectful and holistic care:

1. Instances of advice not being evidence-based and inconsistent.
2. Women feeling bullied and staff not being receptive to their views and requests.
3. Negative experiences due to staff being rude to women, their support people or family members.
4. Instances of staff—both doctors and midwives—not listening to women when they were talking about their choices and what they needed.
5. Feelings of powerlessness during procedures.
6. Experiences of unsympathetic attitudes by some health professionals.
7. Limitations about some health professionals clearly understanding informed consent.
8. Women reporting that their choices were not always respected and feeling belittled or judged regarding their choices.
9. The need for maternity services to better support marginalised or vulnerable groups.
10. Submissions where women felt satisfied with the care they received—elements that could be attributed to this was where women felt confident in the knowledge and expertise of the health professionals involved in their care and the empathy these professionals demonstrated towards them throughout their pregnancy and birth experience.
    * + - 1. Committee comment

The Committee notes evidence received from organisations and groups and individuals to the inquiry fundamentally identified that maternity services and models of care should always respect and protect the rights, beliefs and choice of every woman and their family. Further, women should be treated with dignity and respect throughout their maternity care journey.

The Committee is firmly of the view that—fundamentally—consideration, respect and compassion for every woman and their baby should be the foundation of all maternity care.

The Committee has made a number of recommendations throughout its report focused on strengthening maternity services and models of care to respect and protect the rights, beliefs and choice of every woman and their family throughout the maternity care continuum.

The Committee notes that the Global Respectful Maternity Care Council—a broad group of stakeholders representing research, clinical, human rights and advocacy perspectives—came together to develop the *Respectful Maternity Care Charter: Universal Rights of Mothers and Newborns.* The Charter clarifies and clearly articulates the rights of women and newborns while receiving maternity care within a health care facility.

The Committee recommends that the ACT Government ensure that the planning, design and delivery of maternity services and models of care adopt and uphold the 10 principles outlined in the Global Respectful Maternity Care Council’s *Respectful Maternity Care Charter: Universal Rights of Mothers and Newborns.*

# Maternity care—Choice

This chapter considers evidence (and where applicable, makes recommendations) relating to the system and service value of—choice—that underpins the delivery of maternity care in the ACT.

Evidence received from organisations and groups and individuals concerning choice and informed decision making in the context of maternity care is organised across the categories of: information about local maternity services; and informed decision making.

* 1. Information about local maternity services

In summary, evidence[[218]](#footnote-218) received from organisations and groups to the inquiry identified the following elements relating to information about local maternity services:

1. More information needs to be provided to women at all three stages of having a baby in Canberra. More information needs to be available to assist them in the assessment of their choices.
2. The ACT Health website for maternity services needs improving—at the time many submissions to the inquiry were lodged, it provided minimal useful information and was difficult to access. For example, as compared with other jurisdiction health services—the ACT Health website had no easily accessible evidence-based information available to pregnant women such as fact sheets and/or hyperlinks referring to other websites.
3. Women want reliable publicly available information to assist them in their decision-making. Women also want consistency in information about accessing options and care choices available in the ACT.
4. Information and support provision communication channels—in addition to the traditional mediums—emphasis on innovative use of technology as an enabler—apps, telehealth consultations etc.

In summary, evidence received from individuals to the inquiry identified the following elements relating to information and advice:

1. The elements identified in 9.3 a) and 9.3 c).
2. Contradictory information given to women—for example, receiving confusing and contradictory advice regarding breastfeeding and care for their baby.
3. Some women reported having antenatal classes that covered all the risks as well as the positive aspects of the birthing experience would have helped them be better informed about pregnancy, birth and parenting. Extensive coverage of potential risks and where birthing events may not progress as planned can help women temper expectations and be better placed to address unplanned events in their birthing experience.
4. Contradictory information being provided to women from differing health professionals involved in their care—in particular, differing clinical views with flow-on effects for care and treatment received.

The ACT Ministerial Advisory Council on Women was of the view that there was:

…limited information for patients regarding their best choice of maternal care. As per the ‘Women and Maternal Care in the ACT Consultation Report’ by Melanie Greenhalgh, May 2016, it is suggested and agreed that a central hub of information is made available to women regarding their maternal care choices.[[219]](#footnote-219)

In its written submission, the Government advised that the *ACT Public Maternity Access Strategy* was in the final stages of development after extensive stakeholder consultation led by the Women's Centre for Health Matters throughout 2018. The *ACT Public Maternity Access Strategy* will ‘take a Territory-wide approach to managing demand and informing women about birthing choices in a community setting close to their home. The Strategy will also provide the appropriate referral pathway to meet their pregnancy, birthing and postnatal needs’ and ‘seeks to create a streamlined 'one public maternity system' in the ACT’.[[220]](#footnote-220)

With regard to the Public Maternity Access Program (now *Canberra Maternity Options*)—the Australian College of Midwives—ACT Branch cautioned that the proposed ‘single point entry process for maternity care in ACT will not focus on individual women’s needs or choices when they choose where to birth’.[[221]](#footnote-221) The College added:

ACT Health is currently working on a new access program for women seeking maternity care with the Public Health facilities. This program is attempting to create a single point of entry for women. It will be important that women are offered adequate information about the differences in the hospitals when they are making a choice of where to give birth. Rather than it being simply based on geography and obstetric risk factors. For example women who book at CPH do not have access to water birth or home birth compared to women at CHWC. Use of water in labour or having an option to birth at home are seen as important options of care for some women. As are issues about management of complex medical situations such as raised BMI or gestational diabetes.

Also, it will be important that women can choose a place of birth based on the safest place for them. For some women who have experienced high levels of trauma at one hospital they will need to have access at the other hospital to protect them from ongoing trauma.[[222]](#footnote-222)

Just over 12 months on from the announcement[[223]](#footnote-223) of this inquiry—*Canberra Maternity Options* was launched on 30 September 2019—as a ‘new system to make it easier for women to learn about and access Canberra’s public maternity system’. The key features of the new system include: (i) a single entry point via one phone number to access Canberra’s public maternity services; (ii) an established process for women to engage with a midwife early in their pregnancy to discuss pregnancy and birthing options through the public system—including personal preferences and health care needs; (iii) the provision of local support before, during and after pregnancy;(iv) the provision of consolidated service information online about the maternity system and what birthing and care options are available; and (v) providing GPs with targeted information about the new system and the birthing and care options that are available.[[224]](#footnote-224)

Discussion on improving the availability of quality evidence-based easily understood information about choices in care and associated outcomes in and across the maternity care continuum is set out in Chapter 7 under evidence-based care.

Further discussion on the implementation and effectiveness of the newly launched *Canberra Maternity Options* is also set out in Chapter 5 under woman-centred care.

* + - * 1. Committee comment

The Committee acknowledges the calls from several submitters to its inquiry that more information needs to be provided to women at all three stages of having a baby in Canberra. Importantly, the Committee notes that the availability of comprehensive and easily accessible information on maternity services and models of care assists women in their assessment of their choices—i.e., informed decision making.

The Committee also acknowledges the Government’s recent launch of *Canberra Maternity Options*—a ‘new system to make it easier for women to learn about and access Canberra’s public maternity system’.[[225]](#footnote-225) Notwithstanding, the Committee is of the view that the effectiveness of the implementation of *Canberra Maternity Options* in meeting its stated objectives needs to be regularly assessed and its outcomes publicly reported. The Committee has made comment and recommendations to this effect in Chapter 5.

The Committee also notes the caution expressed by the Australian College of Midwives—ACT Branch regarding the proposed ‘single point entry process for maternity care in ACT’ in that it ‘will not focus on individual women’s needs or choices when they choose where to birth’.[[226]](#footnote-226)

The Committee recommends that the ACT Government take appropriate steps to ensure that the *Canberra Maternity Options* Program can focus on individual women’s needs or choices when they choose where to birth.

As noted previously, the Committee is of the view that more work is needed to support evidenced-based decision making by women and their families in the ACT and has made recommendations to this effect in Chapter 7. As it concerns evidenced-based antenatal education—the Committee notes some submissions raised the importance of antenatal classes covering and addressing all the risks as well as the positive aspects of the birthing experience.

The Committee further notes that strengthening the structure of antenatal education to cover all the risks as well as the positive aspects of the birthing experience—as many women indicated would have helped them be better informed about pregnancy, birth and parenting. Extensive coverage of potential risks and where birthing events may not progress as planned can help women temper expectations and be better placed to address unplanned events in their birthing experience.

The Committee also notes, as the research evidence-base has supported, strengthening the structure of antenatal education in this regard may also be a protective factor for preventing post-natal trauma for women and secondary trauma for their husbands and partners.

The Committee recommends that the ACT Government strengthen the structure of antenatal education to be inclusive of all the potential risks as well as the positive aspects of pregnancy, the birthing experience and parenting. This should include: (i) coverage of where birthing events may not progress as planned; and (ii) planning for unanticipated complications, necessary precautions and redress measures.

* 1. Informed decision making

In summary, evidence received from individuals to the inquiry identified the following elements relating to informed decision making:

1. Many women highlighted the importance of being involved in decision making about their bodies and their babies and being kept informed about what was happening to them, having an understanding about the decisions being made and being able to exercise choices and preferences in regard to decisions about treatment to them and their babies.
2. Some shared the trauma and the adverse impacts for them when they experienced levels of intervention that they were not expecting, had not been informed about or had not understood whether the interventions were needed and/or required.
   * + - 1. Committee comment

As noted in the previous section, the Committee notes that the availability of comprehensive and easily accessible information on maternity services and models of care assists women in their assessment of their choices—i.e., informed decision making.

The Committee further notes that empowering women to be able to make informed decisions about accessing maternity options and care choices is crucial but also of equal importance is that the maternity system and its services needs to respect the choices women want and choose to make.

The Committee has made a number of recommendations throughout its report focused on strengthening maternity services and models of care to respect and protect the rights, beliefs and choices of every woman and their family throughout the maternity care continuum.

# Maternity care—Access

This chapter considers evidence (and where applicable, makes recommendations) relating to the system and service value of—access—that underpins the delivery of maternity care in the ACT.

Evidence received from organisations and groups and individuals concerning access is organised across the following five categories of maternity care: models of maternity care; comment on specific models of care—birth centre, home birth trial and ethos of public hospital maternity services; promotion and support for breastfeeding; postnatal care; and mental health support.

* 1. Models of maternity care

In summary, evidence received from individuals to the inquiry identified the following elements relating to models of maternity care:

1. Women want consistency in the information they are able to access about options and care choices available in the ACT.
2. Women not being satisfied with their preparation for labour and birth—i.e., not being provided with all information—full disclosure about what can go wrong and unexpected events that may happen. In the absence of full disclosure, women felt that actions that may happen leading up to some events, such as an emergency caesarean delivery, could be perceived as unexpected rather than something they could prepare for in the context of expectations.
3. Women not being able to access the model of care they wanted due to eligibility and/or capacity restrictions.
4. Women living locally who have a baby admitted to Neonatal Intensive Care Unit (NICU)/Special Care Nursery (SCN) not being able to stay with their baby—in these instances, after giving birth mothers were discharged whilst their child was admitted for further care. These mothers were not given the option of staying and being with their newborn and expressed considerable emotional concern at not being able to be with their baby during this time but also of the importance of the development of the mother baby bond that is so crucially formed in the days immediately following birth.

In summary, evidence received from organisations and groups to the inquiry identified the following elements relating to maternity models of care:

1. At the time of the call for submissions and the scheduling of public hearings—ACT Health was working on a new access program for women seeking maternity care within public health facilities.[[227]](#footnote-227)
2. ACT Health’s new access program for women seeking maternity care within public health facilities—has created a single point of entry for women. Evidence noted that it will be important that women are offered adequate information about the differences in the hospitals when they are making a choice of where to give birth—as opposed to it being based on geography and obstetric risk factors.[[228]](#footnote-228)
3. Women living locally who have a baby admitted to NICU/SCN not being able to stay with their baby during this time and as a result feel dislocated from their newborn—in these instances, after giving birth mothers were discharged whilst their child was admitted for further care. These mothers were not given the option of staying and being with their child. Whereas in the paediatric unit, parents are expected to stay with their admitted child.[[229]](#footnote-229)
4. A trauma-informed approach to maternity services, including staff training and development in trauma-informed care should be implemented.[[230]](#footnote-230)

The aforementioned evidence all relates to various tangible and intangible components of models of maternity care available in the ACT. As noted in Chapter 2:

A model of care has both tangible components (such as roles, structure, methods, location) and those that are less so (such as philosophy, culture, values). A model of care can be thought of as a ‘recipe’ for how care is provided; it describes the systematic and standardised way that health care (in this case, maternity care) is provided, including who the health-care professionals are, their roles, where care is provided and the care ‘pathway’ that the health-care consumer will follow. The benefit of describing health-care delivery in terms of models is that it ensures that all staff working together in a particular area or unit work in a similar way, within a similar framework and guided by a common set of goals (Davidson et al. 2006).[[231]](#footnote-231)

Further, by defining a model in a systematic way, care can be evaluated on a common basis. Through randomised controlled trials and systematic reviews, an increasing evidence base is being developed on the different outcomes for women and babies under different models of maternity care.[[232]](#footnote-232)

There are eight major model categories[[233]](#footnote-233) of maternity care currently available in the ACT. These models are embedded in an overarching medically-led system with varying degrees/levels of midwifery input.[[234]](#footnote-234) A summary of these model categories is given in Table 2.2 in Chapter 2.

Whilst evidence overwhelmingly advocated for women to have informed access to different models of maternity care to accommodate different choices, individual needs and circumstances—evidence also highlighted a number of obstacles to achieving this, such as funding models.

Another obstacle has been consistency in classification of maternity models of care across Australian jurisdictions and equally important the evaluation of models of care in meeting the needs of the women accessing them. The Australian Institute of Health and Welfare has observed:

The lack of a consistent and agreed method for defining and categorising models of care restricts the ability to accurately compare, or evaluate, different models of care outside of a research design. This has made it exceedingly difficult for women and their families to make informed decisions about accessing different models of care based purely on what they are named locally.[[235]](#footnote-235)

After many years of research and work—a Maternity Care Classification System (MaCCS)[[236]](#footnote-236) for classifying, recording and reporting on data about models of care in Australia is now available. The MaCCS was developed as part of the National Maternity Data Development Project and provides a comprehensive classification system for maternity models of care operating in Australia. The system provides a framework for the meaningful analysis of maternal and perinatal outcomes under different models of care. Importantly, the classification system is not static and provides ‘standardised terminology to describe models of care and is also expandable in the future as models of care evolve’ in response to ‘both consumer demand and a widening evidence-base of the benefits’.[[237]](#footnote-237)

According to key researchers—the MaCCS:

…is a novel system for defining models of care that has not been attempted anywhere else in the world. By classifying models of care based on the characteristics of the models…the MaCCS can also accommodate models developed into the future. The classification is not reliant on local terminology or naming and each of the data elements can be adapted through the addition of more permissible values if required as changes to maternity care arise. High quality, safe, woman-centred maternity care is not a ‘one-size-fits-all’ approach and variations to models of care continue to evolve as new evidence becomes available for improving maternity care. The MaCCS will enable individual health services, jurisdictional health departments and the Commonwealth to report on outcomes for mothers and babies under different models of care and examine the potential influences of different model characteristics to inform health policy and service provision for maternity care in a way that has not been possible before.[[238]](#footnote-238)

* + - * 1. Committee comment

The Committee notes that models of care become the organising framework underpinning the tangible and intangible components of delivery of maternity services in jurisdictions.

The Committee also notes that it has made recommendations to develop funding models that better reflect the delivery of maternity services and support for continuity of care and carer in Chapter 5.

The Committee acknowledges that as part of the *Canberra Maternity Options*—eight major model categories of maternity care are currently available in the ACT. It is unclear to the Committee how many models of care exist across the eight major categories and indeed how their respective outcomes are evaluated and reported on. The Committee is firmly of the view that reporting on the effectiveness of models of care not only provides opportunities for models of care to expand and/or evolve in response to ‘both consumer demand and a widening evidence-base of the benefits’[[239]](#footnote-239) but also to support the development of funding models that better reflect the distinctive nature of how maternity services are delivered and to support the concepts of continuity of care and carer.

The Committee recommends that the ACT Government: (i) adopt the Maternity Care Classification System (MaCCS) and use it when referring to models of care available in the ACT in the information provided to women and their families; and (ii) use the MaCCS to evaluate the effectiveness of all single-models of maternity care available to pregnant and birthing women in the ACT and surrounding region and publicly report this information at regular intervals.

The Committee recommends that the ACT Government—in partnership with key advocacy and consumer stakeholders—develop and facilitate access to specialised models of maternity care for women who have a high risk of poorer outcomes.

* 1. Specific models of care—comment
     1. Birth Centre

In summary, evidence received to the inquiry identified the following elements relating to the Birth Centre:

1. Current wait list for the Birth Centre demonstrates the unmet demand for this service. This in turn may force women who have missed out on securing a place into the private sector to seek the same level of continuity or some women may miss out altogether.[[240]](#footnote-240)
2. Current model of care through the Birth Centre—demonstrates the advantages of continuity in care and improves outcomes for women, their babies and families.[[241]](#footnote-241)
3. The Birth Centre has become a medicalised birth place where obstetric decision making is more valued than midwife decision making—for example, inclusion or exclusion criteria to the Birth Centre is controlled by medical officer decisions rather than evidence-based guidelines such as the *National Consultation and Referral Guidelines for Midwives*.[[242]](#footnote-242)
4. Demand for the Birth Centre outweighs capacity and presents an accessibility issue.[[243]](#footnote-243)
   * + - 1. Committee comment

It is clear to the Committee that the Birth Centre model of care supports the benefits of continuity in care and improves outcomes for women, their babies and families. It is also a model of care that women want and should be able to access.

The Committee also acknowledges that aside from available capacity, criteria for access not based on evidence-based guidelines also limits women’s choices.

The Committee recommends that the ACT Government establish eligibility criteria for the Birth Centre at the Centenary Hospital for Women and Children in accordance with evidence-based guidelines such as the *National Midwifery Guidelines for Consultation and Referral*.

The Committee recommends that the ACT Government expand the capacity of the Birth Centre Unit at the Centenary Hospital for Women and Children to address unmet demand for this major model category of maternity care.

* + 1. Home Birth Trial

The ACT Government commenced a three-year publicly funded home birth trial in October 2016—to provide women in the ACT with ‘an option to birth in the comfort and familiarity of their own home’.[[244]](#footnote-244) The Canberra Hospital and Health Services Framework for a Trial of a Publicly Funded Home birth Service was developed:

…through the ACT Health Nursing and Midwifery Office, Australian Capital Territory Insurance Authority (ACTIA), ACT Health obstetric and midwifery clinicians; and consumer representatives from the ACT Healthcare Consumers Association. The service commenced in October 2016 with a trial of up to one-two births per month over a three year period, while the outcomes were to be monitored and evaluated. Women were recruited to the program from October 2016 with the first homebirth occurring in January 2017.[[245]](#footnote-245)

At the conclusion of the trial in October 2019—participating women were offered an opportunity to provide feedback on their home birth experience. A process review completed in May 2019 informed the finalisation of an interim evaluation report which is now available.[[246]](#footnote-246)

In summary, evidence[[247]](#footnote-247) received to the inquiry identified the following elements relating to the Home Birth Trial:

1. The publicly funded Home Birth Service at CHWC reflects the medicalised model of maternity care.
2. Concerns about the current design of the publicly funded home birth trial—restrictive criteria for access and limitations on the scope of service under the Trial.
3. Public home birth should be a model of care available in the ACT. Eligibility criteria should be consistent with evidence and practice in other jurisdictions. There are barriers to admitting rights for private midwives in public hospitals and MBS arrangements and indemnity insurance issues that limit access to the service.
4. The service offered through the trial period was highly restrictive for women wishing to access a home birth and for midwives wishing to work in it. The restrictive consenting process for women to access a home birth through the publicly funded trial challenges an individual’s right to make a choice.
5. Access to the ACT home birth trial is currently restricted due to program eligibility criteria that go beyond health requirements.

The Primary Home Birth Midwives at Centenary Hospital for Women and Children noted that ‘[w]hilst we respect that any new process does require a period of trial and evaluation, we feel that the ACT approach to implementing a home birth service has been undertaken in an isolated manner. We need not look far to find evidence that is highly relevant to our context which can be used to inform how we provide care to women in the ACT’. The Primary Home Birth Midwives at CHWC urged the ACT Government in its approach to a home birth model of care to examine evidence that is highly relevant to the ACT context, including the recently commenced Royal Hospital (Randwick) home birth service in Sydney, to inform the provision of care to women in the ACT.[[248]](#footnote-248)

The UNSW—Public Services Research Group was of the view that:

Access to the ACT homebirth trial is currently restricted due to program eligibility criteria that go well beyond health requirements.[[249]](#footnote-249)

In its submission the Health Care Consumers’ Association of the ACT noted the commencement of the three-year trial and that it looked forward to the public release of the evaluation of the Trial. The Association further commented:

If the evidence confirms that this is a safe and high-quality service for women and families, HCCA strongly supports making the service a permanent feature of ACT maternity services. Currently, the eligibility criteria are highly restrictive, including being limited to low risk pregnancies and women living within 15 minutes travel time of the Centenary Hospital. We would like to see these criteria brought into line with evidence and practice from other Australian jurisdictions and internationally.[[250]](#footnote-250)

The Association also noted a number of barriers or obstacles to women being able to access home birth. It suggested that another way to support women who choose to have a home birth is to ‘expand the opportunities for private midwives to admit and care for women who may need to be admitted in unforeseen circumstances in public hospitals. This will also improve continuity of midwifery care’. Further, the Association acknowledged ‘that the cost of private home birth is prohibitive for many women’ and encouraged the ‘ACT Government to work through COAG to address Medicare Benefits Schedule (MBS) arrangements and indemnity insurance, which would increase access to private homebirth for women and their families’.[[251]](#footnote-251)

* + - * 1. Committee comment

The Committee notes the concerns raised about the current design of the publicly funded home birth trial—including: that it reflects the medicalised model of maternity care; and its restrictive criteria for access and limitations on the scope of service under the Trial. The Committee further notes that these concerns restricted women seeking access to a home birth and for midwives wishing to work within this model of care during the Trial period.

The Committee notes there is established evidence ‘that planned home birth is at least as safe as hospital birth for women at low risk of obstetric complications when attended by a qualified caregiver who is well networked with mainstream maternity services’.[[252]](#footnote-252) Further, recent research analysing 14 studies dating back to 1990—comparing home and hospital birth outcomes in Sweden, New Zealand, England, Netherlands, Japan, Australia, Canada and the USA—examining the safety of place of birth by reporting on the risk of death at the time of birth or within the first month—‘found no differences in risk between the home and hospital groups. In addition, there were no differences in other neonatal outcomes, including NICU admission, Apgar scores, and the need for resuscitation’.[[253]](#footnote-253)

The Committee is of the view that there is established evidence to support the safety of planned home birth for low risk women attended by professionally educated midwives in integrated settings. The Committee is also of the view that women in the ACT should have planned home birth as a choice in relation to their maternity care and place of birth.

The Committee recommends that the ACT Government establish planned home birth as an ongoing birth option (model of care) for women in the ACT.

The Committee recommends that the ACT Government establish eligibility criteria for planned home birth models of care in accordance with evidence-based guidelines such as the *National Midwifery Guidelines for Consultation and Referral*.

The Committee acknowledges, as raised in evidence, that aside from the availability of home birth as a model of care—there are also are a number of barriers or obstacles to women being able to access home birth in the ACT. This includes improving opportunities for private midwives to exercise visiting and rights of private practice to care for women who may need to be admitted in unforeseen circumstances in public hospitals; and addressing costs regarding private home birth in the context of MBS arrangements and indemnity insurance. The Committee notes that addressing these matters would better support women who choose to have a home birth and would also increase access with regard to this model of care.

The Committee further notes that matters related to MBS arrangements and indemnity insurance reside with the Australian Government.

The Committee recommends that the ACT Government dismantle barriers for private midwives to exercise visiting and rights of private practice to care for women who may need to be admitted in unforeseen circumstances in public hospitals.

The Committee recommends that the ACT Government—in partnership with its Council of Australian Government (COAG) colleagues—advocate for changes to address Medicare Benefits Schedule (MBS) arrangements and indemnity insurance which limit access to private home birth for women and their families.

* + 1. Ethos of public hospital maternity services

The Health Care Consumers’ Association of the ACT noted that:

…some women have reported that the religious ethos of Calvary Public Hospital is not a comfortable fit with their personal values.[[254]](#footnote-254)

Further, in the context of information and feedback received through the complaint handling process administered by the ACT Health Services Commissioner[[255]](#footnote-255) under the ACT *Human Rights Commission Act 2005*, the Commissioner noted that:

[c]oncerns have been raised with me about the limitations on information provided to women about contraception, abortion and other related services from Calvary Public Hospital. With limited availability of maternity services in the ACT and the need for Calvary facilities to be effectively utilised I encourage the Committee to consider those limitations as part of this inquiry. I have been advised some women are reluctant to use Calvary services for these reasons or where they may be in a same sex relationship or marriage. As a publicly funded health service it may be appropriate for the inquiry to consider this issue further.[[256]](#footnote-256)

* + - * 1. Committee comment

The Committee acknowledges the concerns regarding limitations on information and advice provided to women about aspects of maternity services at Calvary Public Hospital—Bruce (CPHB).

The Committee also acknowledges that maternity services provided by CPHB are publicly funded health services and form part of a suite of maternity services and models of care available to women in the ACT and region. The availability of different models of care and service providers supports the concept of woman-centred care and that women should have choice as to where they choose to birth and the maternity services they seek to access.

* 1. Promotion of and support for Breastfeeding

Evidence to the inquiry from organisations, groups and individuals highlighted a range of issues regarding the promotion of and support for breastfeeding across the maternity continuum. This included:

* + Contradictory information given to women—for example, receiving confusing and contradictory advice regarding breastfeeding and care for their baby.
  + Inconsistency in the information and the approaches of practitioners during postnatal care, including regarding breastfeeding—some women described feeling confused, not having much confidence, unsupported, pressured and fearful.
  + Where women wanted to breastfeed, some expressed frustration at the lack of support, information or referrals.
  + Women who had a shorter hospital stay reported that they returned home without having breastfed properly or having their milk coming in.

The Australian Breastfeeding Association expressed a concern that ‘breastfeeding mothers in the ACT are not being supported in their desire to breastfeed’[[257]](#footnote-257) and urged that action be taken to promote and support breastfeeding in and across the maternity care continuum in the ACT.

The Health Care Consumers’ Association of the ACT noted the findings of the Women’s Centre for Health Matters consultation that:

…many women who gave birth in hospital wanted to stay longer than 24 hours, in particular to establish breastfeeding. These women felt that they were discharged without enough access to help and support in hospital to establish breastfeeding, and insufficient access to timely assistance from appropriately skilled health professionals in the community. Some women struggled with confusing and contradictory advice about breastfeeding from health professionals and were not sure where to go for support.[[258]](#footnote-258)

The Health Care Consumers Association called on the ACT Government to identify and implement strategies to improve breastfeeding advice and support—including exploring the feasibility of establishing a day stay lactation clinic for the ACT; resourcing peer breastfeeding support organisations; and working through COAG to advocate for a Medicare rebate for professional lactation consulting services.[[259]](#footnote-259)

* + - * 1. Committee comment

The Committee is of the view that the benefits of breastfeeding for the health outcomes of mothers and babies are well established[[260]](#footnote-260) should women choose to breastfeed.

The Committee is also of the view that more needs to be done to strengthen the promotion of and support for breastfeeding in and across the maternity continuum in the ACT.

The Committee recommends that the ACT Government, pursuant to the *ACT Breastfeeding Strategic Framework 2010–2015,* ensure the provision of effective, consistent, up to date and evidence-based breastfeeding information and services for mothers and babies in hospital and community settings.

The Committee recommends that the ACT Government collect annual statistics on breastfeeding outcomes 0–24 months for hospitals and clinics, and publish annual ACT breastmilk production, performance of ACT hospitals and health services on breastfeeding outcomes performance, especially for at-risk groups. The Committee further recommends that the Government consider publishing this information in the *ACT Public Health Services Quarterly Performance Report*.

The Committee recommends that the ACT Government strengthen the promotion of and support for breastfeeding across the maternity continuum—including by: (i) making Baby-Friendly Health Initiative (BFHI) accreditation mandatory in all health facilities where babies are born; (ii) creating supportive breastfeeding services in all communities by adopting the Baby Friendly Community Initiative (BFCI); (iii) facilitating compulsory and adequate breastfeeding education for all health professionals who may encounter women of reproductive age, both during their initial training and when undertaking ongoing professional development; (iv) promoting Australian Breastfeeding Association (ABA) health professional seminars—annual health professional education (seminars) as well as workshops and study modules; (v) ensuring well-informed referral by health professionals to breastfeeding support organisations, including the ABA, and informing mothers adequately about the work of breastfeeding-support groups in the community, such as the provision of Breastfeeding Education Classes for expectant parents and local peer support groups (not just handing them a brochure or placement of a sticker on their baby book); and (vi) ensuring all health professionals who encounter mothers and their breastfed babies understand and follow the evidence-based *National Health and Medical Research Council (NHMRC) Australian Infant Feeding Guidelines*.

To further strengthen efforts to improve breastfeeding advice and support—the Committee believes there is merit in exploring the feasibility of establishing a day stay lactation clinic for the ACT and working through COAG to advocate for a Medicare rebate for professional lactation consulting services.

The Committee recommends that the ACT Government explore the feasibility of establishing a day stay lactation clinic for the ACT.

The Committee recommends that the ACT Government—in partnership with its Council of Australian Government (COAG) colleagues—advocate for a Medicare rebate for professional lactation consulting services.

The Committee notes that some evidence to the inquiry raised the implementation of a ‘milk bank to support parents wishing to use donor breastmilk’.[[261]](#footnote-261) The Committee is also aware that there have been calls to establish an official milk bank in the ACT for parents in the community setting. The ACT Legislative Assembly passed a resolution[[262]](#footnote-262) on 31 October 2018 calling on the ACT Government to investigate the feasibility of establishing an official milk bank in the ACT and/or partnering with neighbouring jurisdictions: (a) to give ACT region women an opportunity to donate; and (b) to supply breast milk to babies in and out of a hospital setting.

At the time the aforementioned motion was debated—the then Minister for Health and Wellbeing told the Assembly:

As has been recognised, the supply of donor milk to the Centenary Hospital for Women and Children neonatal intensive care unit is from the Mothers’ Milk Bank, which operates from Tweed Heads in northern New South Wales. This provision of donor milk at the Centenary hospital is, though, limited at the moment to situations where babies are born premature or are unwell or where there is not enough expressed milk when feeds are introduced. Of course every effort is made to use the mother’s milk in preference to donor milk, but it is the parent’s decision as to whether the baby will receive donor milk. As much information as possible is provided to assist parents in making decisions about this important issue.

…the Red Cross are developing milk banks across Australia. I am pleased to advise that the ACT will move to obtaining supply from the Red Cross milk bank in 2019, once they get up and running. Representatives from Canberra Health Services are on the New South Wales Health and New South Wales Red Cross working party, and negotiations are already underway. The Red Cross Blood Service has leveraged its wealth of experience and expertise in high quality donor management, therapeutic goods administration, goods manufacturing, practice regulations and donation disease-screening processes, in order to position itself nationally in this important role.[[263]](#footnote-263)

The Committee notes that the Government released its findings from the investigation into the feasibility of establishing an official milk bank in the ACT on 28 November 2019. The Minister for Health advised:

The ACT Health Directorate has completed the investigation on the feasibility of a local milk bank. This work included consultation with key subject matter experts across the areas of milk bank management, nutrition, neonatology, lactation support, milk sharing practices and community perceptions.

Through exploring the available options, practicalities and required infrastructure, the ACT Health Directorate has determined creating a locally run milk bank is not a feasible option for the ACT.

Minister for Health Rachel Stephen-Smith said the most feasible solution is to maintain current arrangements by sourcing pasteurised donor milk from an interstate milk bank.[[264]](#footnote-264)

Notwithstanding the findings from the recent investigation into the feasibility of establishing an official milk bank in the ACT—the Committee is of view that an official milk bank should be established in the ACT.

The Committee recommends that the ACT Government establish an official milk bank in the Australian Capital Territory (ACT) to: (a) give ACT and region women an opportunity to donate; and (b) supply breast milk to babies in and out of a hospital setting.

* 1. Postnatal care

In summary, evidence received from individuals to the inquiry identified the following elements relating to postnatal care:

1. Women not feeling appropriately supported in the postpartum period—in particular, in relation to assistance with breastfeeding.
2. Women highlighted that with shorter stays in hospital there was a need for increased support at home following discharge from hospital during the postnatal period.
3. Impact of early discharge on both parents’ mental health if they do not feel supported and confident in basic baby care tasks such as feeding and other aspects of the transition to parenthood.
4. Inconsistency in the information and the approaches of practitioners during postnatal care, including regarding breastfeeding—some women described feeling confused, not having much confidence, unsupported, pressured and fearful.
5. Submissions that reported positive experiences of postnatal care felt that this was attributable to midwives and nurses spending time with them, who listened and understood, made helpful suggestions and gave reassurance.

In summary, evidence[[265]](#footnote-265) received from organisations and groups to the inquiry identified the following elements relating to postnatal care:

1. With shorter hospital stays there is a need for increased support at home following discharge from hospital during the postnatal period.
2. Impact of early discharge on both parents’ mental health if they do not feel supported and confident in basic baby care tasks such as feeding and other aspects of the transition to parenthood.
3. The element identified in 10.58 d).
4. Importance of programs and support during this stage as a key contributor to early childhood development, supporting transition to parenthood and addressing gaps in service for vulnerable and disadvantaged families.
   * + - 1. Committee comment

In considering evidence concerning weaknesses and strengths in the delivery and scope of postnatal care—it is clear to the Committee more needs to be done to strengthen postnatal care.

The Committee has made a number of recommendations throughout its report focused on strengthening maternity services and models of care as it concerns focus on woman-centred care; continuity of care and carer; and the importance of evidence-based care informing the planning, design and delivery of maternity services and care. It is the Committee’s view that these recommendations are relevant to supporting work that will also strengthen postnatal care for women, their babies and their families.

The Committee notes that strengthening the promotion and support for breastfeeding is a key aspect of effective postnatal care. The Committee has also made comment together with recommendations in the previous section[[266]](#footnote-266) in this regard.

The Committee further notes that effective postnatal care can prevent short, medium and long-term mental health and well-being issues arising for women. In the section following (mental health support), the Committee makes recommendations specifically focused on strengthening mental health support for women and their families in the postnatal period.

The Committee notes as referenced in the National—*Woman-centred care: Strategic directions for Australian maternity services—*Australia does not have any national evidence-based guidelines or standards for postnatal care. The Committee is of the view that the development and use of guidelines in this regard has the potential to not only improve care for women, their babies and families but also support and ensure continuity of care and consistency of care across health sectors.[[267]](#footnote-267)

The Committee recommends that the ACT Government—in partnership with its Council of Australian Government (COAG) colleagues—advocate for the development and implementation of national evidence-based guidelines for postnatal care.

* 1. Mental health support

In summary, evidence received from individuals to the inquiry identified the following elements relating to mental health support:

1. Several submissions highlighted that they had experienced trauma during their birthing experience—with some submissions commenting on how it had been handled in helpful and respectful ways and others where it had been handled in unhelpful and disrespectful ways.
2. Where a woman was given a debriefing session within a short period after a traumatic birth—it was explained how the opportunity to debrief had made a difference to how they were able to: (i) reconcile what had occurred with the expectations they had initially taken into the birthing process; and (ii) to better understand why unplanned or unexpected events had taken place.
3. Several submissions highlighted adverse/traumatic birth experiences and subsequent diagnoses of PTSD for these women.
4. Women diagnosed with PTSD reported difficulties in accessing appropriate mental health professional care. Diagnoses of PTSD were not until sometime after birthing experiences—highlighting the importance of debriefing in hospital after such events and that postpartum care needs to provide ongoing emotional support to women and assess for the presence of trauma symptoms.
5. The mental health and well-being of women and their partners needs to be considered throughout their contact with maternity services. Importantly, maternity services need to be delivered in ways that do not intensify mental health problems but should instead prioritise these needs as central to the pregnancy and birthing experience.

In summary, evidence[[268]](#footnote-268) received from organisations and groups to the inquiry identified the following elements relating to mental health support:

1. Mental health considerations need to be integrated throughout the maternity care continuum. Mental health should not be an optional consideration, or a matter addressed when a woman is in crisis but should be an integral preventative strategy that enhances outcomes for the mother baby family unit.
2. The elements identified in 10.66 d) and e).
3. Mental and physical health is interconnected—mental health and well-being problems can be pre-existing, arise during the antenatal stage or emerge following birth—the well-being of mothers and the family unit is central to an effective maternity care system. Pregnant women and new mothers need to be screened to assess the likelihood of developing and/or experiencing mental health problems in pregnancy and the first year following birth.
4. Inpatient requirements for perinatal mental health services, including the establishment of mother-baby units. That a dedicated unit in Canberra for mothers requiring residential mental health care be established for women to access both antenatally, and where possible, with their baby after the birth.

Lack of access to and provision of mental health supports and services in and across the maternity care continuum is a feature across Australian jurisdictions. Limited numbers of ‘psychologists are employed within Australian maternity hospitals, despite the evidence for the importance of assisting women in the perinatal period with mental health difficulties, and more generally in their adjustment to parenting’. These supports and services are of particular importance for ‘women who experience anxiety, depression or have had a previous traumatic birth’.[[269]](#footnote-269)

Whilst upskilling ‘for the perinatal health workforce, including midwives and obstetricians, to detect perinatal mental health issues during pregnancy and in the immediate postnatal period’ is an important strategy in this regard—‘screening alone is insufficient’ and ‘it must be accompanied by increased service provision to meet the needs of women who are identified with mental health difficulties’.[[270]](#footnote-270)

* + - * 1. Committee comment

The Committee acknowledges that mental and physical health is interconnected—mental health and well-being problems can be pre-existing, arise during the antenatal stage or emerge following birth. Importantly, the well-being of mothers and the family unit is central to an effective maternity care system is well established.

As noted earlier in this report, it is clear to the Committee of the importance and value of instituting, after birthing, a formalised birth debriefing opportunity for women and their husbands or partners with a qualified health professional—as a potential protective factor for addressing the potential effects of adverse birthing experiences. The Committee has made comment and recommendations to this effect in Chapter 7.

In considering evidence to this inquiry regarding elements of the current maternity system and its models of care—it is clear to the Committee that more can be done to strengthen mental health and well-being support in and across the maternity care continuum. Accordingly, the Committee makes the following recommendations:

The Committee recommends that the ACT Government ensure that women and their families accessing maternity services are educated about the availability of resources such as the Centre of Perinatal Excellence (COPE)—*Ready to COPE e-guide to pregnancy*.

The Committee recommends that the ACT Government ensure that perinatal mental health is included in health professional training and the existing maternity care workforce accesses professional development in perinatal mental health (such as the Centre of Perinatal Excellence online training package).

The Committee recommends that the ACT Government in the planning, design and delivery of maternity services and models of care adopt the *Australian Practice Guidelines for the Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*.[[271]](#footnote-271)

The Committee recommends that the ACT Government—in partnership with its Council of Australian Government (COAG) colleagues—advocate for changes to the *Australasian Health Facility Guidelines* (AusHFG) to include inpatient requirements for perinatal mental health services for the mother-baby family unit, including the establishment of mother baby family units in all jurisdictions.

The Committee recommends that the ACT Government in the planning, design and delivery of maternity services and models of care ensure that expectant mothers are screened to assess the likelihood of developing and/or experiencing mental health problems in pregnancy and the first year following birth.

The Committee recommends that the ACT Government establish a dedicated unit in Canberra for mothers requiring residential mental health care for the mother baby family unit to access both antenatally, and where possible, with their baby after the birth.

# Conclusion

…it's doing the right thing, at the right time, by the right person—the application of the best evidence to a patient's problem, in the way the patient wishes, by an appropriately trained and resourced individual or team. But that's not all—that individual or team must work within an organisation that is accountable for the actions of its staff, values its staff (appraises and develops them), minimises risks, and learns from good practice, and indeed mistakes.[[272]](#footnote-272)

The aforementioned quote is referring to clinical governance—if the Committee was to scale back this inquiry to first principles—at the heart of the issues raised in evidence and to which the Committee has carefully and rigorously considered has been the effectiveness of the clinical governance of maternity services in the ACT.

In seeking to respond to these issues—the Committee has been forward looking in setting out its recommendations using a framework that encompasses evidence relating to the overarching strategy for maternity services in the ACT, its governance framework and the system and service values of—safety; respect; choice; and access.

The Committee recognises the considerable efforts of people working on policy development and at the frontline of the delivery of maternity services in the ACT. The Committee also recognises that no area of health care delivery should be immune from critical examination at any time and it would be unrealistic to accept that the delivery of maternity services and care in the ACT is incapable of improvement.

The Committee acknowledges the professional staff—midwives, doctors, nurses, allied health and other clinicians—who deliver maternity services in and across the maternity care continuum in the ACT and the vast array of non-clinical staff (including significant numbers of volunteers) who support the professionals in the delivery of these services. The Committee also acknowledges that maternity services and care is delivered in the ACT—24 hours a day, 7 days a week, 52 weeks a year, often under significant pressure and increasing demand.

The Committee wishes to thank all of those who have contributed to its inquiry, by making submissions and/or appearing before it to give evidence. The Committee recognises the significant commitment of time and resources, and for many the emotional heartache and distress, required to participate in an inquiry of this nature and is grateful that it was able to draw on a broad range of expertise and experience in its deliberations. In its report, the Committee has based many of its recommendations on suggestions by inquiry participants.

The Committee notes that with regard to ensuring that Aboriginal Torres Strait Islander women; parents of disabled children; LGBTQI+ parents; and women with disabilities have access to individualised safe and responsive maternity care in the ACT—in the main, its consideration, comment and recommendations (where applicable) of the many important issues raised in this inquiry have been informed by evidence from organisations and groups representing and advocating for and on behalf of these women and parents.

The Committee also notes that the right to have access to quality, respectful, safe and equitable maternity services is not limited to Australia. The Committee wishes to pay tribute to a prominent Australian who sadly passed away on 18 March 2020—Dr Catherine Hamlin AC—who made a lifetime commitment to improving women’s access to quality, respectful, safe and equitable maternity services. Catherine together with her late husband, Dr Reginald Hamlin[[273]](#footnote-273)—each both obstetricians and gynaecologists—answered an advertisement in the *Lancet* medical journal in 1958 for gynaecologists to set up a school of midwifery in Addis Abba, Ethiopia. After finding themselves treating women suffering obstetric complications[[274]](#footnote-274) ‘on a scale unimaginable in a western hospital’—what was to be a three-year stay in Addis Abba, became a lifetime commitment of maternal care service by the Hamlins to Ethiopia.[[275]](#footnote-275)

Vale—Dr Catherine Hamlin AC—24 January 1924 to 18 March 2020. The Hamlin’s legacy is Hamlin Fistula Ethiopia—:

…a healthcare network of over 550 Ethiopian staff—many trained by Catherine—servicing six hospitals, Desta Menda rehabilitation centre, the Hamlin College of Midwives and 80 Hamlin supported Midwifery Clinics. Hamlin is the reference organisation and leader in the fight to eradicate obstetric fistula around the world, blazing a trail for holistic treatment and care that empowers women to reassert their humanity, secure their health and well-being, and regain their roles in their families and communities.[[276]](#footnote-276)

The Committee has made **74** recommendations in relation to its inquiry into maternity services in the ACT.

In concluding, many participants to this inquiry shared deeply personal experiences and contemplating and preparing these contributions would not have been easy. Again, the Committee thanks these women, husbands and partners for these valuable and personal contributions.

Ms Bec Cody MLA

Chair

3 June 2020

List of written submissions

Submission received by the Committee to the inquiry:

|  |  |
| --- | --- |
| Sub No. | Author/Organisation |
| 1 | Individual submission |
| 2 | N. O’Connor |
| 3 | Individual submission |
| 4 | Centre of Perinatal Excellence |
| 5 | Individual submission |
| 6 | ACT Ministerial Advisory Council on Women |
| 7 | Individual submission |
| 8 | ACT Government |
| 9 | T. Mitchell |
| 10 | K. Tasker |
| 11 | K. Uddin |
| 12 | Individual submission |
| 13 | Individual submission |
| 14 | J. Garvan |
| 15 | Individual submission |
| 16 | Australian College of Midwives ACT Branch |
| 17 | G. Smyth |
| 18 | Women with Disabilities ACT |
| 19 | UNSW Public Service Research Group |
| 20 | Individual submission |
| 21 | Individual submission |
| 22 | Red Nose Australia |
| 23 | Safe Motherhood for All Inc. |
| 24 | Maternity Services |
| 25 | S. Moloney |
| 26 | Australian Breastfeeding Association |
| 27 | Primary Home Birth Midwives—Centenary Hospital for Women and Children |
| 28 | Perinatal Wellbeing Centre (formerly known as PANDSI) |
| 29 | C. Jamieson |
| 30 | Australian Nursing and Midwifery Federation |
| 31 | Confidential |
| 32 | Individual submission |
| 33 | J. Campton |
| 34 | Health Care Consumers’ Association of the ACT |
| 35 | Women’s Centre for Health Matters |
| 36 | ACT Human Rights Commission |
| 37 | Confidential |
| 38 | K. Schlage |
| 39 | Individual submission |
| 40 | Individual submission |
| 41 | Individual submission |
| 42 | Individual submission |
| 43 | Individual submission |
| 44 | Individual submission |
| 45 | N. Shahidullah |
| 46 | C. Hooker |
| 47 | Individual submission |
| 48 | A. and C. Farnham |
| 49 | A. Gunn |
| 50 | Tresillian Family Care Centres |
| 51 | Sands Australia |
| 52 | Individual submission |
| 53 | Confidential |
| 54 | Individual submission |
| 55 | Individual submission |
| 56 | Confidential |
| 57 | Confidential |
| 58 | Confidential |
| 59 | Individual submission |
| 60 | D. Braddock |
| 61 | Confidential |
| 62 | Individual submission |
| 63 | J. Cruz Coleman |
| 64 | Confidential |
| 65 | K. Randle |
| 66 | A. Grant |
| 67 | Individual submission |
| 68 | S. Wilson |
| 69 | J. Clancy |
| 70 | Confidential |
| 71 | S. Wood |
| 72 | Individual submission |
| 73 | Individual submission |
| 74 | Individual submission |
| 75 | J. Clearihan |
| 76 | T. Greenhalgh |
| 77 | Confidential |

Committee public hearings

Witnesses who appeared before the Committee at public hearings:

**Tuesday 9 July 2019**

* Mr Jonathan Campton and Ms Claire Buxton (Individuals—Submission No. 33);
* Mrs Sarah Moloney (Individual submitter—Submission No. 25); and
* Mrs Karen Schlage (Individual submitter—Submission No. 38).

**Thursday 11 July 2019**

* Ms Clare Moore, Chief Executive Officer, Women with Disabilities ACT;
* Dr Yvonne Luxford, Chief Executive Officer, Perinatal Wellbeing Centre (formerly PANDSI);
* Ms Mary Kirk, Public Officer, Safe Motherhood for All Inc.; and
* Ms Marcia Williams, Chief Executive Officer, Women’s Centre for Health Matters.

**Tuesday 6 August 2019;**

* Ms Rachel Stephen-Smith, Minister for Health;
* Ms Katrina Bracher, Executive Director, Women, Youth and Children, Canberra Health Services (CHS);
* Associate Professor Boon Lim, Clinical Director, Obstetrics and Gynaecology, CHS;
* Mr Dave Peffer, Deputy Director-General, Health Systems, Policy and Research Group, Health Directorate; and
* Ms Karen Toohey, Discrimination, Health Services, Disability and Community Services Commissioner, ACT Human Rights Commission.

**Tuesday 15 October 2019**

* Ms Mary Kirk, Executive Officer, Canberra Mothercraft Society; and
* Ms Natasha Shahidullah (Individual submitter—Submission No. 45).

Summary of models of care

Current models of maternity care in Australia[[277]](#footnote-277) include:

**1. Private obstetrician (specialist) care:** Antenatal care 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.

**2. 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.

**3. GP obstetrician care:** Antenatal care 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.

**4. Shared care:** Antenatal care is provided by a community maternity service provider (doctor and/or midwife) in collaboration with hospital medical and/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).

**5. Combined care:** Antenatal care provided by a private maternity service provider (doctor and/or midwife) in the community. Intrapartum and early postnatal care provided in the public hospital by hospital midwives and doctors. Postnatal care may continue in the home or community by hospital midwives.

**6. Public hospital maternity care:** Antenatal care is provided in hospital outpatient clinics (either onsite or outreach) by midwives and/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.

**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 by hospital doctors and midwives. Postnatal care may continue in the home or community by hospital midwives.

**8. 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.

**9. 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 care and postnatal care is usually provided in the hospital, community or home with intrapartum care in a hospital, birth centre or home.

**10. 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 and/or doctor. Antenatal and postnatal care, including high- and low-risk pregnancies, as well as consultations for the management of gestational diabetes is currently provided via telehealth in a number of areas. 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.

**11. Private obstetrician and privately practicing 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 and/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.

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5. SO 216—In the ACT, Standing Committees are established by Assembly resolution and governed by standing orders. [↑](#footnote-ref-5)
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16. Rolfe MI, Donoghue DA, Longman, JM, *et al.* (2017) ‘The distribution of maternity services across rural and remote Australia: does it reflect population need?’, *BMC Health Serv Res* 17,163. [↑](#footnote-ref-16)
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18. Refer: https://www.pregnancybirthbaby.org.au/medicare-during-pregnancy [↑](#footnote-ref-18)
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21. The AIHW’s Maternity Care Classification System (MaCCS) provides a standardised terminology and descriptive data for maternity models of care. National collation of these data enables analysis and comparisons of maternal and perinatal outcomes between differing models of care. [↑](#footnote-ref-21)
22. COAG Health Council as represented by the Department of Health (2019) *Woman-centred care: Strategic directions for Australian maternity services* was prepared under the auspices of the COAG Health Council, p. 4. [↑](#footnote-ref-22)
23. COAG Health Council as represented by the Department of Health (2019) *Woman-centred care: Strategic directions for Australian maternity services* was prepared under the auspices of the COAG Health Council, p. 4. [↑](#footnote-ref-23)
24. Australian Institute of Health and Welfare (2016) *Maternity Care Classification System: Maternity Model of Care Data Set Specification national pilot report November 2014—National Maternity Data Development Project Stage 2*, Canberra, p. 4. [↑](#footnote-ref-24)
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31. Canberra Health Services (2019) *Supporting Canberra Mums and Mums-To-Be—Engagement Report*, September, p. 7. [↑](#footnote-ref-31)
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35. The proposed changes were that women will: (i) call one phone number to arrange their first appointment with a midwife; (ii) meet a midwife early to talk about public pregnancy and birthing options available in Canberra and their personal preferences and health care needs; and (iii) receive local support before, during and after their pregnancy. [↑](#footnote-ref-35)
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40. Refer: http://www.hansard.act.gov.au/hansard/2017/comms/default.htm#economic [↑](#footnote-ref-40)
41. As expressed in written submissions and by witnesses at public hearings—drawn from 57 written submissions and evidence given by six witnesses at public hearings. [↑](#footnote-ref-41)
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43. Chalmers B, Mangiaterra V, Porter R (2001) ‘WHO principles of perinatal care: the essential antenatal, perinatal, and postpartum care course’, *Birth* 28, pp. 202–207. [↑](#footnote-ref-43)
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87. Submission No. 50—Tresillian Family Care Centres, p. 11. [↑](#footnote-ref-87)
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89. Submission No. 23—Safe Motherhood for All Inc., p. 2.

    \* ‘Relaxing into Parenting + Baby Makes Three’ is an evidence-based parenting programdeveloped by the Canberra Mothercraft Society in partnership with Relationships Australia ACT and Region. The Canberra Mothercraft Society funded and ran the program at the Queen Elizabeth II Family Centre (QEII) from its inception until the Society ceased operating QEII at the end of June 2019. Since that time, the Canberra Mothercraft Society has funded Relationships Australia ACT and Region to run the program from its centre in Deakin. [↑](#footnote-ref-89)
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107. Including: Submission No. 16—Australian College of Midwives ACT Branch; Submission No. 6—ACT Ministerial Advisory Council on Women; Submission No. 19—UNSW Public Services Research Group; Canberra Mothercraft Society—*Transcript of evidence*, 15 October 2019. [↑](#footnote-ref-107)
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109. Submission No. 30—Australian Nursing and Midwifery Federation; Submission No. 51—Sands Australia. [↑](#footnote-ref-109)
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113. 18 September 2018. [↑](#footnote-ref-113)
114. Ms Meegan Fitzharris MLA. [↑](#footnote-ref-114)
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120. Including: Submission No. 34—Health Care Consumers’ Association of the ACT; Submission No. 23—Safe Motherhood for All Inc.; Submission No. 28—Perinatal Wellbeing Centre (formerly PANDSI); Submission No. 16—Australian College of Midwives—ACT Branch. [↑](#footnote-ref-120)
121. Submission No. 23—Safe Motherhood for All Inc.; Submission No. 34—Health Care Consumers’ Association of the ACT [↑](#footnote-ref-121)
122. Submission No. 34—Health Care Consumers’ Association of the ACT. [↑](#footnote-ref-122)
123. Including: Submission No. 23—Safe Motherhood for All Inc.; Submission No. 34—Health Care Consumers’ Association of the ACT; Submission No. 16—Australian College of Midwives—ACT Branch; and Submission No. 28—Perinatal Wellbeing Centre (formerly PANDSI). [↑](#footnote-ref-123)
124. Submission No. 23—Safe Motherhood for All Inc., p. 4. [↑](#footnote-ref-124)
125. Submission No. 23—Safe Motherhood for All Inc., p. 4. [↑](#footnote-ref-125)
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128. Submission No. 8—ACT Government, p. 8. [↑](#footnote-ref-128)
129. Submission No. 8—ACT Government, p. 8. [↑](#footnote-ref-129)
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132. Submission No. 36—ACT Human Rights Commission (ACT Health Services Commissioner), p. 4; *Transcript of evidence*—6 August 2019. [↑](#footnote-ref-132)
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134. Including: Submission No. 6—ACT Ministerial Advisory Council on Women; Submission No. 16—Australian College of Midwives—ACT Branch; Submission No. 19—UNSW Public Services Research Group; Submission No. 35—Women’s Centre for Health Matters. [↑](#footnote-ref-134)
135. Submission No. 16—Australian College of Midwives ACT Branch, p. 2. [↑](#footnote-ref-135)
136. Submission No. 16—Australian College of Midwives ACT Branch, pp. 5–6. [↑](#footnote-ref-136)
137. Submission No. 30—Australian Nursing and Midwifery Federation. [↑](#footnote-ref-137)
138. Submission No. 30—Australian Nursing and Midwifery Federation. [↑](#footnote-ref-138)
139. Submission No. 16—Australian College of Midwives ACT Branch, p. 7. [↑](#footnote-ref-139)
140. Submission No. 16—Australian College of Midwives ACT Branch, p. 7. [↑](#footnote-ref-140)
141. Submission No. 8—ACT Government, p. 10. [↑](#footnote-ref-141)
142. Submission No. 8—ACT Government, p. 10. [↑](#footnote-ref-142)
143. Submission No. 16—Australian College of Midwives ACT Branch, pp. 2–3. [↑](#footnote-ref-143)
144. Submission No. 16—Australian College of Midwives—ACT Branch; Submission No. 23—Safe Motherhood for All Inc.; Submission No. 34—Health Care Consumers’ Association of the ACT; Submission No. 35—Women’s Centre for Health Matters; Canberra Mothercraft Society—*Transcript of evidence*, 15 October 2019. [↑](#footnote-ref-144)
145. Submission No. 16—Australian College of Midwives ACT Branch, pp. 5–6. [↑](#footnote-ref-145)
146. Submission No. 28—Perinatal Wellbeing Centre (formerly PANDSI); Submission No. 4—Centre for Perinatal Excellence; Submission No. 34—Health Care Consumers’ Association of the ACT. [↑](#footnote-ref-146)
147. Submission No. 16—Australian College of Midwives ACT Branch, pp. 5–6. [↑](#footnote-ref-147)
148. Submission No. 23—Safe Motherhood for All Inc., p. 8. [↑](#footnote-ref-148)
149. Submission No. 23—Safe Motherhood for All Inc., p. 8. [↑](#footnote-ref-149)
150. Submission No. 23—Safe Motherhood for All Inc., p. 4. [↑](#footnote-ref-150)
151. Submission No. 23—Safe Motherhood for All Inc., p. 4. Safe Motherhood for All Inc. refers to systemic disrespect occurring when organisations, institutions or governments discriminate, either deliberately or inadvertently and whether by act or omission, against women. In the view of Safe Motherhood for All Inc.—systemic disrespect regularly and systematically disadvantages child bearing women. [↑](#footnote-ref-151)
152. Including: Submission No. 6—ACT Ministerial Advisory Council on Women; Submission No. 23—Safe Motherhood for All Inc.; Submission No. 34—Health Care Consumers’ Association of the ACT; Submission No. 16—Australian College of Midwives—ACT Branch. [↑](#footnote-ref-152)
153. Ms Mary Kirk—Canberra Mothercraft Society, *Transcript of evidence*, 15 October 2019, p. 90. [↑](#footnote-ref-153)
154. Ms Mary Kirk—Canberra Mothercraft Society, *Transcript of evidence*, 15 October 2019, p. 88. [↑](#footnote-ref-154)
155. Ms Mary Kirk—Canberra Mothercraft Society, *Transcript of evidence*, 15 October 2019, p. 90. [↑](#footnote-ref-155)
156. Ms Mary Kirk—Canberra Mothercraft Society, *Transcript of evidence*, 15 October 2019, p. 95. [↑](#footnote-ref-156)
157. Submission No. 30—Australian Nursing and Midwifery Federation, p. 4. [↑](#footnote-ref-157)
158. Submission No. 8—ACT Government, p. 6. [↑](#footnote-ref-158)
159. Including: Submission No. 6—ACT Ministerial Council on Women; Submission No. 16—Australian College of Midwives—ACT Branch; Submission No. 19—UNSW Public Service Research Group; Submission No. 23—Safe Motherhood for All Inc.; Submission No. 34—Health Care Consumers’ Association of the ACT; Submission No. 35—Women’s Centre for Health Matters; Submission No. 26—Australian Breastfeeding Association; Submission No. 27—Primary Home Birth Midwives—Centenary Hospital for Women; Canberra Mothercraft Society—*Transcript of evidence*, 15 October 2019. [↑](#footnote-ref-159)
160. Submission No. 16—Australian College of Midwives ACT Branch, p. 4. [↑](#footnote-ref-160)
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164. Including: Submission No. 34—Health Care Consumers’ Association of the ACT; Submission No. 35—Women’s Centre for Health Matters. [↑](#footnote-ref-164)
165. Including: Submission No. 51—Sands Australia; Submission No. 4—Centre for Perinatal Excellence; Submission No. 28—Perinatal Wellbeing Centre (formerly PANDSI). [↑](#footnote-ref-165)
166. Submission No. 38—K. Schlage; *Transcript of evidence*—9 July 2019. [↑](#footnote-ref-166)
167. Submission No. 6—ACT Ministerial Advisory Council on Women; Submission No.34—Health Care Consumers Association; Submission No. 35—Women’s Centre for Health Matters; Submission No. 19—UNSW Public Services Research Group; Submission No. 16—Australian College of Midwives—ACT Branch. [↑](#footnote-ref-167)
168. Submission No. 35—Women’s Centre for Health Matters. [↑](#footnote-ref-168)
169. Submission No. 35—Women’s Centre for Health Matters. [↑](#footnote-ref-169)
170. Submission No. 51—Sands Australia, p. 5. [↑](#footnote-ref-170)
171. Submission No. 51—Sands Australia, p. 6. [↑](#footnote-ref-171)
172. Sands Australia—Hospital to Home program provides a tailored support plan to meet the individual needs of bereaved parents with input from midwives and others in the hospital setting, provides intensive support to bereaved parents following stillbirth and newborn death. [↑](#footnote-ref-172)
173. Submission No. 51—Sands Australia, p. 7. [↑](#footnote-ref-173)
174. Submission No. 38—K. Schlage; Submission No. 38 (Addendum)—K. Schlage; *Transcript of evidence*—9 July 2019. [↑](#footnote-ref-174)
175. Including: Submission No. 34—Health Care Consumers’ Association of the ACT; Submission No. 35—Women’s Centre for Health Matters; Submission No. 6—ACT Ministerial Council on Women; Submission No. 16—Australian College of Midwives—ACT Branch; Submission No. 28—Perinatal Wellbeing Centre (formerly PANDSI); Submission No. 4—Centre for Perinatal Excellence; Submission No. 23—Safe Motherhood for All Inc.; Submission No. 18—Women with Disabilities ACT; Submission No. 36—ACT Human Rights Commission (ACT Health Services Commissioner). [↑](#footnote-ref-175)
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182. Submission No. 34—Health Care Consumers’ Association of the ACT, p. 17. [↑](#footnote-ref-182)
183. Including: Submission No. 14—J. Garvan; Submission No. 14A—J. Garvan; Submission No. 34—Health Care Consumers’ Association of the ACT. [↑](#footnote-ref-183)
184. Submission No. 34—Health Care Consumers’ Association of the ACT, pp. 12; 17–18. [↑](#footnote-ref-184)
185. Including: Submission No. 18—Women with Disabilities ACT; *Transcript of evidence*, 11 July 2019; Submission No. 34—Health Care Consumers’ Association of the ACT; Submission No. 6—ACT Ministerial Advisory Council on Women. [↑](#footnote-ref-185)
186. Including: Submission No. 18—Women with Disabilities ACT; Submission No. 34—Health Care Consumers’ Association of the ACT; and Inquiry into the Child and Youth Protection System (Part 2), *Transcript of evidence*, 29 January 2020—Canberra Restorative Community Network, pp. 73–77. [↑](#footnote-ref-186)
187. *Transcript of evidence*, 11 July 2019. [↑](#footnote-ref-187)
188. Ms Clare Moore, *Transcript of evidence*, 11 July 2019, p. 24. [↑](#footnote-ref-188)
189. Submission No. 18—Women with Disabilities ACT, p. 11. [↑](#footnote-ref-189)
190. Submission No. 18—Women with Disabilities ACT, p. 11. [↑](#footnote-ref-190)
191. Submission No. 34—Health Care Consumers’ Association of the ACT, p. 17. [↑](#footnote-ref-191)
192. Submission No. 34—Health Care Consumers’ Association of the ACT, p. 17. [↑](#footnote-ref-192)
193. Submission No. 36—ACT Human Rights Commission (ACT Health Services Commissioner), p. 5. [↑](#footnote-ref-193)
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196. Submission No. 36—ACT Human Rights Commission (ACT Health Services Commissioner), p. 5. [↑](#footnote-ref-196)
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198. Submission No. 6—ACT Ministerial Advisory Council on Women, p. 4. The ACT Women's Plan 2016–26 sets out the ACT Government's strategic framework to work in partnership with non-government organisations, business and the broader community towards gender equality for all ACT Women. [↑](#footnote-ref-198)
199. Submission No. 34—Health Care Consumers’ Association of the ACT, p. 18. [↑](#footnote-ref-199)
200. Submission No. 34—Health Care Consumers’ Association of the ACT, p. 18. [↑](#footnote-ref-200)
201. Submission No. 34—Health Care Consumers’ Association of the ACT, p. 18; *Our Booris, Our Way review*, viewed 21 May 2020, *<*https://www.strongfamilies.act.gov.au/our-booris,-our-way>. [↑](#footnote-ref-201)
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203. Including: Submission No. 30—Australian Nursing and Midwifery Federation; Submission No. 16—Australian College of Midwives—ACT Branch. [↑](#footnote-ref-203)
204. Including: Submission No. 23—Safe Motherhood for All Inc.; Submission No. 34—Health Care Consumers’ Association of the ACT; Submission No. 35—Women’s Centre for Health Matters. [↑](#footnote-ref-204)
205. Including: Submission No. 23—Safe Motherhood for All Inc.; Submission No. 34—Health Care Consumers’ Association of the ACT; Submission No. 35—Women’s Centre for Health Matters. [↑](#footnote-ref-205)
206. Including: Submission No. 30—Australian Nursing and Midwifery Federation; Submission No. 4—Centre for Perinatal Excellence; Submission No. 51—Sands Australia; Submission No. 18—Women with Disabilities ACT; Submission No. 26—Australian Breastfeeding Association; Submission No. 22—Red Nose Australia; Canberra Mothercraft Society—*Transcript of evidence*, 15 October 2019. [↑](#footnote-ref-206)
207. Including: Submission No. 30—Australian Nursing and Midwifery Federation; Canberra Mothercraft Society—*Transcript of evidence*, 15 October 2019; Submission No. 16—Australian College of Midwives—ACT Branch. [↑](#footnote-ref-207)
208. Ms Mary Kirk—Canberra Mothercraft Society, *Transcript of evidence*, 15 October 2019, p. 89. [↑](#footnote-ref-208)
209. Ms Mary Kirk—Canberra Mothercraft Society, *Transcript of evidence*, 15 October 2019, p. 89. [↑](#footnote-ref-209)
210. Ms Mary Kirk—Canberra Mothercraft Society, *Transcript of evidence*, 15 October 2019, p. 89. [↑](#footnote-ref-210)
211. Ms Mary Kirk—Canberra Mothercraft Society, *Transcript of evidence*, 15 October 2019, p. 89. [↑](#footnote-ref-211)
212. Submission No. 16—Australian College of Midwives—ACT Branch, p. 7. [↑](#footnote-ref-212)
213. Submission No. 16—Australian College of Midwives ACT Branch, p. 5. [↑](#footnote-ref-213)
214. Submission No. 30—Australian Nursing and Midwifery Federation, p. 6. [↑](#footnote-ref-214)
215. Submission No. 30—Australian Nursing and Midwifery Federation, p. 4. [↑](#footnote-ref-215)
216. Ms Mary Kirk—Canberra Mothercraft Society, *Transcript of evidence*, 15 October 2019, p. 89. [↑](#footnote-ref-216)
217. Submission No. 30—Australian Nursing and Midwifery Federation, p. 4. [↑](#footnote-ref-217)
218. Including: Submission No. 4—Centre for Perinatal Excellence; Submission No. 8—ACT Government: Submission No. 6—ACT Ministerial Advisory Council on Women; Submission No. 16—Australian College of Midwives—ACT Branch; Submission 19—UNSW Public Services Research Group; Submission No. 22—Red Nose Australia; Submission No. 23—Safe Motherhood for All Inc.; Submission No. 34—Health Care Consumers’ Association of the ACT; Submission No. 35—Women’s Centre for Health Matters; Submission No. 24—Maternity Services at the CHWC. [↑](#footnote-ref-218)
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220. Submission No. 8—ACT Government, p. 9. [↑](#footnote-ref-220)
221. Submission No. 16—Australian College of Midwives—ACT Branch, p. 4. [↑](#footnote-ref-221)
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227. Including: Submission No. 8—ACT Government; Submission No. 16—Australian College of Midwives—ACT Branch; Submission No. 24—Maternity Services—CHWC; and Submission No. 35—Women’s Centre for Health Matters. [↑](#footnote-ref-227)
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230. Submission No. 28—Perinatal Wellbeing Centre (formerly PANDSI); Submission No. 35—Women’s Centre for Health Matters; Submission No. 34—Health Care Consumers’ Association of the ACT. [↑](#footnote-ref-230)
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232. Australian Institute of Health and Welfare (2016) *Maternity Care Classification System: Maternity Model of Care Data Set Specification national pilot report November 2014—National Maternity Data Development Project Stage 2*, Canberra, p.4. [↑](#footnote-ref-232)
233. Pursuant to the Maternity Care Classification System (MaCCS). [↑](#footnote-ref-233)
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235. Australian Institute of Health and Welfare (2016) *Maternity Care Classification System: Maternity Model of Care Data Set Specification national pilot report November 2014—National Maternity Data Development Project Stage* 2, Canberra, p. 1. [↑](#footnote-ref-235)
236. Viewed 4 May 2020, < https://meteor.aihw.gov.au/content/index.phtml/itemId/559937>. [↑](#footnote-ref-236)
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249. Submission No. 19—UNSW Public Services Research Group, p. 1. [↑](#footnote-ref-249)
250. Submission No. 34—Health Care Consumers’ Association of the ACT, p. 6. [↑](#footnote-ref-250)
251. Submission No. 34—Health Care Consumers’ Association of the ACT, p. 6. [↑](#footnote-ref-251)
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254. Submission No. 34—Health Care Consumers’ Association of the ACT, p. 7. [↑](#footnote-ref-254)
255. Under the ACT *Human Rights Commission Act 2005*, the ACT Health Services Commissioner ‘can accept complaints about any health service provided in the ACT and any registered health practitioner. This includes but is not limited to hospitals, private health and medical services, individual doctors, midwifes, nurses etc.’ [Submission No. 36—ACT Human Rights Commission (ACT Health Services Commissioner), p. 1.] [↑](#footnote-ref-255)
256. Submission No. 36—ACT Human Rights Commission (ACT Health Services Commissioner), p. 4. [↑](#footnote-ref-256)
257. Submission No. 26—Australian Breastfeeding Association, p. 4. [↑](#footnote-ref-257)
258. Submission No. 34—Health Care Consumers Association’ of the ACT, p. 13. [↑](#footnote-ref-258)
259. Submission No. 34—Health Care Consumers Association’ of the ACT, p. 14. [↑](#footnote-ref-259)
260. Submission No. 26—Australian Breastfeeding Association, pp. 6–7. [↑](#footnote-ref-260)
261. Submission No. 45—N. Shahidullah. [↑](#footnote-ref-261)
262. Motion moved by Ms Tara Cheyne MLA, 31 October 2018; ACT Legislative Assembly, *Minutes of Proceedings*, No. 77, 31 October 2018, pp. 1096–1097; ACT Legislative Assembly, *Hansard*, 31 October 2018, pp. 4502–4520. [↑](#footnote-ref-262)
263. Ms Meegan Fitzharris MLA, ACT Legislative Assembly, *Hansard*, 31 October 2018, p. 4515. [↑](#footnote-ref-263)
264. Ms Rachel Stephen-Smith MLA—Media release: ‘Feasibility of establishing a milk bank in the ACT’, issued 28 November 2019, viewed 21 May 2020, <https://www.cmtedd.act.gov.au/open\_government/inform/act\_government\_media\_releases/rachel-stephen-smith-mla-media-releases/2019/feasibility-of-establishing-a-milk-bank-in-the-act>. [↑](#footnote-ref-264)
265. Including: Submission No. 16—Australian College of Midwives—ACT Branch; Submission No. 23—Safe Motherhood for All Inc.; Submission No. 26—Australian Breastfeeding Association; Submission No. 34—Health Care Consumers Association’ of the ACT; Submission No. 35—Women’s Centre for Health Matters; Submission No. 50—Tresillian Family Care Centres. [↑](#footnote-ref-265)
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270. Australian Health Ministers’ Advisory Council Consultation—APS Submission regarding the development of a National Strategic Approach to Maternity Care, July 2018. [↑](#footnote-ref-270)
271. Kezelman CA, Stavropoulos PA (2012) *Practice guidelines for treatment of complex trauma and trauma informed care and service delivery*, Sydney: Blue Knot Foundation. [↑](#footnote-ref-271)
272. Gray C (2005) ‘What is Clinical governance?’, *BMJ*, 330, p. 254. [↑](#footnote-ref-272)
273. 21 April 1908 to 4 August 1993. [↑](#footnote-ref-273)
274. Obstetric fistulas—before the Hamlins arrived in Ethiopia, patients with obstetric fistulas who sought medical treatment at hospitals were turned away as there was no cure for their humiliating condition. The Hamlin’s made a commitment to eradicate fistula in Ethiopia through the establishment of fistula hospitals dedicated to treating women suffering from this obstetric complication. There are now six Hamlin Fistula Hospitals across Ethiopia. Over 61 years—more than 60,000 Ethiopian women have had life-changing surgery and care, changing their lives and the lives of their families and communities. [↑](#footnote-ref-274)
275. Hamlin Fistula Australia (2020) *Autumn Newsletter*. [↑](#footnote-ref-275)
276. Hamlin Fistula Australia (2020) *Autumn Newsletter*. [↑](#footnote-ref-276)
277. Donnolley N, Butler-Henderson K, Chapman M et al. ‘The development of a classification system for maternity models of care’. *Health Inf Manag*. 2016; 45(2): 64-70. [↑](#footnote-ref-277)