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Report to Department of Human services

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Contents:

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Aims of the 3 Centres Collaboration

The **3 Centres Collaboration** refers to the **collective decisions** undertaken by a joint Steering Group comprised of senior obstetric and midwifery managers from the Mercy Hospital for Women, the Royal Women's Hospital, Melbourne and Monash Medical Centre (Southern Health), and two senior Department of Human Services' [DHS] representatives. It also refers to the **joint work program** undertaken by various project teams and to the **core value** underpinning all working relationships.

The steering group is the primary decision-making body for guideline development, implementation and review but convened in 1999 with a single project focus - the development of evidence-based consensus guidelines for antenatal care. The group hoped the development and implementation of clinical practice guidelines would assist their respective centres to improve their quality of care and health outcomes, and reduce unnecessary interventions during pregnancy and childbirth.

The following aims were affirmed in December 2005 and underpin the work program which is currently being developed for 2006

According to the terms of reference the Collaboration exists to:

- **Provide a multidisciplinary, collaborative forum** for medical and midwifery leaders/managers in the tertiary hospitals to discuss matters of mutual interest/concern
- Participate in and sponsor **the development, review and implementation of clinical practice guidelines** (CPG's) for maternity care.
- **Enable the three centres to co-ordinate services and provide leadership** as tertiary referral centres for Victoria in collaboration with key professional groups.

The collaboration is supported by DHS. The funds are currently held and administered by Southern Health.

Guideline Review

The Clinical Practice Improvement Unit (CPIU) from the Royal Women's Hospital conducted the literature searches for each of the seven topics undergoing review. In order to gather midwives, obstetricians and GPs with experience in appraising research evidence, a Guideline Advisory Group (GAG) was convened. This group acted as a subcommittee of the 3Centres Steering Group. After much debate about overlapping interests of members and what skills were required the GAG was made up of 3 midwives (2 of whom had a lot of experience in research and were in the process of completing PhDs), 3 obstetricians, a GP representative nominated by GPDV and two consumers. Two of the obstetricians were also members of the Steering Group. The consumer representatives were selected after advertising via consumer advisory groups at each of the hospitals, the Centre for Consumer Participation in Health website and the Maternity Coalition. The Guideline Advisory Group evolved into a highly functional expert group, working its way through some very difficult evidence and debate to reach consensus.

As the CPIU gained experience and acted on feedback from the 3 Centres Steering Group they refined their processes and were able to produce evidence tables and recommendations which made it easier for the Guideline Advisory Group to assess and debate the evidence presented.

The experience gained from attendance at the Guidelines International Network (GIN) Conference at the end of 2004 was invaluable in enabling an international best practice model to be set up. (Within the limits of the budget and timeframes)

The topics reviewed were:

- Routine Weighing
- Number and timing of routine antenatal visits
- Hepatitis C
- Prevention of Early Onset Group B Streptococcal Disease
- Urinalysis for Proteinuria
- Asymptomatic Bacteriuria
- Prenatal Screening for Down syndrome

Education and training

The education and training function of the 3 Centres has largely been absorbed by the State Wide Antenatal Education Project. The antenatal education program was based on the 3 Centres guidelines which has raised awareness and the profile of 3 Centres. This project has also increased awareness of and demand for the "Guide to tests and investigations for uncomplicated pregnancies" booklet. The 3 Centres is likely to seek partnerships and liaise with projects such as this in the future rather than conduct further workshops itself.

Conferences, presentations and professional development

The Corangamite Clinical Management Group, centred in Camperdown, asked the project coordinator to talk to the group about clinical practice guideline development, appraisal and adaptation in November, 2005. Resources including the AGREE instrument and sources of well researched guidelines were shared.

The project coordinator took advantage of the free professional development opportunities afforded by Southern Health in 2005 and attended short courses in "Effective Time Management", "Business Writing" and a 2 day short course in "Introduction to Evidence Based Medicine." The latter was run by the Centre for Clinical Effectiveness.

Meetings

- The Steering Group met in June, September, October and December 2005. Membership was stable and attendance at meetings was consistent.
- The chair was held jointly by Denise Patterson, Director of Maternity Services and the Family Birth Centre, Mercy Hospital for Women, and Liz Chatham, Director, Women's Services, Royal Women's Hospital. Liz has been on maternity leave for much of 2005 but has attended most meetings and continued to provide input.
- The midwifery managers met with the Project Coordinator to discuss the work program whenever face to face communication was required.
- The project coordinator met with the Director of Nursing, Women's and Children's Program, Southern Health who has functioned as the line manager, on a monthly and as needs basis.

Coordination and Management

The Project Coordinator is responsible for actively managing the work program, and ensuring coordination and continuity for the Steering Group. Most communications are effected via email. The system of communication and feedback between the Project Coordinator and Steering Group members is generally timely, effective and efficient. Steering Group members have high level jobs with substantial work pressure and many responsibilities of which the 3centres is just one. The role of the coordinator is to keep enough focus on 3 Centres to keep the work program to schedule without making unreasonable demands. The 3 Centres Steering group has evolved into an effective team with high levels of trust and good will between members. Vigorous debate has taken place without jeopardising relationships. DHS representatives also have strong, positive relationships with the steering group and project coordinator.

3 Centres personnel may change in 2006 with a new leader of obstetrics at Southern Health to be appointed. The 3 Centres team thanks Dr Christine Tippett for her valuable input and expertise from 2002 through 2005.

The 3 Centres team also thanks Tanya Farrell, Acting Director of Maternity Services, Royal Women's Hospital who has provided valuable input into 3 Centres processes whilst Liz Chatham has been on maternity leave.

3 Centres Steering group 2005

Co-chairs: Liz Chatham, Director, Women's Services, RWH and **Denise Patterson**, Clinical Director, Obstetric and Maternity Services, MHW

Tanya Farrell, Acting Director, Women's Serives, RWH

Helen Gillies, DON, Women's and Children's Program, SH

Jeremy Oats, Medical Director, Women's Services, RWH

Christine Tippett, Director, Maternal-Fetal Medicine, SH

Bernadette White, Medical Director, Obstetric and Maternity Services, MHW

Trevor Sutherland, Manager Ambulance and Acute Programs, DHS

Wendy Dawson, Senior Project Officer, Programs Branch, Metropolitan Health and Aged Care Services, DHS

Principles

To the greatest extent possible our antenatal care is:

Safe & Scientific

The safety and wellbeing of mothers and babies is fundamental to maternity care

Care is based on relevant, evidence-based research and reviewed regularly

Woman-centred

Women are acknowledged as individuals who differ in their needs, values and preferences

Informed choice is an integral part of decision-making throughout the continuum of care

Equitable & Accessible

Care is available to women regardless of socioeconomic or cultural background, ability to pay, disability or place of residence

Cost Effective

Care is delivered in an efficient and cost effective manner to maximise health outcomes

Consultant and medical expertise is used where there is the greatest need or risk

Collaborative

Doctors, midwives and allied health staff adopt a multidisciplinary team approach to care, consultation and referral

Every woman is a partner in the decision-making process. Her support network is acknowledged and valued

Care providers and consumers are expected to treat each other with honesty and respect

A positive learning experience

Women are supported and prepared for pregnancy, birth and recovery

Doctors, midwives and allied health staff learn, practice and improve their skills. There is a positive environment for training undergraduates and postgraduates

Women are consulted regularly regarding their experiences of care and their insights considered in the planning, delivery and quality of maternity care.

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reached by the Guideline Advisory Group. The resulting guidelines have been well researched and robustly debated.

Fortunately the evidence for routine weighing, number and timing of antenatal visits, Hepatitis C and Asymptomatic bacteriuria was more straightforward and able to be debated and consensus reached at one meeting.

The Down syndrome screening topic is extremely complex and the literature searches required were beyond the scope of the work commissioned from the CPIU. The ever evolving changes in technology and the research required to make accurate assessment of the various options is beyond the budget and resources of the 3 Centres Collaboration. There are large studies being conducted in the United Kingdom and it seemed more prudent to wait for international and national research than to make new recommendations which may have policy, infrastructure and resource implications beyond the sphere of influence of the 3 Centres.

Key lessons and recommendations from the Guideline review process:

- In the next review process the research questions will need to be re-written. This update to the guidelines was restricted by the original research questions. In many cases different research questions would have been more helpful in revising the guidelines.
- The Guideline Advisory Group was a highly functional and skilled multidisciplinary group and has provided a model which could be utilised in the future.
- The consumer representatives provided valuable perspectives where appropriate and coped well with the research evidence. Judiciously, they left the clinical debates to the clinicians.
- There was a cross over of personnel between the CPIU, The Guideline Advisory Group and the Steering Group. This caused some concerns and potential conflicts of interest but all problems were overcome through open discussion and with integrity. The membership of the 3 groups, their responsibilities, segregation and reporting processes could all be decided at the outset next time. In 2004/05, this process was new and therefore evolved over a period of months with difficulties being encountered and resolved as they arose.
- International experience suggests that rigorous guideline development is a $500,000, 3 year process. Resource sharing and adaptation of guidelines is the way of the future.
- The United Kingdom, National Institute for Clinical Excellence is due to publishes guidelines on Intrapartum care, Diabetes in pregnancy, Antenatal and postnatal Mental Health and Postnatal care over the next 2-3 years. These could prove to be valuable documents for adaptation to the Victorian context.
- The planning and review process has been slower than expected but a lot has been achieved on a relatively small budget.

The Steering group plans to publish the revised guidelines to the web and not to print hard copies to make future amendments more economical. Desk top publishing expertise will be sought early in 2006 in order to make the new guidelines widely available as soon as possible. An n official launch and publicity strategy will take place in early 2006.

Consumer Information

The “orange book”, “A guide to tests and investigations for uncomplicated pregnancies” has been distributed widely throughout the state with 20,000 copies sold in 2005. Approximately 15,000 copies were distributed by the 3 Centres and the other 5,000 have been purchased by 21 different health services throughout Victoria and one health service in Tasmania. Minor revisions to reflect the revised guidelines have been made and a print run of 25,000 is currently being printed. It is expected that more will be required before the end of 2006. The State wide pregnancy education project and the VMR have played a large role in promoting the booklet throughout Victoria. Consumer feedback from the VMR evaluation and further staff consultation will inform a major update to the information midway through 2006. This booklet has been a very effective tool for promoting the 3 Centres guidelines and has filled and important gap in evidence based consumer information about the test and investigations in pregnancy for many health services and the women they care for. Access to the booklet very early in pregnancy and staff training to optimise the effectiveness of the booklet are two aspects that could be further improved in 2006. Ideally GPs would have copies of the booklet available for women as soon as they confirm their pregnancy.

Audit Tool

The objectives of the 3 Centres audit are:

- to develop a tool to monitor compliance and appropriate application of the 3 Centres guidelines,
- to undertake a pre and post implementation audit and provide a report of findings to the Collaboration.

Outcomes will provide benchmarking opportunities, identify where further implementation interventions are required, detect changes in pre and post 3 Centres guidelines antenatal care. These benchmarks will also provide useful comparative information when the guideline review is completed and guideline updates are implemented and audited. The tool should be able to be used by other agencies to help them detect where improvements to care are required.

The Steering Group decided to engage the services of Dr Marie Pirotta from the Melbourne University Department of General Practice to lead the audit. Dr Pirotta and a statistician from her department were commissioned for 80 hours of consultancy to develop the database, provide the statisitical analysis and interpretation and write the report.

After many meetings and much debate audit items were agreed to by the 3 Centres Steering group and Dr Pirotta. The tool was built on a Microsoft Access platform with data being entered directly onto laptop computers. Each of the 3 Centres provided a laptop, an electronically generated list of histories for pre and post audit and a midwife auditor. An audit coordinator with expertise in record management was appointed at each site and asked to be on call if the auditors needed help interpreting records. The three auditors worked for 3 days at each site conducting the pre and post audit.. Many difficulties were encountered with obtaining enough histories which met the inclusion criteria, getting through the workload at the first site, agreeing on interpretation of the notes and what constituted a valid response, and personnel issues. Team work and support from senior management, the administration staff and medical records staff at each of the 3 sites enabled the process to be successfully completed. The initial data “cleaning” process uncovered several problems requiring the midwife auditors to was hoped that it would be finished by December 2005 but there were delays caused by relevant personnel being on annual leave, and The Mercy Hospital relocation and accreditation process access records electronically in order to fill the gaps. This process has recently been completed and the data is being analysed by the Melbourne University team. The report is now due to be completed in January 2006. It.

Key learning and recommendations:

- 80 hours of consultancy does not go very far! Much additional work has been required from the 3Centres project coordinator to achieve the objectives of the audit.
- Getting the right people to conduct an audit is essential as not every personality type is suited to the concentration and attention to detail required. Staff should volunteer for the job, not be coerced or forced to do it. People work at varying speeds and this can cause difficulties if not carefully managed. An incentive payment helped motivate the auditors as they would probably find their normal work an easier option!
- At least 50% more histories than the target number were needed as there were many exclusions which were not be picked up via the electronic systems. This should get easier as electronic record systems evolve and contain more patient detail.

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3 Centres Collaboration Report to DHS December, 2004