SUBJECT: **Concerns regarding the availability of emergency birthing services at the Mossman Hospital.**

☐ Approved ☐ Not approved ☐ Noted ☐ Further information required (see comments)	Signed…… Date……../……../…….. Hon Steven Miles MP, Minister for Health and Minister for Ambulance Services Comments:

ACTION REQUIRED BY There is no specific timeframe required.

RECOMMENDATION
It is recommended the Minister:

- **Sign** the attached letter of response to Attachment 1).
- **Note** that sustained . A meeting with the Cairns and Hinterland Hospital and Health Service, to further discuss the concerns was held on 2019.

ISSUES

1. On 2019, wrote to outlining concerns with the resources available and the clinical management of following presentation to Hospital after .
2.
   2.1.1. Mossman Hospital is assessed with Clinical Services Capability Level 1 (Maternity) due to the unavailability of specialist maternity and obstetric services, absence of operating theatre within the facility to address obstetric emergencies and inability to provide more than antepartum and post-partum care.
   2.1.2. There are no midwives available to provide an on-call service at Mossman.
   2.1.3. Nurses and medical staff are trained in imminent birthing in rural and remote areas, but this does not make this cohort of staff expert in midwifery or obstetrics. This is a supporting strategy whilst retrieval/ transfer is organised.
   2.1.4. The medical records state
   2.1.5.
   2.1.6.
   2.2.
   2.2.1. Letter sent to on 2019 from Dr , Medical Superintendent, Mossman Hospital, Cairns and Hinterland HHS (Attachment 2).

2.2.2. concerns were brought to the attention of

3. the following points were discussed:
   3.1. Emergency transfer options between facilities involving air and road. Decisions about which mode of transport are based on patient priority and availability of the transport asset and are coordinated between medical staff at each facility, Queensland Ambulance Service and Queensland Health Retrieval Services Queensland for helicopter transfers. Confirming this process was undertaken;
   3.2. Mossman Hospital is a rural service supported by Cairns for emergencies. It does not have an operating theatre but does have effective transfer arrangements for such eventualities;
   3.3. Extensive maternity emergency services are not provided at Mossman. This level of service is based in Cairns with the required specialist support services, theatre and anaesthetic staff;
   3.4. The Cairns and Hinterland HHS has a hybrid medical record process where Cairns hospital is electronic and rural facilities are paper based. The process of patient identification is always adhered to by checking patient details manually rather than assuming electronic or paper systems are correct;
   3.5.
   3.6. A concurrent review being undertaken of Mossman Maternity services as part of a broader rural maternity services initiative called the Queensland Rural and Remote Maternity Services Planning Framework to understand the level of service provision required in rural facilities;
   3.7.
   3.8. .

BACKGROUND

4.
5. .
6.
7.
8. Advice on maternity services in Mossman was provided to SDLO in July 2019 (Attachment 3).
9. Rural Maternity Taskforce
   9.1. The Minister established the Rural Maternity Taskforce in August 2018 to investigate steps to minimise risk for mothers and babies in rural and remote communities, while providing services as close as possible to where they live.
   9.2. At the Cairns Maternity Summit held on 18 and 19 June 2019, the Queensland Health Rural Maternity Taskforce presented a report, including six recommendations to address issues and concerns with the safety and access of rural and remote maternity services and the draft Rural and Remote Maternity Services Planning Framework (Attachments 4 and 5).
   9.3. The Minister accepted all six recommendations in the Rural Maternity Taskforce Report and requested their implementation.
   9.4. The Minister requested that all HHSs review each of their rural health services using the new evidence-based Rural and Remote Maternity Services Planning Framework within two years, in collaboration with local consumers and clinicians. Mossman has been identified as a potential Service to pilot the Planning Framework.

RESULTS OF CONSULTATION

10. No consultation was required for this brief.

RESOURCE/FINANCIAL IMPLICATIONS

11. There are no resource or financial implications associated with this brief.

SENSITIVITIES/RISKS

12. Several women are requesting increased maternity services in Mossman, generating some media attention.

ATTACHMENTS

13. Attachment 1: Letter to
    Attachment 2: Letter sent to on 2019 from Dr , Mossman Hospital
    Attachment 3: SDLO advice

Attachment 4: Rural Maternity Taskforce Report
Attachment 5: QLD Rural Maternity Planning Framework_1Aug 2019-Draft v 1.02 for trial

Author	**Cleared by (Dir/Snr Dir)**	**Content verified by (DDG/CE)**	**Director-General Endorsement**
Name: Patricia McIntyre Position: Senior Correspondence and Liaison Officer Unit: Communications and Engagement Tel No: Date Drafted: 2 October 2019	Name: Dr Donald Mackie Position: Executive Director Branch: Medical Services Tel No: Date Cleared: 8 October 2019 **Note clearance contact is also key contact for brief queries**	Name: Clare Douglas Position: Chief Executive Division: Cairns and Hinterland HHS Tel No: Date Verified: 9 October 2019	Name: Dr John Wakefield Signed Date ……/……/……

Edits
Name: Patricia McIntyre Position: Senior Correspondence and Liaison Officer Unit: Communications and Engagement Tel No: Date Drafted: 29 October 2019

ATTACHMENT 3

SDLO Request for Advice

Topic: Maternity Services Mossman, Far North Queensland Cairns and Hinterland Hospital and Health Service

Date due to SDLO: 10 July 2019

Details of request:

[redacted] emailed the Office of the Federal Member for [redacted] 2019, regarding the lack of birthing facilities in the Douglas Shire. The email was forwarded to the Office of the Member for [redacted].

Response:

- When providing maternity services, the safety of mothers and infants is always highest priority.
- The Mossman Multi-Purpose Health Service is assessed as Clinical Services Capability Framework (CSCF) level 1.
  - This means for maternity services; the facility has the capability to provide maternity care in the form of antenatal and postnatal care.
  - Intra-partum care is provided by Cairns or Mareeba and it is the pregnant woman's choice which service is selected.
- The CSCF for Public and Licensed Private Health Facilities outlines the minimum support services, staffing, safety standards and other requirements required in both public and private health facilities to ensure safe and appropriately supported clinical services. It serves two major purposes:
  - to provide a standard set of capability requirements for most acute and sub-acute health facility services provided in Queensland by public and private health facilities.
  - to provide a consistent language for health care providers and planners to use when describing health services and planning service developments.
  - The CSCF outlines modules for each service area and defines levels of service provision within each area.
  - These apply to both public and private health facilities.
- All treatments need to be delivered within the assessed CSCF level.
  - Mossman maternity services has been assessed under the CSCF to provide community antenatal and/or postnatal care for women and infants. This CSCF level does not include planned births or inpatient maternity services.
  - At Mossman, nurses and medical staff are trained in imminent birthing, to mitigate the risks associated with unplanned births in non-birthing facilities.
- From 2004 onward, the CSCF has applied to public and licensed private health facilities in Queensland.
  - Planned births or maternity inpatient services have not been offered at Mossman since 2004.
  - The Mossman operating theatre was decommissioned and closed in 2009.

Prepared by: Patricia McIntyre	Approved by: Gabrielle Honeywood	DLT Member / HSCE: Clare Douglas
Position Senior Correspondence and Liaison Officer	Position: Executive Director, Rural and Remote	Position Chief Executive
Telephone: [redacted]	Telephone: [redacted]	Telephone: [redacted]
Date:11 July 2019	Date: 12 July 2019	Date:12 July 2019

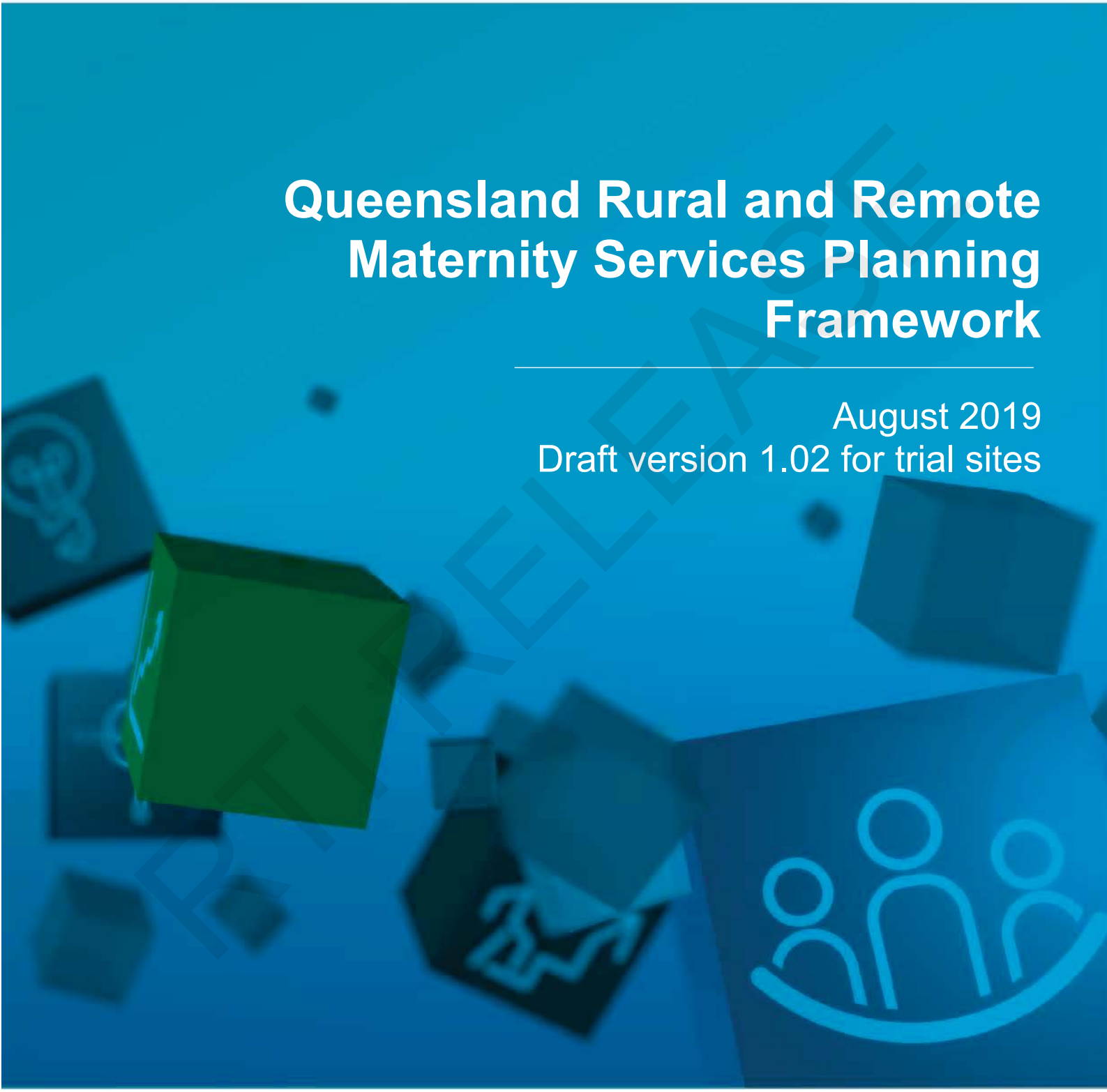
- Within the coming months, the Cairns and Hinterland Hospital and Health Service propose to undertake a maternity service assessment in Mossman to better inform service capability and requirements.
  - In conjunction with patient safety and quality practices, any decision-making on maternity services in Mossman will be guided by the level of services determined by the CSCF and the Nursing and Midwifery Governance Framework.
- [redacted] feedback has been forwarded to the Patient Liaison Service who will in consultation with the Cairns and Hinterland HHS, Patient Safety and Quality Unit staff coordinate a review of [redacted] episode of care to determine any opportunities for improvement.

Contact person:

Ms Tracey Morgan, Director of Nursing and Midwifery, Rural and Remote Services, Cairns and Hinterland Hospital and Health Service Phone: [redacted] Mobile: [redacted]

Queensland Rural and Remote Maternity Services Planning Framework

August 2019
Draft version 1.02 for trial sites



Queensland Rural and Remote Maternity Services Planning Framework

Published by the State of Queensland (Queensland Health), August 2019
IBNN or ISBN if needed

For more information contact:
Patient Safety and Quality Improvement Service, Clinical Excellence Division, Department of Health, GPO Box 48, Brisbane QLD 4001, email rural_maternity_taskforce@health.qld.gov.au, phone 07 3328 9430.

An electronic version of this document is available at www.insert.website.here.com

Disclaimer:

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About this Framework

The *Queensland Rural and Remote Maternity Services Planning Framework* is a guide for Queensland Hospital and Health Services (HHS). Its purpose is to help us review, assess and design our maternity services.

The Framework has been developed by the Queensland Rural Maternity Services Taskforce. It is informed by evidence review, analysis of maternity services data, and consultation with rural and remote women, communities and service providers.

This Framework is not intended to replace any organisational or workforce-specific policies or guidelines. The Framework is a resource to support HHS in providing comprehensive, woman-centred approaches to maternity service planning.

For ease of reading, we use the term 'rural' through the Framework to encompass both rural and remote communities.

Why do we need a Framework?

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

Maternity care encompasses the following stages:

- preconception
- antenatal (from conception to before birth)
- intrapartum (from onset of labour through to delivery of the placenta)
- postnatal care (generally up to six weeks after birth) for women and babies. Postnatal care extends beyond six weeks for women and babies with ongoing postnatal care needs.

Many women who live in rural areas have difficulty accessing their preferred models of maternity care. This is especially so for those women who live a great distance from urban centres.

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

The issues of providing maternity services in rural and remote areas of Queensland include:

- Women in rural areas are less likely to receive antenatal and postnatal care.
- Women in rural areas are more likely to have health risks in pregnancy that increase the likelihood of complications.
- People whose care needs are more complex need to travel to larger centres to access their care.
- Rural health services do not have specialist workforce or equipment required to provide more complex care.

- Women who need to travel for the birth of their child may have increased risk of giving birth before they arrive at the birthing facility. This is referred to as 'born before arrival'.

A shared approach to planning

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

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

Phase 1: Reviewing existing rural maternity services.

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

Phase 1:
Reviewing current rural maternity services

Planning maternity services

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

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

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

Aim

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

Objectives

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

Principles

High-quality maternity care is underpinned by the following design principles:

- A woman should receive continuity of maternity care.
- A woman should access care that is individualised.
- A woman should access care that is evidence-based.
- A woman should have access to planned births as close to home as possible.

Engaging with stakeholders

Maternity service consumers and community members are essential to the stakeholder engagement process. The health service must engage with stakeholders from the beginning of the planning process (Figure 1). Stakeholders will guide the design of maternity services, review relevant data and information, and provide feedback and evidence as the planning progresses.

The HHS Board and Executive should be actively engaged and informed at each step of the planning process of maternity services planning. Other stakeholders to consider engaging with include:

- local government
- professional bodies and associations in healthcare
- health service funders.

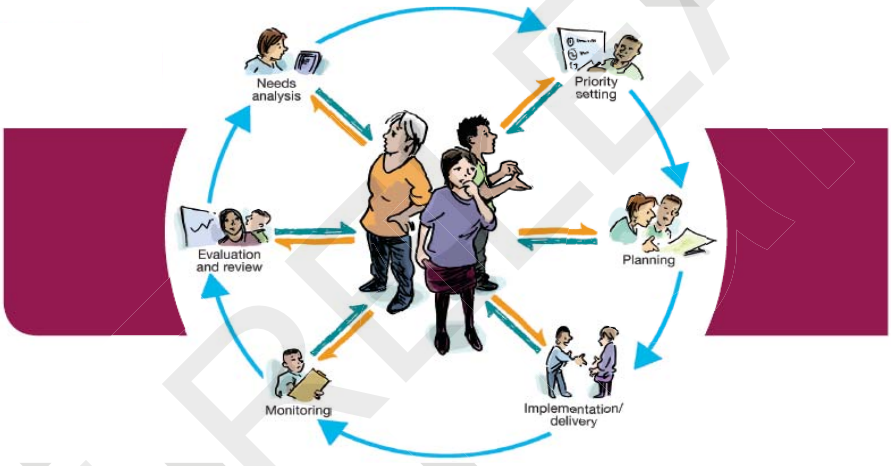

Figure 1. When do we engage?

Consumer engagement refers to the activities and processes through which past, present and future consumers and their communities can partner with health organisations in the design, delivery, evaluation and monitoring of their services.

We must also engage with:

- clinicians who deliver maternity services (midwives, doctors credentialled in obstetrics)
- clinicians who support them within the HHS (doctors, nurses, allied health providers)
- General Practitioners
- Aboriginal Community Controlled Health Organisations
- ambulance and air retrieval services
- primary health networks
- tertiary services and retrieval services to whom rural maternity services refer.

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

Informal mechanisms of engagement will also be required to ensure consumers and clinicians participate in the planning process.

Consumer and community engagement

The *National Safety and Quality Health Service Standards (NSQHS) Standard 2: Partnering with consumers* articulates that HHS must engage with consumers and demonstrate partnerships with consumers in service planning, designing care and service measurement and evaluation[1].

It is important to understand and differentiate between consumer and community engagement. Both levels of engagement provide useful information[2].

Engaging with consumers

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

Consumers need to be resourced and supported to enable their engagement in maternity services planning. Consider flexible approaches to engaging with consumers. Practical strategies to meaningfully engage with consumers are described within Health Consumers Queensland's *A Guide for Health Staff: Partnering with Consumers (2018)[3].*

The Health Consumers Queensland's (HCQ) *Consumer and Community Engagement Framework for Health Organisations and Consumers (2017)[4]* (Engagement Framework) has documented good principles of consumer engagement. The Engagement Framework outlines the building blocks for partnerships between staff in organisations and their consumer representatives.

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

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

The relationship between these elements is represented in the framework diagram (Figure 2).[5]

[1] https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/national-safety-and-quality-health-service-standard-2-partnering-with-consumers/
[2] http://www.hcq.org.au/our-work/framework/
[3] http://www.hcq.org.au/wp-content/uploads/2018/06/HCQ_StaffGuide.pdf
[4] http://www.hcq.org.au/our-work/framework/
[5] http://www.hcq.org.au/wp-content/uploads/2018/06/HCQ_StaffGuide.pdf

The key to effective and successful consumer partnerships is to keep consumers at the centre of all planning, design, delivery and evaluation. This means formally and informally partnering with consumers across varying levels of influence (as indicated in Figure 2) from informing, consulting, involving, collaborating through to consumer led.

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

Figure 2. The Consumer and Community Engagement Framework

Engaging with communities

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

This active partnering ensures that health policy, planning, service delivery and evaluation are informed by consumer experience. When reviewing or planning maternity services, it is important to do both levels of engagement.

Engaging with Aboriginal and Torres Strait Islander peoples

Authentic and effective engagement means investing time and building relationships.[6] Good consumer engagement relies on effective engagement with Aboriginal and Torres Strait Islander people living in local communities.

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

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

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

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

Aboriginal Health Workers, Aboriginal Health Practitioners and Indigenous Liaison Officers and Aboriginal Community Controlled Organisations within your organisation and HHS can provide advice on engagement with Aboriginal and Torres Strait Islander peoples in your area.

Resources are available which are designed to support health staff in developing services that are responsive to the cultural needs of Aboriginal and Torres Strait Islander Queenslanders. Health organisations may find these resources to be valuable when they are developing services for Aboriginal and Torres Strait Islander Queenslanders in rural and remote settings.[7] [8]

Planning maternity care for Indigenous communities

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

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

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[6] http://www.hcq.org.au/wp-content/uploads/2018/06/HCQ_StaffGuide.pdf (pg. 19)

[7] User Guide for Aboriginal and Torres Strait Islander Health https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-User-Guide-for-Aboriginal-and-Torres-Strait-Islander-Health.pdf

[8] Draft Growing deadly families: Aboriginal and Torres Strait Islander Materiality Services Strategy. (Queensland Health, 2019)

The 11 models of maternity care

There are broadly 11 models of maternity care that have been defined for the Australian health system[9]. These definitions do not reflect all of the ways in which maternity care is delivered in rural communities but are useful for planning.

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

Comprehensive maternity service planning should consider how women can access all 11 models, even if they are not available locally. Rural and remote maternity services and Aboriginal Community Controlled Health Organisations may include features of one or more of these models to deliver services.

Table 1. Models of maternity care[10]

Model	Description
1. Combined care	■ Antenatal care is provided by a private maternity service provider (doctor or midwife) in the community. ■ Intrapartum and early postnatal care is provided in the public hospital by hospital midwives and doctors. ■ Postnatal care may continue in the home or community by hospital midwives.
2. GP obstetrician care	■ Antenatal care is provided by a GP obstetrician. ■ Intrapartum care is provided in either a private or public hospital by the GP obstetrician and hospital midwives in collaboration. ■ Postnatal care is usually provided in the hospital by the GP obstetrician and hospital midwives and may continue in the home or community.
3. Midwifery Group Practice caseload care	■ Antenatal, intrapartum and postnatal care is provided within a publicly-funded caseload model by a known primary midwife with secondary backup midwife/midwives providing cover and assistance, with collaboration with doctors in the event of identified risk factors. ■ Antenatal care and postnatal care is usually provided in the hospital, community or home with intrapartum care in a hospital, birth centre or home.
4. Private midwifery care	■ Antenatal, intrapartum and postnatal care is provided by a private midwife or group of midwives in collaboration with doctors in the event of identified risk factors. ■ Antenatal, intrapartum and postnatal care could be provided in a range of locations including the home.
5. Private obstetrician (specialist) care	■ Antenatal care is provided by a private specialist obstetrician. ■ Intrapartum care is provided in either a private or public hospital by the private specialist obstetrician and hospital midwives in collaboration.

[9] Australian Institute of Health and Welfare 2014. Nomenclature for models of maternity care: literature review, July 2012—Foundations for enhanced maternity data collection and reporting in Australia: National Maternity Data Development Project Stage 1. Cat. no. PER 62. Canberra: AIHW.

[10] Aboriginal Health Workers may support the delivery of maternity care to Indigenous people in any of these models

Model	Description
	■ Postnatal care is usually provided in the hospital by the private specialist obstetrician and hospital midwives and may continue in the home, hotel or hostel.
6. Private obstetrician and privately practising midwife joint care	■ Antenatal, intrapartum and postnatal care is provided by a privately practicing obstetrician and midwife from the same collaborative private practice. ■ Intrapartum care is usually provided in either a private or public hospital by the privately practicing midwife or private specialist obstetrician in collaboration with hospital midwifery staff. ■ Postnatal care is usually provided in the hospital and may continue in the home, hotel or hostel by the privately practicing midwife.
7. Public hospital high risk maternity care	■ Antenatal care is provided in hospital outpatient clinics (either onsite or outreach) by midwives or doctors. Care could also be provided by a multidisciplinary team. ■ Intrapartum and postnatal care is provided in the hospital by midwives and doctors in collaboration. ■ Postnatal care may continue in the home or community by hospital midwives.
8. Public hospital maternity care	■ Antenatal care is provided in hospital outpatient clinics (either onsite or outreach) by midwives or doctors. Care could also be provided by a multidisciplinary team. ■ Intrapartum and postnatal care is provided in the hospital by midwives and doctors in collaboration. ■ Postnatal care may continue in the home or community by hospital midwives.
9. Remote area maternity care	■ Antenatal and postnatal care is provided in remote communities by a remote area midwife (or a remote area nurse) or group of midwives sometimes in collaboration with a remote area nurse or doctor. ■ Antenatal and postnatal care, including high- and low-risk pregnancies, as well as consultations for the management of gestational diabetes may be provided via telehealth 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.
10. Shared care	■ Antenatal care is provided by a community maternity service provider (doctor or midwife) in collaboration with hospital medical or midwifery staff under an established agreement, and can occur both in the community and in hospital outpatient clinics. ■ Intrapartum and early postnatal care usually takes place in the hospital by hospital midwives and doctors, often in conjunction with the community doctor or midwife (particularly in rural settings).
11. Team midwifery care	■ Antenatal, intrapartum and postnatal care is provided by a small team of rostered midwives (no more than eight) in collaboration with doctors in the event of identified risk factors. ■ Intrapartum care is usually provided in a hospital or birth centre. ■ Postnatal care may continue in the home or community by the team midwives.

Why should we review and assess services?

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

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

- individual services
- the network as a whole.

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

Linkages and communication between services

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

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

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

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

Frequency of review and assessment

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

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

How do we review and assess our maternity services?

Maternity service review and assessment comprises the following tasks, all of which should be undertaken collaboratively with the service's Executive, Board, clinical and consumer representatives:

1. **Analysing relevant data and service information**
2. **Reviewing consumer and community feedback and information**
3. **Reviewing clinician feedback and information**
4. **Assessing maternity service system risks**

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

Analysing relevant data and service information

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

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

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

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

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

a. Review the population size and population projections for geographical areas within the HHS catchment.

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

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

   - maternity services
   - planned birthing services
   - caesarean section-capable planned birthing services

   Population projections provide information about projected changes in the size of local populations and their age structure. The Queensland Government Statistician's Office Queensland Regional Database provides a spatial and temporal overview of Queensland's current and projected population within regional areas[11]. Alternatively, the Statistical Services Branch in Queensland Health can assist with data requests from health services.

b. Determine the number of births for women. You need to know the number of births at each facility and the number of births for women who live in each geographical area within your HHS, and which facility they birth at. The Queensland Regional Database records the number of births each calendar year to women residing within different geographical areas.

c. Describe the maternity service map within the HHS catchment. Identify:

   - Maternity services that are available (antenatal, birth, postnatal)

[11] https://statistics.qgso.qld.gov.au/pls/qis_public/qis1110w$.startup

- Different models of maternity care available within the HHS catchment (the 11 maternity models) and where these are located, including those models that are accessible only outside the HHS catchment
- Aboriginal Community Controlled Health Organisations that deliver aspects of maternity care within the HHS catchment
- the geographic proximity of each facility in the service network to the nearest facility that can perform emergency caesarean section.

Describe the operating theatre capacity, utilisation and suitability of infrastructure across HHS sites.

Describe the transport and accommodation available for women and their families and any costs associated with accessing these, including reimbursement schemes available to women and their families.

Describe the current maternity and support services designations of each facility according to the Queensland Clinical Services Capability Framework[12].

d. Prepare a workforce map which should describe:

- the available maternity workforce in each discipline
- where the workforce is located
- the credentials and scope of practice of the available workforce
- any maternity recruitment and retention challenges that have been experienced, including data on staff recruitment and retention.

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

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

f. Share these results with stakeholders. Relevant data and information should be shared with the stakeholders who are engaged in the planning process. Stakeholders should consider the findings from the available data. The data may raise questions that need to be explored with consumers and clinicians. This will inform the consultation phase of the review and assessment process.

Queensland Clinical Services Capability Framework

The Clinical Services Capability Framework (CSCF) is a Queensland Health tool that outlines the minimum service and workforce requirements, as well as specific risk considerations required in both public and private health facilities to ensure safe and appropriately supported clinical services. Categorisation is based on the hospital's self-assessment and

[12] https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf

rating of their maternity service into CSCF levels ranging from Level 1 (lowest) to Level 6 (highest).

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

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

Table 2 provides a summary of the Queensland CSCF descriptions of the various levels of maternity service.

Table 2. Levels of maternity service provision, Queensland CSCF

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

Australian Rural Birthing Index

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

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

The index is calculated based on:

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

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

Detailed instructions on how to calculate the ARBI are available at the weblink below (see footnote).[13]

The final ARBI score recommends an appropriate level of service able to be supported in the rural catchment as follows (Table 3).

Table 3. Australian Rural Birthing Index score

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

[13] https://ucrh.edu.au/wp-content/uploads/2018/05/AUSTRALIAN-RURAL-BIRTH-INDEX-TOOLKIT-FINAL-24Sep2015.pdf

Reviewing consumer and community feedback and information

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

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

Key questions to ask consumers

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

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

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

- *What can be improved?*

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

- *What is working well?*

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

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

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

How to seek consumer feedback

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

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

Formal consumer feedback can be obtained through consumer representatives on HHS governance bodies, local reference groups or committees and from consumer organisations. Ensure that the consumers who take part in this formal mechanism have lived experience of the maternity services for whom you are consulting.

It can be useful to engage independent organisations and individuals to obtain feedback on behalf of the HHS.

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

Feedback on cultural aspects of care

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

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

Birthing on-country is culturally important in some Aboriginal and Torres Strait Islander communities, and this importance varies between communities. It is important that the HHS understands this well through the consultation process. The service should seek feedback and input from Aboriginal Health Workers, Aboriginal Health Practitioners and Indigenous Liaison Officers within the HHS, and from the local Aboriginal Community Controlled Health Organisations, to identify appropriate strategies to receive feedback from Aboriginal and Torres Strait Islander stakeholders.

Share the findings from the consultation with stakeholders

The HHS and maternity service providers should consider the spiritual, social, cultural and health needs identified through the engagement process and how these can be addressed through maternity service design or re-design within the HHS. Involving consumers in the redesign process is a crucial and important step. Ensure you close the feedback loop and communicate to all consumers who you have partnered with in culturally appropriate way.

Reviewing clinician feedback and information

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

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

- How are maternity services delivered within the local community?
- Which aspects of care can women access locally and which aspects of care do women have to travel to access? What care could be delivered locally but is not?
- What care needs necessitate women and babies being transferred to a higher-level service? How well do these arrangements work? What could be improved?

Describe the clinical governance

Health services configure their maternity services as a network of providers, from least to most specialised. Identify the clinical protocols, procedures and guidelines that support the delivery of maternity care across the clinical network.

- Identify the protocols, procedures and guidelines that document the processes for the referral of women and babies between different facilities within the maternity services network.
- Identify any gaps in protocols and procedures that link services within the HHS maternity network.
- Ensure reciprocity in all communication including feedback of advice or transfer processes as it applies to the woman and or her baby from both the primary and specialised maternity sites' experiences.

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

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

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

Understand the workforce

The rural and remote maternity workforce deliver maternity care in a challenging environment with fewer resources and specialist supports than larger maternity centres. This workforce

has distinctive training, skills development, and maintenance needs in maternity, neonatal, emergency and cultural aspects of care.

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

- How are providers supported to deliver maternity care locally? What could be improved?
- How are workforce training and professional development needs met? What else is required?
- What are the arrangements to ensure the psychological safety of staff working in rural maternity roles? How can arrangements be strengthened?

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

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

Share the feedback with stakeholders

Feedback should be shared with the stakeholders who are engaged in the planning process. Stakeholders should consider the issues raised by clinicians and raise these within the HHS for maternity service design or re-design.

Assessing maternity service system risks

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

> *"There will always be an element of risk in birth, whatever the choice of birthplace. However, safety in childbirth is intrinsically related to the mother's emotional, psychological and physical well-being during labour. This, in turn, is influenced by the choices which are made during pregnancy, choices which should enable a woman to give birth at ease with her environment, her attendants and herself."*[14]

- Review the available safety and quality information for each service within the maternity services network. Review health outcomes for women and babies (including breastfeeding, physical health and maternal mental health outcomes). Compare the service outcomes against the National Core Maternity Indicators[15].
- Determine the rates and trends of babies being born before arrival and imminent births at non-birthing services within the network.
- Review summary results of root cause analyses, Coroner's reports and any other service reviews.
- Review referrals and transfers of women and / or babies with time critical care needs between different facilities within the HHS maternity services network and to services outside the network. Review outcomes in cases where women needed transfer for care.

Key considerations for stakeholders in assessing risk

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

- clinical
- cultural (women and their families and communities)
- emotional
- financial
- ethical impacts on rural families, communities and clinicians of how maternity services are delivered[16].

[14] Re-Birthing: Report of the Review of Maternity Services in Queensland, Cherrell Hirst, 2005
[15] AIHW. National Core Maternity Indicators. Available at: https://www.aihw.gov.au/reports/mothers-babies/ncmi-data-visualisations/contents/summary
[16] Barclay L et al. The closure of rural and remote maternity services: Where are the midwives? Midwifery 2016; 9-11.

Clinical risks of closing or reducing services

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

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

Evidence shows that Level 2 CSCF maternity services (Table 2) in rural areas demonstrate safe outcomes.[17] [18] [19] [20] These units may provide a valuable birthing option in rural areas for women with low-risk pregnancies who choose this birthing option and who understand the limitations of this service[21].

The Australian College of Midwives *National Midwifery Guidelines for Consultation and Referral* (2013) provide an evidence-based framework for inter-professional collaboration in the maternity care of women. The Framework guides decisions regarding appropriate levels of maternity care for women with different levels of clinical risk.[22]

Share the summary results with stakeholders

These summary results should be shared with the stakeholders who are engaged in the planning process. Stakeholders should consider the findings from the available information. They should also consider if questions this information raises need to be explored with consumers and clinicians. This will inform the consultation phase of the review and assessment process.

[17] Van Wagner V et al. Remote midwifery in Nunavik, Quebec. Canada: outcomes of perinatal care for the Inuulitisivik health centre. 2000-2007. Birth 2012; 39: 230-237.
[18] Kruske S et al. A retrospective, descriptive study of maternal and neonatal transfers and clinical outcomes of a Primary maternity Unit in rural Queensland, 2009-2011. Women and Birth 2015; 28: 30-39.
[19] Kornelsen J and Ramsey M. Maternal and newborn outcomes in a rural midwifery-led maternity service in British Columbia. Canadian Journal of Midwifery Research and Practice 2015; 13: 8-17.
[20] Dixon L et al. What evidence supports the use of free-standing midwifery led units (primary units) in New Zealand. New Zealand College of Midwives Journal 2012; 46: 13-20.
[21] Grzybowski S, Stoll K, Kornelsen J. Distance matters: a population based study examining access to maternity services for rural women. BMC Health Services Research 2011; 11:147.
[22] Australian College of Midwives. National Midwifery Guidelines for Consultation and Referral. 3rd Edition. 2013.

Phase 2:
Design or redesign of rural maternity services

How should we design maternity services?

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

The Statewide Maternity Decision Making Framework (DMF) and associated Library Toolkit is available, along with a library of resources (as an adjunct to this guide for rural facilities) to assist in the review, redesign and transition to continuity of care and carer models (link to be placed here).

Planning for co-designed maternity services

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

1. Create a stakeholder engagement plan

Create a draft stakeholder engagement and co-design plan, which considers the activities you will undertake to engage with women, communities and clinicians. This may include:

- A steering committee to oversee the review process, with membership consisting of consumers, community representatives, management, clinicians, union representations, Primary Healthcare Network (PHN) reps, GPs, etc
- surveys
- externally facilitated workshops with all stakeholders
- morning tea, kitchen table conversations and yarning circles with consumers.

2. Communicate back to stakeholders

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

Figure 3. Feedback loop with stakeholders

3. Evaluate

Ongoing and continuous improvement are important steps of any service design and delivery. Plan and ensure that consumers are involved at all stages of the use of this Framework at a service and HHS level, as well as a longer-term review of implementing the Framework across the State.

For further information on evaluating consumer partnering, please refer to A Guide for Health Staff: Partnering with Consumers[23].

Service design considerations

- Engage stakeholders early who are likely to be affected by any service design solutions. This will support more informed service decision-making.
- The cultural needs of women are a central consideration of how services are designed. It is essential to enable women with culturally-specific care needs to participate in this process.
- Good maternity care relies upon interdisciplinary collaboration within facilities and between different maternity services in the network. Involve clinicians across disciplines and affected facilities within the network[24].
- Communities should be well informed about:
  - the maternity care available locally
  - how service availability might vary (for example, on weekends and when various staff may be unavailable)
  - how service delivery is supported at regional and tertiary levels
  - the potential limitations on local services if unexpected complications arise during pregnancy
  - referral and transfer arrangements if unexpected complications arise.
- Care for pregnant women in rural and remote Australia is delivered by midwives, doctors, nurses and allied health providers, including an Indigenous workforce, that work together to support local maternity services.
  - Care arrangements between providers and services within the maternity services network should be guided by locally agreed protocols and referral guidelines.
- Women in rural communities should have early access to pre-pregnancy counselling.
  - Individual risk assessment and counselling, particularly with respect to early pregnancy screening tests, are important in helping women to make well-informed decisions about their ongoing care.
- Communities and clinicians need to be informed and supported through any major changes in models of maternity service delivery.

[23] http://www.hcq.org.au/wp-content/uploads/2018/06/HCQ_StaffGuide.pdf
[24] RANZCOG. Maternity Care in Australia. A framework for a healthy new generation of Australians. 2017.

Antenatal care

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

- maintain and improve health and general wellbeing
- emphasise the importance of a healthy diet and exercise
- provide advice to avoid smoking, alcohol and illicit drugs
- provide for the mental health care needs of women
- screen for managing pregnancy complications through detailed history, clinical examination and appropriate investigations throughout the pregnancy
- manage any pregnancy complications as they arise.

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

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

- the course of an uncomplicated pregnancy
- the possible need for obstetric treatment
- the common obstetric procedures
- options for pain relief in labour, both pharmacological and non-pharmacological
- transition to parenthood (services and peer support)
- other topics (mental health, breastfeeding, domestic and family violence)

Identify and describe how this will be provided.

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

Postnatal care

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

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

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

Postnatal care can be provided by a range of health professionals, including midwives, nurses, obstetricians, General Practitioners and Aboriginal Health Workers.

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

- Work with stakeholders to identify options for women to address gaps in postnatal care (identified in the service review and assessment phase).
- Identify and document the responsibilities of health services and community based providers in caring for mother and baby.
- Ensure any postnatal care arrangements promote continuity of care for women and babies across the full range of services involved in their care and that robust systems for communication and information sharing between providers are in place.
- Determine and document referral pathways to inform service providers of how women who require additional postnatal care can be managed and treated by the appropriate specialist teams if problems are identified.

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

Planned births and neonatal care

Planned births are provided across the HHS's network of providers, from least to most specialised. Identify where planned births will be provided for within the maternity services network.

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

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

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

Unplanned births

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

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

Service network design considerations

Clinical governance

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

The HHS should work with stakeholders to determine and document the clinical governance arrangements to:[25]

- provide clinical leadership of the maternity service network
- monitor the quality of maternity and neonatal care
- foster clinical excellence and ongoing improvement of standards
- foster a culture of psychological safety for clinicians
- provide clear accountability for all team members.

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

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

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

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

Clinical protocols, procedures and guidelines

Rural maternity services should comply with evidence-based guidelines for the provision of high-quality clinical care. Queensland Health provides a suite of maternity and neonatal clinical guidelines that translate evidence into best clinical practice[26].

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

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

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[25] Rural Doctors Association of Australia. Policy position on rural maternity services.
[26] Queensland Health. Maternity and Neonatal Clinical Guidelines. Available at: https://www.health.qld.gov.au/qcg/publications

Some women will choose to decline the recommended care. Describe procedures for documentation when women decline recommended care and for clinicians who decline to provide the woman's preferred care. Ensure staff are trained in these.

The Australian College of Midwives *National Midwifery Guidelines for Consultation and Referral* (2013) provide an evidence-based framework for inter-professional collaboration in the maternity care of women. The Framework guides decisions regarding appropriate levels of maternity care for women with different levels of clinical risk.[27]

Equipment and resources

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

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

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

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

Maternity workforce

High-quality rural maternity services rely on an appropriate workforce with leadership, skills mix and experience to provide excellent care. HHS must ensure that all maternity service providers across the maternity service network participate in continuing professional development and maintain knowledge and skills relevant to their clinical work, as well as improving and updating their skills as required.

- Work with clinician stakeholders to identify the workforce required to deliver maternity care specified in the CSCF for each rural setting in the service network.
  - Describe workforce recruitment and retention issues – work with stakeholders to develop strategies for how these will be addressed.
  - Identify workforce skills requirements – work with stakeholders to describe requirements for maternity service providers continuing professional development and knowledge and skills maintenance relevant to their setting of work and professional role and how the workforce will be supported to maintain their skills across the network.
  - Describe arrangements for networking professionals across settings in the maternity service network to facilitate inter-professional engagement and learning. Determine mechanisms for clinicians to participate in regular multidisciplinary clinical audit and reviews of clinical services, including outcomes.

[27] Australian College of Midwives. National Midwifery Guidelines for Consultation and Referral. 3rd Edition. 2013.

- All healthcare providers must recognise and respect the diversity of ethnic, religious, social and cultural values and beliefs of the women for whom they care. Cultural competency should underpin the maternity service that we provide.
- For Aboriginal and Torres Strait Islander women and their families, cultural competence directly influences the engagement of women in antenatal, planned birth and postnatal care. These, in turn, directly influence the health and wellbeing outcomes of Aboriginal and Torres Strait Islander women and neonates. A culturally competent workforce is vital to improving health outcomes.
- Describe how the education and training needs of the maternity workforce to support the delivery of culturally competent care will be addressed.
- Determine the systems and processes that will assure the psychological safety of the rural maternity workforce across the proposed network. Describe systems of reflective practice and professional supervision encompassing all professional disciplines involved in delivery of maternity care.

Maternity workforce roles

Provision of maternity services is based on different health disciplines participating in providing quality care that is tailored to meet each woman's maternity needs. The aim is to provide continuity of antenatal, intrapartum and postnatal care.[28] The majority of women will see both practicing midwives and medical professionals during their pregnancy. Communication and information sharing between team members is vital for delivering high quality care.

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

   Work with Aboriginal and Torres Strait Islander stakeholders, including women, their communities, the Indigenous workforce and Aboriginal Community Controlled Organisations to determine and develop Indigenous workforce roles that can support the delivery of culturally tailored maternity care. Plan for how these can be introduced and maintained within the maternity services network.
2. All rural maternity service networks should have a designated lead midwife. Rural maternity services should aim to develop the capacity for women to receive continuity of midwifery care during pregnancy, birth and transition to parenthood. Each midwife collaborates with the supporting obstetric medical team. For women who are not suitable for, or choose not to access, continuity of midwifery care, it is essential they have access to midwives who provide antenatal, intrapartum and postnatal care.
3. Registered nurses support the delivery of maternity care across antenatal, birthing and postnatal phases. Registered nurses work with midwives, doctors, retrieval and emergency transport personnel and the broader healthcare team to support the delivery of local operating theatre, ward based and emergency care in many rural facilities. Rural

[28] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Maternity Care in Australia: A framework for a healthy new generation of Australians. 2017.

maternity service networks will designate responsibility for organising and managing operating theatres to registered nurses.

4. All rural maternity service networks should have a designated lead medical practitioner credentialled in obstetrics. Each medical practitioner providing maternity care will collaborate with the supporting midwifery team. Women with high-risk pregnancies, including where complications associated with birth are anticipated, should receive care in collaboration with and under the supervision of an obstetrician.
5. Rural maternity service networks may have a designated lead anaesthetist (specialist or GP) with responsibility for organising and managing the obstetric anaesthetic service.[29]
6. Rural maternity service networks may have a designated lead medical practitioner with responsibility for organising and managing neonatal services, including for ensuring guidelines for accessing neonatal retrieval services are in place in all rural facilities and clinical staff are familiar with their use.
7. General Practitioners (GPs) have a pivotal role in the care of women and their families.
   - **Pre-pregnancy care.** Regardless of whether the GP has a special interest in obstetrics, he or she will mostly be responsible for delivering pre-pregnancy care, including family planning and pre-pregnancy planning.
   - **The first pregnancy consultation.** For most women, the first consultation in pregnancy is with the woman's GP. Given the increasing complexities of first-trimester care, particularly with respect to genetic counselling, this emphasises the considerable responsibility that all GPs have in the care of pregnant women. The GP should discuss maternity service models and how to access these and arrange for timely access to the woman's chosen model.

     As most GPs are not employed by HHS, the HHS should consider mechanisms to ensure the role of the GP in maternity care is supported. Education and training, resources such as clinical pathways and referral templates can enable this role.
   - **Ongoing care.** GPs provide continuity of care for the woman and her family, especially in rural communities.
   - For Aboriginal women, their Aboriginal Medical Service may provide initial and ongoing support. Their initial contact may be with an Aboriginal Health Worker or Aboriginal Health Practitioner rather than a GP.

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

Appendices

Acronyms and Abbreviations

Acronym	Definition
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ANZCA	Australian and New Zealand College of Anaesthetists
APV	Adjustment for Population Vulnerability
ARBI	Australian Rural Birthing Index
CALD	culturally and linguistically diverse
CPAP	continuous positive airway pressure
CSCF	Clinical Services Capability Framework
DMF	Decision making Framework
GP	General Practitioner
HCQ	Health Consumers Queensland
HHS	Hospital and Health Services
IF	isolation factor
MMM	Modified Monash Model of rurality classification
PBS	Population Birth Score
PHN	Primary Health Networks
NSQHS	National Safety and Quality Health Service Standards
RA	Remoteness Area
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists

SUBJECT: Mareeba Hospital - temporary changes to maternity services

☐ Approved ☐ Not approved ☐ Noted ☐ Further information required (see comments)	Signed…… Date……../……../…….. Dr John Wakefield, Director-General, Queensland Health Comments:

ACTION REQUIRED BY - There is no specific timeframe required.

RECOMMENDATION
It is recommended the Director-General:

- **Note** the temporary closure of the Mareeba Hospital operating theatre from 9 to 16 October 2019 due to theatre refurbishment in preparation for the new endoscopy service.
- **Note** the temporary change in Mareeba Hospital maternity services due to the operating theatre refurbishment.
- **Note** medical workforce shortage from 16 October to 11 November 2019 due to the lack of medical officers with advanced specialist skills in rural and remote medicine.

ISSUES

1. The Mareeba Hospital operating theatre building is being refurbished to accommodate a new endoscopy service which is expected to be operational by the end of the year.
   - 1.1 Since works commenced in August, the operating theatre has only been operational for obstetric emergencies and is isolated from the works by a temporary wall.
   - 1.2 However, final refurbishments (painting, laying floors, installing and connecting gas ports) require the full closure of the operating theatre from 9 to 16 October 2019.
2. The Mareeba Hospital Maternity Unit is assessed and provides a Clinical Services Capability Framework (CSCF) level 3 service.
   - 2.1 During the refurbishment, the Mareeba Maternity Unit CSCF level has been temporarily reduced to CSCF level 2 to minimise the likelihood of the operating theatre being used for an obstetric emergency, while continuing to support low risk women to birth at Mareeba.
   - 2.2 When the operating theatre is closed from 9 to 16 October 2019, the Mareeba Maternity Unit, for safety reasons can only offer a CSCF Level 1 service.
   - 2.3 Only antenatal and postnatal care will be offered to women during this time.
   - 2.4 From 16 October to 11 November 2019, the Mareeba Maternity Unit will be offering a CSCF level 2 service.
     - 2.4.1 11 November 2019 is the estimated date for completion of the building project and reopening of the theatre at full-service capability.
     - 2.4.2 From 16 October to 11 November 2019 the temporary theatre will be available for obstetric emergency cases only.
3. The Cairns and Hinterland HHS, Maternity Bypass from Rural Birthing Facilities may need to be activated for short periods from 16 October to 11 November due to medical workforce shortages. (Attachment 1)
   - 3.1 Medical officers with advanced skills in rural and remote medicine separations and accessing leave has resulted in the medical workforce shortage. Recruitment is in progress and locums are engaged in the interim.

BACKGROUND

4. The provision of endoscopy services at the Mareeba Hospital will support the Cairns and Hinterland Hospital and Health Service (HHS) strategic objective to bring care close home. It also supports the HHSs capacity to:
   - 4.1 provide endoscopy services within clinically recommended timeframes;
   - 4.2 meet the future demand for endoscopy services; and
   - 4.3 meet the zero long wait target.
5. The refurbishment of the Mareeba Hospital's operating theatre for endoscopy services commenced on 5 August 2019. The project is 'on track' for works to be completed in November 2019 to offer endoscopy services (low-use procedure room maximum of 10 procedures per list / 52 lists per year).
6. The Mareeba Hospital has been assessed to provide a Clinical Services Capability Framework (CSCF) level 3, maternity service.

6.1 As the Operating Theatre has been deemed suitable for use in an emergency only, the Mareeba Hospital's Maternity Service was reduced from a CSCF Level 3 service to a Level 2 service for the duration of the construction period.
6.2 To reduce the likelihood of patients requiring surgical intervention during or following labour, an exclusion criterion was developed to identify high risk patients.

RESULTS OF CONSULTATION Maternity staff at Mareeba Hospital have been informed of any service disruptions and have participated in the development of strategies to mitigate risk.

8. The Queensland Nurses and Midwives Union (QNMU) were invited to the initial project meeting. Since then the QNMU have been updated post-meetings by the Cairns and Hinterland HHS Director of Nursing and Midwifery, Rural and Remote Services.
9. As part of the Maternity By-pass procedure, it is the Medical Superintendent who informs stakeholders and partners such as Queensland Ambulance Service and Cairns Hospital Director of Obstetrics and Gynaecology Cairns Hospital of the By-pass arrangements.
10. Women scheduled to birth at Mareeba during the construction phase have been advised of disruptions to services and implications for planned birthing arrangements.

RESOURCE/FINANCIAL IMPLICATIONS

11. There are no resource or financial implications associated with this brief.

SENSITIVITIES/RISKS

12. The *Save Mareeba Hospital Services group* advocated for the return of endoscopy services to Mareeba. The Group has generated considerable media regarding Mareeba Hospital since 2017 when Mareeba Hospital's eligibility to be funded as a public health site under the Council of Australian Governments (COAG) *s19(2) Exemptions Initiative* ceased. The Initiative enabled Mareeba Hospital to claim against the Medicare Benefits Schedule for non-admitted, non-referred professional services and was used to resource primary community services.
13. The media and public and have been kept informed of the upgrade, the reduced services and progress with the endoscopy service via media releases and social media.
14. The Maternity By-pass poses a risk to pregnant women who present unexpectedly to Mareeba Hospital, requiring immediate surgical intervention.
    12.1 There is a risk of delays in access to Queensland Ambulance Service transfers for obstetric emergencies.

ATTACHMENTS

15. Attachment 1.Cairns and Hinterland HHS, Maternity Bypass from Rural Birthing Facilities

Author	**Cleared by (Dir/Snr Dir)**	**Content verified by (DDG/CE)**
Name: Dr Nikki Patching Position: Med Super Unit: Mareeba Hospital Tel No: [redacted] Date Drafted: 7 Oct 2019	Name: Gabrielle Honeywood Position: ED Rural and Remote Branch: CHHHS Tel No: [redacted] Date Cleared: 9 October 2019 **Note clearance contact is also key contact for brief queries**	Name: Clare Douglas Position: CE Division: CHHHS Tel No: [redacted] Date Verified: 10 October 2019

Procedure

Document Number: CHHHS-Clin-Proc-IWHU-594-V2-02/21
Version No. 2.0
Review Date: February 2021

Maternity Bypass from Rural Birthing Facilities Cairns and Hinterland Hospital and Health Service

Purpose

This Procedure describes the processes to be implemented in the event of no Medical Obstetric, Midwifery or Anaesthetic cover in Cairns and Hinterland Hospital and Health Services (CHHHS) rural birthing facilities i.e. Atherton, Mareeba, and Innisfail Hospitals.

Scope

This Procedure relates to all staff working in the CHHHS Maternity Units.

Procedure including roles and responsibilities

In the event where a CHHHS rural birthing facility has no Obstetric Medical, Midwifery or Anaesthetic cover the following process must be followed to initiate and communicate Maternity bypass.

The Rural Facility Medical Superintendent /Director of Nursing & Midwifery (DONM) /Facility Manager (FM) should send out an email outlining the reason for bypass, dates of intended bypass and the intended receiving facility to:

1. Rural Facility Medical Superintendents
2. CHHHS DONM/FMs
3. CH Nursing & Midwifery Nursing Director
4. CH Obstetrics and Gynaecology Clinical Director
5. Regional Maternity Services Coordinator
6. Executive Director of Rural and Remote Services
7. Director of Nursing Midwifery Rural and Remote Services
8. Medical Superintendent Hinterland and Cassowary

- Queensland Ambulance Service (QAS) should also be notified of any Maternity bypass occurring within the CHHHS.
- Confirmation of the notification email should be made by phoning the following:
    - CH Nursing & Midwifery Nursing Director: [redacted]
    - CH Obstetrics and Gynaecology Clinical Director: 42260000 (CH switch board)
    - CHHHS Regional Maternity Services Coordinator: [redacted]
    - Executive Director of Rural and Remote Services: [redacted]
    - Medical Superintendent Hinterland and Cassowary: [redacted]
    - CHHHS Patient Flow Unit: [redacted]
- The CHHHS Rural DONM/FM and Rural Facility Medical Superintendent of the receiving facility should also be phoned if Cairns Hospital is not the intended receiving hospital.

If no contact can be made or bypass occurs out of hours contact MUST be made to the following:

- **If Cairns Hospital is to be the receiving facility phone:**
    - On call CH Obstetric Registrar 42260000 (CH switch board);
    - CMC CH Birth Suite [redacted]
    - Patient Flow Unit [redacted] **AND**
    - Rural Facility Medical Superintendent on-call

OR

- **If Cairns Hospital is not the intended receiving facility phone:**
    - Rural Hospital DONM/FM on call of receiving facility,
    - Rural Facility Medical Superintendent on-call to contact on-call CH Obstetric Registrar 42260000 (CH switch board)
    - Patient Flow Unit [redacted] **AND**
    - Executive Officer on-call
- Bypass to be communicated to all Medical, Midwifery and Nursing staff at both bypass and receiving facilities
- Antenatal women to be notified of all bypass dates in advance (where possible) and the potential need to birth in another CHHHS facility
- Facilities that are able to accommodate low risk birthing must step down to a Clinical Services Capability Framework (CSCF) Level 2 Primary Midwifery Model of Care and must have in place risk management strategies consistent with Australian and New Zealand Risk Management Standard ISO 31000:2009 and clinical governance structure for midwifery models.
- Where women are to be transferred the responsibility of the midwife will be:
    - To assess the woman prior to transfer if she presents to bypass facility
        - Proceed with transfer if < 5cm dilated, if appropriate and notify receiving facility's midwife/birth suite team leader
        - To contact the on call O&G Consultant at Cairns Hospital if >5cm dilated or high risk
- Where possible, Midwifery Group Practice Caseload Midwives from bypass facilities will continue care for their labouring women at the receiving Maternity Unit.

Supporting documents

Type	Title	Document ID/link
Authorising Policy, Directive or Standard/s	• NSQHS Standard 6 – Communicating for Safety	Webpage link
	• Queensland Government Clinical Services Capability Framework for Public and Licensed Private health Facilities V3.2	Webpage link

Procedures, Guidelines, Protocols	• CHHHS Inter Hospital Transfer Procedure • QLD Maternity and Neonatal Operational Framework: o Non-urgent referral for antenatal care o Australasian College of Midwives: National Midwifery Guidelines for Consultation and Referral	CHHHS-Gen-Proc-CBH-399 Link Link

Audit Strategy

Level of risk	Moderate
Audit strategy	Clinical incidents/Monthly data collection reports
Audit tool attached	N/A
Audit date	Monthly clinical incident reports/Monthly data report
Audit responsibility	NUMs/O&G Medical Staff
Key elements / indicators / outcomes	100% compliance with procedure

Document Communication and Implementation Plan

Action	Responsible Position
Identify the target group: • All clinical staff working in Maternity Units in CHHHS	RMSC
Provide a time line for communication and implementation milestones: • Procedure already in place, communication when update published	RMSC
Identify method of communication: • Email • Procedures newsletter • CHHHS Intranet	RMSC Clinical Document Coordinator
List education and training available to support implementation: • N/A	N/A
Identify frequency of communication: • Following procedure updates	RMSC

Consultation

Key stakeholders (position and business area) who reviewed this version are:

- Midwives CHHHS
- Maternity NUMs CHHHS
- Directors of Nursing and Midwifery/Facility Managers CHHHS
- Medical Superintendents CHHHS
- Obstetrics & Gynaecology Consultants CH
- Obstetrics & Gynaecology Medical Staff CHHHS
- Clinical Director Obstetrics & Gynaecology CH
- Nursing & Midwifery Director Women's Health CH
- Director of Medical services CH
- Director of Medical services, Rural and Remote Services
- Director of Nursing Midwifery, Rural and Remote Services
- Director of Nursing Midwifery, CH
- Executive Director of Nursing & Midwifery CHHHS
- Executive Director of Medical Services CHHHS

Maternity Bypass from Rural Birthing Facilities

Procedure Approval

Approval Date: 28/06/2018	**Effective Date: 28/06/2018**	**Review Date: February 2021**

Approving Officer:	Dr Nicki Murdock **Executive Director Medical Services**	**Signature:**
Supersedes:	Maternity bypass, rural facilities	
Key Words:	Version 1.0	
Accreditation references:	http://qheps.health.qld.gov.au/cairns/html/quality-standards.htm	

Procedure Revision History

Version No.	Custodian (created/modified by)	Endorsing Officer/Committee	Authorising Approval
1.0 09/2014	NM Maternity Services Coordinator CHHHS	Clinical Director Obstetrics & Gynaecology, Cairns Hospital	Executive Director of Medical Services CHHHS
2.0 02/2018	NM Maternity Services Coordinator CHHHS	Clinical Director Obstetrics & Gynaecology, Cairns Hospital	Executive Director of Medical Services CHHHS

From: Erica Judd
To: DG Correspondence
Cc: Erica Judd
Subject: AMA Qld correspondence re Maternity Services
Date: Monday, 11 November 2019 3:53:17 PM
Attachments: AMAQ_DG_Maternity Services 11 11 19.pdf
Importance: High

Dear Dr Wakefield

Please find **attached** AMA Queensland correspondence regarding maternity services for your attention.

Kind regards

Erica Judd | PA to CEO & President | Australian Medical Association Queensland
88 L'Estrange Terrace, Kelvin Grove Q 4059 | PO Box 123, Red Hill Q 4059
T: 07 [redacted] | **E**: [redacted]com.au | **W**: amaq.com.au | **F**: 07 3856 4727
Facebook | **LinkedIn** | **Twitter** | **Instagram** | **YouTube**

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ACN: 009 660 280
ABN: 17 009 660 280

11 November 2019

Dr John Wakefield
Director-General Queensland Health
GPO Box 48
BRISBANE Qld 4001
By email: ***DG_Correspondence@health.qld.gov.au***

Dear Dr Wakefield

AMA Queensland is writing to you about a newly established Maternity Services Working Group and a perceived lack of progress by Queensland Health in addressing the recommendations contained in the Report from the Rural Maternity Services Taskforce.

Last week, AMA Queensland held the first meeting of a Maternity Services Working Group (MSWG) which has been formed to address a number of issues related to maternity services in Queensland, including the Rural Maternity Services Taskforce recommendations, education and upskilling opportunities for the maternity workforce and addressing the unmet needs of Aboriginal and Torres Strait Islander women.

The MSWG highlighted the lack of progress by Queensland Health in addressing the recommendations contained in the Report from the Rural Maternity Services Taskforce and poor communication with key stakeholders who were represented on the Rural Maternity Services Taskforce.

For instance, AMA Queensland understands that an internal committee has been established by Queensland Health to address the recommendations from the Rural Maternity Services Taskforce (headed by Assoc. Professor Rebecca Kimble Chair Queensland Maternity and Perinatal State-wide Clinical Network) and that no external representatives have been invited to participate.

There are a number of issues which members of the AMA Queensland Maternity Services Working Group wish to raise with you. Firstly, there seems to be a lack of transparency in the process of appointing members to the internal Queensland Health committee, and the lack of GP representation on this committee.

Secondly, if there is a GP representative, do they have sufficient experience in the delivery of maternity services in Queensland, particularly in rural and remote areas?

Thirdly, without a nominated representative being involved in the committee AMA Queensland is unable to contribute to the development of strategies to support implementation of the recommendations from the Rural Maternity Taskforce Report.

Last week, AMA Queensland was pleased to receive an invitation from Queensland Health to meet with Assoc. Professor Rebecca Kimble and Lisa Davies-Jones to obtain an update on progress in addressing the recommendations contained in the Report from the Rural Maternity Services Taskforce (since the Maternity Services Summit in June 2019), but our representatives left the meeting disappointed.

AMA Queensland was informed that since the Maternity Services Summit the only progress which had been made was the development of a draft implementation plan and formation of the internal committee. AMA Queensland was also informed that no additional resources had been allocated by Queensland Health to address the recommendations.

AMA Queensland believes there is an urgent need to address the recommendations contained in the Report from the Rural Maternity Services Taskforce and the lack of communication and engagement by Queensland Health in keeping AMA Queensland informed about progress on this issue is concerning.

AMA Queensland is seeking an urgent meeting with you to discuss these matters.

Yours sincerely

Dr Dilip Dhupelia
President
AMA Queensland

Jane Schmitt
Chief Executive Officer
AMA Queensland

From: Trish Nielsen
To: DG Correspondence
Cc: DDGCEQ
Subject: C-ECTF-19/13236
Date: Thursday, 14 November 2019 2:54:42 PM
Attachments: trish.nielsen-health.qld.gov.au_14-11-2019_14-50-24.pdf
image001.png
image002.png
image003.png
image004.png
image005.png
image006.png
image007.png
Importance: High

Hi Belinda

Please see the DG's comments on the attached letter from the AMAQ – reference as per subject line.

Would you please allocate to CEQ. I have cc'd them in as the DG has requested that this be actioned as a matter of urgency.

Thank you.
Trish

Trish Nielsen
Senior Executive Assistant to
Dr John Wakefield, Director-General

Phone: 07
Address: Level 14, 33 Charlotte Street Brisbane Qld 4000
Email : Trish.Nielsen@health.qld.gov.au

Queensland Health
Office of the Director-General

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Queensland's Health Vision: By 2026 Queenslanders will be among the healthiest people in the world.

Queensland Health acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and future.

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GPO Box 48
BRISBANE Qld 4001
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Yours sincerely

Dr Dilip Dhupelia
President
AMA Queensland

Jane Schmitt
Chief Executive Officer
AMA Queensland

Keith,
Please can you
- respond to this – contact them
- ASAP. and see if you can
- resolve.

Thanks.

DG 13/11/19