Implementing Visiting Access for Medicare Eligible Midwives

A Guide for Hospitals and Health Services
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Australian College of Midwives

The Australian College of Midwives (ACM) is a national, not-for-profit organisation which is the peak professional body for midwives in Australia. The College was founded nationally in 1984, when midwifery associations in a number of States and Territories came together to create a national peak body for Australian midwives.

The College strives to maximize the quality of midwifery and maternity care for Australian women and their families through:

- Providing a unified voice for the midwifery profession.
- Supporting midwives to reach their full potential.
- Ensuring all childbearing women have access to continuity of care by a known midwife.
- Setting professional practice and education standards

The ACM's work is guided by the following values:

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<tr>
<th>Ethical practice</th>
<th>Applying evidence to everything we do. NMBA code of ethics, conduct, practice and standards.</th>
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<tbody>
<tr>
<td>Collaboration</td>
<td>The NHMRC defines collaboration as “In maternity care, collaboration is a dynamic process of facilitating communication, trust and pathways that enable health professionals to provide safe, woman-centred care. Collaborative maternity care enables women to be active participants in their care. Collaboration includes clearly defined roles and responsibilities for everyone involved in the woman’s care, especially for the person the woman sees as her maternity care coordinator”</td>
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<th>Ethical practice</th>
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<th>Ethical practice</th>
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<th>Ethical practice</th>
<th>Innovation</th>
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<td>Be open to new ideas and understand that there is always another way and that anything is possible •Striving for continuous improvement</td>
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The Australian College of Midwives provides support and advocacy for privately practising midwives.

Introduction

This guide was originally developed by the Nursing and Midwifery Office of Queensland (NMOQ) as a “how to” guide for public hospitals and Health Services (HS) in Queensland to effectively work with Medicare eligible midwives to give women more options for maternity care. The NMOQ kindly gifted the guide to the Australian College of Midwives, who have adapted the guide for use nationally.

This guide is designed to support hospital and health service staff who are implementing new maternity care models. The College recognises that the guide may not be applicable for all jurisdictions and local adaptations will need to occur to ensure the implementation of workable models for differing contexts. The ACM hope you find both the guide and the examples provided to be of assistance in implementing increased access to woman-centred midwifery and supporting continuity of care provided by private midwives.

The College acknowledges the innovative work by the NMOQ and appreciates their generosity in sharing their intellectual property for the benefit of midwives, women and families across Australia.

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Section 1: Background

Commonwealth reforms
The Australian Government introduced a range of Australia-wide reforms, implemented in 2010, intended to improve women’s access to continuity of midwifery care in the private system. Some of the reforms included:

- A range of antenatal, intrapartum and postnatal MBS rebates were enabled by the Commonwealth, for services provided by Medicare eligible midwives in private practice2.
- The “eligible midwife” notation was introduced by the Nurses and Midwives Board of Australia (NMBA)3, enabling access to Medicare provider numbers by eligible midwives.
- An “endorsement for scheduled medicines” was introduced by the NMBA4, allowing Medicare eligible midwives to prescribe.
- Reforms of States’ and Territories’ drugs and poisons legislation occurred to legalise prescribing by midwives with an ‘endorsement for scheduled medicines’. 
- Commonwealth-subsidised professional indemnity insurance was made available to Medicare eligible midwives.

These reforms are described in the National Maternity Services Plan 2010-2015 (The Plan)5 and have been endorsed by State and Territory Governments.

Public and private maternity services should be collaborating with Medicare eligible midwives. Scope also exists for maternity services to establish hybrid models in which antenatal and postnatal care is provided privately by Medicare eligible midwives, and for some rural or remote facilities to access Medicare rebates for antenatal and postnatal care by Medicare eligible employed staff midwives under Section 19.2 of the Health Insurance Act 1973 exemptions6.

Medicare eligible midwives
Medicare eligible midwives are enabled to provide MBS-rebatable services. Midwives do not have to

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4 See above
PBS and the Nursing and Midwifery National prescribing Formulary for midwives\(^7\).

The benefits of eligibility are that women may be admitted to hospital as a private client of a midwife in the same way as they can be admitted under the care of a private obstetrician. Women are able to claim some of the costs of private midwifery care from Medicare. This increases options for women and includes increased access to private models of maternity care. Eligibility allows privately practising midwives greater opportunities to extend their practice and work collaboratively with HS. In turn, the advantage of eligibility for the HS is that financial savings are made midwifery care is at no cost to the HS and reductions in acute care demand are achieved by the continuity of midwifery care model.

**Medicare Provider**

Once a midwife has notation as a Medicare eligible midwife they are able to apply for a Medicare provider number. This enables the Medicare eligible midwife to provide MBS-rebatable services for antenatal care, birth care in hospital and postnatal care, subject to certain conditions.

MBS rebates are available for a range of midwifery services\(^8\).

**Collaborative Arrangements\(^9\)**

The legislation that outlines the requirements that a midwife must meet in order to become a Medicare eligible midwife is known as the National Health Determination 2010\(^10\). ‘The Determination’ was amended in July 2013\(^11\) to further expand opportunities for Medicare eligible midwives.

Payment of MBS rebates for services of Medicare eligible midwives is conditional on the midwife providing the service under a “collaborative arrangement” with one or more “specified medical practitioners”\(^12\). “Specified medical practitioners” are defined as:

- an obstetrician;
- a medical practitioner who provides obstetric services; or
- a medical practitioner employed or engaged by a hospital authority and authorised by the hospital authority to participate in a collaborative arrangement.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the Australian College of Midwives jointly approved principles that underpin communication between Medicare eligible midwives and Obstetricians (GP or specialist).

**What is a collaborative arrangement?**

A collaborative arrangement is a legislative requirement for Medicare eligible midwives to have in place in order for women to be able to claim Medicare rebates for the private midwifery care provided by Medicare eligible midwives.

With a collaborative arrangement in place, an Medicare eligible midwife may provide birthing services to a woman under her private care in a public hospital.

Collaborative arrangement allow obstetric participation and intervention when necessary whilst supporting continuity of care provided by a private midwife.

In brief, there are five options for "collaborative arrangements":

- Midwife is employed or engaged by an obstetrician or medical specified practitioner who provides obstetric services, or an entity which employs at least one obstetric specified doctor
- Midwife has a signed agreement with a specified doctor (who could be authorised by a hospital authority)
- Midwife provides care to a woman referred to her by a specified doctor, or medical practitioner at a hospital who is authorised to participate in collaborative arrangements
- Midwife follows a documentation trail with a named doctor acknowledging care ("midwife’s written records") – a complex process outlined in the ’Determination’
- Midwife is credentialed for a hospital, meaning the midwife has successfully undergone a formal process to assess the midwife’s ability to provide safe, high quality maternity care at the hospital. Midwife is granted a defined scope of clinical practice for the hospital, and is authorised to provide midwifery care to his or her own patients privately at the hospital. The hospital must employ or engage at least one specified medical practitioner.

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The requirement for “collaborative arrangements” does not give doctors responsibility for the practice of Medicare eligible midwives, as they are separately regulated health practitioners. Additionally, according to Government statements in Parliament and consistent with the National Health and Medical Research Councils’ National Guidance on Collaborative Maternity Care, the requirement for “collaborative arrangements” is not intended “to provide a right of veto over another health professional’s practice.” The purpose of the requirement, as described in the legislation, is to provide for ease of consultation, referral or transfer when the woman’s care requires it.

**Insurance**

All private practice (self-employed) midwives require insurance to cover all aspects of the care they provide. The only exception is intrapartum care in the home, which is exempt from the insurance requirement until the end of December 2016.

Medicare eligible midwives can purchase the government-subsidised insurance package from Medical Insurance Group Australia (MIGA) insurance. This insurance package requires midwives to fulfil a number of additional requirements including participation in risk management programs. The MIGA product does not cover birth in the woman’s home but does cover private birth care in hospital.

**Credentialing**

With eligible midwives providing services which attract a Medicare rebate for intrapartum care in hospital, there is now a need for credentialing processes for midwives, similar to those for visiting medical officers (VMOs). A process of credentialing may be required as part of any visiting access agreement for Medicare eligible midwives providing care to women who are admitted as private patients in a public health service.

**Visiting Access**

For women to be able to receive continuity of carer from their private midwife and plan to birth in a recognised health service, mechanisms for visiting access by Medicare eligible midwives to public and private health services are necessary.

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All States and Territories committed to facilitating women’s access to in-hospital care by Medicare eligible midwives in the National Maternity Services Plan.

At the time of writing, the following jurisdictions have policy in place; Queensland, Victoria, Western Australia and South Australia.

**Models and Options**

Medicare funding is relatively new and associated midwifery models of care continue to be established and refined.

Parameters for consideration:

1. Midwives must be notated as Medicare eligible, and have Medicare provider numbers

2. Midwives must have professional indemnity insurance and practice within associated limitations

3. Midwives must provide services within private practice (with limited rural and remote exceptions under section 19.2 of the Health Insurance Act 1973) – see below.

4. Care provision must involve a “collaborative” arrangement

5. Intrapartum care outside a hospital does not attract a Medicare rebate

6. Intrapartum care in hospital must be for a woman who is admitted as a private patient to attract Medicare rebates

7. Midwives providing care in hospital must be credentialled by the hospital and have an access agreement to enable them to admit women as private patients

8. Medicare eligible midwives need to maintain currency across the full scope of midwifery practice.

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1D1/$FILE/Eligible%20Midwives%20%26%20Collaborative%20Arrangements.pdf


Within these parameters, the following models are possible options:

| Private midwifery group practice models providing midwifery continuity of care | These model are possibly the most likely to develop in a relatively short time frame, and early models are operating. Midwives in private midwifery group practices will approach public hospitals seeking collaborative arrangements for antenatal and postnatal care. They will also seek credentialing and visiting access to provide Medicare-funded intrapartum care as a visiting practitioner. Examples of this model operate in Queensland at Toowoomba Base and Gold Coast Hospitals. |
| Solo midwives with a Medicare provider number providing midwifery continuity of care | Midwives in solo private practice will require the same arrangements and use the same documentation, processes and pathways as midwives in private group practices. An example of this model operates at Bundaberg Hospital in Queensland. |
| Midwives providing an element of midwifery care | The opportunity also exists for midwives to provide one element of care – such as only antenatal or only postnatal care. Whilst the Medicare eligible midwife has to maintain currency across the full scope of midwifery practice, the midwife may provide one element in private practice and maintain currency in the remaining elements in employed practice. Examples of this are lactation consultant services and antenatal education services. |
| Hybrid private + public models | Women may be able to receive continuity of midwifery carer with their midwife in private practice for antenatal and postnatal care, and with the midwife working in employed public hospital practice for intrapartum care. This model will depend on good collaboration between private midwives and public hospital management. An example of this model is available in Queensland at Toowoomba Hospital. Rural GP-obstetricians frequently work under arrangements of this type. |
| Section 19.2 Rural and remote public facilities | Section 19.2 of the Health Insurance Act 1973 allows specific public facilities to be enabled by Ministers to work under different funding rules. Section 19.2 allows public hospital employees to provide MBS-rebated outpatient services in declared rural and remote locations. In these locations Medicare eligible midwives might work as employees while providing MBS bulk-billed outpatient care. |
| Aboriginal Medical Services or other entities | A Medicare eligible midwife employed in an Aboriginal Medical Service (AMS), which also employs an obstetrician or specified medical practitioner, would meet the requirements of option 1 for "collaborative arrangements". Such a midwife could also be employed by a public facility for provision of intrapartum care. Private midwives working with an AMS could enter a licence/access agreement with a public hospital. An example of this model is available in Queensland at Dalby Hospital with Goondir AMS. |
| Midwives employed by private obstetricians or specified medical practitioners | Some private specialist obstetricians or specified medical practitioner may employ Medicare eligible midwives in their practices. These midwives could potentially provide care in public or private hospitals as well as in doctors’ rooms. However, they may not provide Medicare-rebatable intrapartum care if the doctor plans to deliver the baby. |
| Private hospitals | Medicare eligible midwives could provide intrapartum care in private hospitals, in private midwifery practice. This would require cooperation with private obstetricians, and supportive health service management. |


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Section 2: Steps to access by Medicare eligible midwives

The recommended steps to enable Medicare eligible midwives to admit women to hospitals/health services for Medicare-rebated care are listed here, and discussed further in the following pages. These steps are intended as a guide only and may require adaptation to suit different locations and jurisdictions.

Five steps for the implementation of access by Medicare eligible midwives

| Preparation | • Delegation of management responsibilities  
             | • Establish a steering committee to oversee Medicare eligible midwife arrangements  
             | • Identify local needs and issues. |
| Credentialing | • Develop a credentialing process to ensure competence of Medicare eligible midwives using hospital facilities  
               | • Establish a credentialing committee, including an application form, a statement of credentialing and a process to review the conduct of the credentialed midwife if a problem occurs. |
| License Agreement | • Draft and endorse an access licence agreement document, defining the terms of access to hospital facilities by each Medicare eligible midwife  
                    | • This may include provision for a “signed agreement” collaborative arrangement. |
| Administrative Systems | Develop, document and approve processes and pathways for Medicare eligible midwives’ interactions with the hospital, including:  
                          | • Access to local computer systems to admit private clients, access results and fulfill other administration requirements  
                          | • Orientation to the service and access to mandatory continuing professional development  
                          | • Provisions for parking and storage of essential items. |
| Models to Enable Continuity | Consider mechanisms to ensure continuity of midwifery care for women, including:  
                            | • Processes for women admitted as private patients who require obstetric care. This may include options such as employment of the private midwife and/or agreement by medical staff to treat the woman as a private patient  
                            | • Options for non-insured women to access continuity for intrapartum care, including employment arrangements for Medicare eligible midwives. |
Step 1: Preparation
Implementing public-private partnership midwifery models involves significant cultural change within services and requires high level leadership and support. Preparation involves the steps taken by senior management to enable the establishment of a new model of care.

1. The Chief Executive Officer (CEO) of the HHS\(^{21}\) acknowledges that a private practice midwifery partnership is a model of care that is appropriate for the maternity services within the HS.

2. The CEO procures an executive sponsor (usually the Executive Director of Nursing and Midwifery, or Director of Midwifery (or equivalent)) who is responsible for leading the establishment of the new model of care provision.

3. The executive sponsor convenes a steering group to oversee the implementation of the partnership model (sample terms of reference (TOR) are available at Appendix 1).

4. If the HS already has a steering committee for an existing midwifery model of care the TOR of the existing committee could be modified and this group used to oversee the implementation of the public-private partnership model.

5. The executive sponsor or delegate (usually the Director of Nursing and Midwifery) identifies and contacts local internal and external stakeholders, including local privately practising midwives, who may be potential steering committee members. Including stakeholders on the steering committee is designed to ensure relevant and appropriate consultation takes place throughout the development of the credentialing process.

6. The steering committee develops an implementation plan with targets and time lines; this plan determines the scope of the partnership, outlines processes for consultation, and includes an evaluation strategy, and is based on local needs.

7. The executive sponsor/delegate ensures that the credentialing process, licence agreement and collaborative arrangement processes are in place.

8. The steering committee develops and sends out an expression of interest to local privately practicing midwives inviting them to apply for visiting access and credentialing.

9. The steering committee monitors the progress and evaluation of the implementation of the model.

Step 2: Credentialing
Credentialing of Medicare eligible midwives follows the same processes used in the existing routine credentialing and defining a scope of practice for medical staff. Equivalent processes have been developed for credentialing of nurse practitioners. In most cases, the documentation Medicare eligible midwives have assembled for their application to AHPRA for notation as Medicare eligible and their professional practice review (Midwifery Practice Review) will meet most requirements of the HS credentialing committee.

1. If the HS has a nursing credentialing committee for nurse practitioners, approach the chair and get agreement to include credentialing for Medicare eligible midwives. If not, approach the chair of the HS credentialing committee and seek agreement to form a midwifery sub-committee.

2. Speak with the administration support for the existing credentialing committee to get an understanding of how the committee processes work and the timeframes.

3. If forming a new sub-committee, develop a draft TOR (example available in Appendix 2). The facility Director of Nursing and/or Midwifery will need to approve the TOR.

4. If a nursing credentialing committee already exists, negotiate changes to the membership and terms of reference to ensure the appropriate midwifery expertise is incorporated, including a midwife who is or has had experience of being a privately practising midwife.

5. The credentialing committee administration support will send out and receive application forms (example available in Appendix 3) to/from any Medicare eligible midwife who applies for credentialing. NB: Appendix 3 may need to be re-visited depending on changes that the NMBA make to registration standards for midwives in 2015.

6. The credentialing committee administration support will usually ensure that all the required documentation has been supplied by the

\(^{21}\) This terminology changes in each jurisdiction e.g. Local Health District, Local Health Network
midwife (example checklist available in Appendix 4) and references from the nominated referees (example reference document available in the Appendix 5) have been received before sending the documentation to the chairs of both the overarching credentialing committee and the midwifery credentialing sub-committee.

7. Temporary credentialing is authorised by the chair of the overarching credentialing committee and the midwife is notified.

8. The chair of the midwifery subcommittee ensures that the documents are sent to the members of the committee for consideration prior to the next meeting.

9. The sub-committee meets and makes a recommendation which is recorded in the sub-committee minutes, and the chair ensures that the overarching credentialing committee endorses the sub-committee’s recommendations.

10. The chair of the overarching credentialing committee sends a memo to the HS Chief Executive Officer (CEO or equivalent) endorsing the sub-committee’s recommendation (example of letter available in Appendix 6).

11. The CEO notifies the midwife of the credentialed scope of practice (example of credentialed scope of practice available in Appendix 7).

12. If the midwife’s application for credentialing is not supported, the CEO notifies the midwife of the reason and supplies information on appeal processes.

Step 3: License Agreement

In order to use the facilities and resources of the HS Medicare eligible midwives will need to enter into a contract with the HS. A licence agreement contains the agreed elements of the contract between the midwife and the HS, providing clear terms and conditions for the use of the facilities and resources.

The following elements are recommended, but not limited to:

1. Term of the agreement
2. Agreed access to premises and facilities
3. Agreed use of the premises and facilities
4. Agreed use of resources such as telephones, car park, staff
5. Agreed fees and expenses
6. Governance for safety and quality
7. Insurances required
8. Indemnity and limitation of liability
9. Confidentiality
10. Agreed dispute resolution process
11. Termination of the contract

The process in Queensland was as follows:

Two licence agreements, Toowoomba and Gold Coast (see Appendix 8) are currently in operation in Queensland. Both licence agreements have been through an extensive legal process of endorsement both by the local HS legal department and the midwives’ insurer MIGA. The Toowoomba Licence Agreement also requires a collaborative arrangement document (see Appendix 9).

Step 4: Administrative Processes

Medicare eligible midwives with visiting rights need to be provided with orientation and access to appropriate systems. This will usually be coordinated by the midwifery manager responsible for the clinical area.

The following elements are recommended, but are not limited to:

Orientation to the Clinical Unit (including antenatal, birth and postnatal areas):

- Introduction to maternity unit staff, and key staff in other areas of the hospital
- Security access and identification, including after-hours access to all relevant areas
- Fire and safety
- Workplace health and safety
• Infection control processes and waste disposal
• Emergency procedures
• Support services such as team leader, administration, house keeping
• Physical layout of the unit, with particular focus on emergency equipment
• Documentation requirements
• Parking, including appropriate parking provisions for visiting midwives.

Access to Clinical and Administration Programs:
• Admission/discharge processes and access to computer systems for same
• Medical records systems and access to computer systems and personnel for same (including after-hours processes for retrieval and return of charts)
• Pathology/diagnostics and pharmacology systems and access to computer systems both internally (within hospital) and externally (for midwife when outside hospital) for same. Ensure after-hours processes for urgent pathology are clear.
• Billing systems and processes for access to personnel who assist with billing
• Birth registration and perinatal data collection systems.

Clinical Governance:
• Communication pathways including ACM National Midwifery Guidelines for Consultation and Referral Guidelines (examples available in Appendix 10)
• Access to in-house mandatory continuing professional development
• Access to clinical practice guidelines and work instructions
• Access to risk-assessment forms and processes
• Access to perinatal morbidity and mortality review meetings
• Formal introduction to senior decision-making staff.

Step 5: Models to Enable Continuity
Engagement between public hospitals and Medicare eligible midwives is able to deliver greatly improved continuity of carer to women. This brings increased satisfaction and a range of clinical benefits to women and babies. In addition, there are significant financial and clinical benefits to hospitals from collaborating with Medicare eligible midwives, and these benefits are largely dependent on achieving maximum continuity.

Delivering continuity in the context of women’s different clinical needs and financial and private health insurance circumstances requires a range of care options. Some women will need transfer to public care for part of their care, and achieving continuity will depend on flexible and evolving arrangements between the hospital and Medicare eligible midwife.

When planning options for collaborating with Medicare eligible midwives, managers should keep in mind that any part of care provided by an Medicare eligible midwife yields a significant financial benefit to the HS. Managers are encouraged to consider models of collaboration with Medicare eligible midwives that include an element of employment (e.g. fractional employment under the caseload award, for intrapartum care) to facilitate provision of care by Medicare eligible midwives to a wider range of women, and deliver financial and clinical benefits to the HS.

A range of models are possible for maximising continuity and have been discussed on page 8 (see also Appendix 11) Medicare eligible midwives and HSs may mix and match models to suit each woman’s needs and financial circumstances. It is important to recognise that women employing Medicare eligible midwives will expect maximum continuity of care from their midwife, and will expect public hospitals to take reasonable steps to facilitate this.
Appendix 1- Example Terms of Reference Collaborative Arrangements Steering Committee

Committee Purpose

The purpose of Collaborative arrangements Committee is to:

- Streamline access for consultation, referral and transfer options
- Provide strategic advice and recommendations
- Guide the development of clear consultation and referral pathways

The committee should consider relevant local, state and national plans, Australian standards, relevant legislation and professional guidelines.

Membership

The Committee members shall be appointed by the CEO.

- Director of Nursing and Midwifery Services
- Consumer representative
- Director for Health Information Services
- Director Midwifery
- Director of Medical Services
- Director of Obstetrics
- GP representative
- Private Practice Midwives
- Midwifery Unit Managers

Quorum Arrangements

The quorum for the Collaborative Arrangement Committee meetings will be half the committee number plus one

Scope of the Committee

The Collaborative Arrangement Committee undertakes the following:

- Map an agreed pathway of care between Private Practice Midwives and the Hospital and Health Service (HHS)
- Supports collaboration between all parties
- Endorsement of resources
- Develop an implementation plan
- Oversees the credentialing process
- Facilitates the process of endorsing the licence agreement

Frequency of Meetings

- Fortnightly/Monthly/Bi-monthly
- [day][time]

Chair

The Chair will be appointed by the CEO.

Reporting Responsibilities
The Collaborative Arrangement Committee provides the following reports:

- Reports to the CEO

**Issue Escalation**

Issues unable to be resolved by the Collaborative Arrangement Committee are escalated to Executive Director of Nursing and Midwifery Services

**Additional Notation**

Members of the committee are governed by the [insert relevant] Confidentiality Agreement for all employees

All minutes and documentation from the committee shall be stored as per requirements of [insert relevant]
Appendix 2 – Example Terms of Reference Credentialing Committee

Credentialing and Defining Scope of Clinical Practice Committee (Credentialing Committee)

Membership

The core credentialing committee is responsible for reviewing an applicant’s credentials and requested scope of clinical practice and recommending to the Chief Executive Officer (CEO) or delegate, a scope of clinical practice for the applicant.

The Committee members shall be appointed by the CEO merit following an Expression of Interest (EOI) process. The CEO may on occasion invite representatives to join the committee outside of the EOI process.

The credentialing committee should be comprised of at least five members including:

- Director of Nursing and Midwifery or delegate
- Midwife who possess the knowledge and experience to provide independent high quality advice
- Senior midwife in the applicant’s clinical area of expertise
- Midwifery education representative (University/Hospital)
- Medical practitioner who possess the knowledge and experience to provide independent high quality advice

Quorum arrangements

The quorum for the Credentialing Committee meetings will be half the committee number plus one (or no less than three for a five member committee)

Length of appointments

Each member of the Committee shall be appointed by the CEO for a term of 3 years and is Medicare eligible to apply for one further 3 year term up to a maximum of six consecutive years on the Committee. At the end of the maximum term of appointment (2 terms of 3 years each), individuals shall be required to undertake a period of ‘downtime’ for a minimum of 2 years before being appointed onto the Committee again unless they are specifically appointed by the CEO to the Committee at the end of this period. Members of the Committee may resign their position with 4 weeks’ notice in writing of their intention to do so.

Chair

The Committee shall be chaired by a member of the Committee as approved by the CEO.

Frequency of meetings

This may be determined locally based on requirements and the volume of work of the credentialing committee. The chair may convene an extraordinary meeting where in the opinion of the chair a matter should not reasonably wait for the next meeting of the credentialing committee.

Role and function of the credentialing committee

The credentialing committee must at all times conduct itself in accordance with relevant legislation including but not limited to legislation relating to privacy, trade practices, equal opportunity, and defamation. Each credentialing committee must obtain a written undertaking from each member of the committee that they will abide by the credentialing committee’s terms of reference and procedures.
The Credentialing Committee will:

- Follow the established terms of reference, written protocols and procedures for evaluation of credentials and defining the scope of clinical practice as stipulated in the institution's policy
- Maintain confidentiality throughout all processes
- Ensure that all members understand that their role is to bring to the credentialing committee relevant expertise and experience and not to act in a way that represents their personal interests
- Produce a timetable for the introduction and periodic formal review and verification of the credentials and scope of clinical practice of all practitioners with existing appointments
- Undertake the process of assessing credentials and recommending appropriate scopes of clinical practice for new applicants
- Determine specific criteria with reference to the job description of an Medicare eligible midwife
- Make recommendations to the CEO or delegate in respect of all Medicare eligible midwives whose scope of clinical practice has been considered
- Ensure comprehensive records of all deliberations and recommendations of the credentialing committee are maintained as per the provisions of the [insert relevant body]
- Ensure that the credentialing and defining the scope of clinical practice process is conducted in a fair, transparent, timely and legally robust manner.

Requirement to comply with principles of natural justice and procedural fairness

The credentialing committee's determinations and deliberations must at all times be carried out in accordance with the principles of natural justice and procedural fairness.

The credentialing committee must, as a minimum, adhere to the following principles of natural justice and procedural fairness:

- Act fairly, in good faith and without bias or perception of bias
- Ensure all relevant documents which are being considered by the credentialing committee are disclosed in a timely manner to the parties concerned
- Ensure, where relevant, the applicant knows what allegations/claims are made against them
- Allow the applicant sufficient time to prepare their responses to those issues or claims
- Ensure the applicant is given the opportunity to adequately state their case and correct or contradict any statement prejudicial to their case
- All members of the credentialing committee must declare if there is any actual or perceived bias and/or conflict of interest and manage those in consultation with the chair. Appropriate management may range from merely declaring the conflict, through to resignation from the credentialing committee.
- When a committee member is excluded he/she must physically leave the meeting, and must not take any action to influence the credentialing committee's deliberations.
- When a member is excluded, the reason for that exclusion should be documented in the minutes of the credentialing committee meeting.
- It is essential that any decision maker who is in competition or stands to benefit from any outcome of the proceedings declare that conflict, and manage it in a transparent and appropriate manner.

Documentation / written procedures

The credentialing committee, in consultation with the relevant CEO, must ensure that written procedures for dealing with the process of assessment of credentials and delineation of scope of clinical practice is in place

Any documents obtained or created by the credentialing committee will be accessible under the Right to Information Act 2009 and other court processes, for example, subpoena.

Education and training
On appointment, core credentialing committee members shall be provided with local education and training by the Chair to assist them in their role on the committee. Members must be informed that their responsibility is to bring to the credentialing committee their experience and expertise, rather than to act as a representative of any nominating organisation.

*Indemnity of committee members*

Members of the credentialing committee are indemnified in accordance with [insert relevant institution] indemnity arrangements.

These Terms of Reference will be reviewed in [insert relevant month] of each year in conjunction with the annual committee performance evaluation.
Appendix 3 - Example Application for defining Scope of Clinical Practice

Information included on this application is for Medicare eligible midwife credentialing. The information requested on this application form is additional to information contained within your current CV. Please attach certified copies of your:

- Qualifications
- Registration
- Insurance
- Midwifery Practice Review completion certificate

Access to this information is limited to the credentialing committee.

<table>
<thead>
<tr>
<th>Application Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Medicare eligible Midwife</td>
</tr>
<tr>
<td>[ ] Medicare eligible Midwife</td>
</tr>
</tbody>
</table>

[ ] New Application  [ ] Scheduled Review Application  [ ] Additional/Changed scope of clinical practice

Personal Details:

Last name:  
First Name/s:  

Previous Name: (Please include your previous name if that appears on certificates)

Date of Birth:  
Gender:  

Address Details:

Home Address: Preferred Address for Correspondence:  
Work Address: Preferred Address for Correspondence:

Phone/Fax/Email Contacts:

Home:  
Work:  
Mobile:  
Fax:  
Email 1:  
Email 2:  

PROFESSIONAL INDEMNITY (Please Attach)

Current indemnity insurance  
[ ] Yes  [ ] No

Insurance Company:  
Category of coverage:  
Expiry Date:  

AHPRA Requirements

<table>
<thead>
<tr>
<th>Item</th>
<th>Requirement</th>
<th>Applicant</th>
<th>Panel Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Registration: as a midwife in Australia with no restrictions on Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>Work History</strong>  – Nursing/Midwifery experience that constitutes the equivalent of 3 years full time post initial registration as a midwife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><strong>Reference &amp; work history</strong>: Current competence to provide Nursing/Midwifery (pregnancy, labour, birth and post natal care to women and their infants.) care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><strong>Midwifery Practice Review</strong> - Successful completion of an approved professional practice review program for midwives working across the continuum of midwifery care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td><strong>Continuous Professional Development Points</strong> – (Medicare eligible Midwives - 20 additional hour’s continuous professional development relating to the continuum of midwifery care).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td><strong>Medication Management</strong> - Medicare eligible Midwives - Formal undertaking to complete within 18months of recognition: accredited and approved program of study determined by the board to develop knowledge and skills in prescribing or a substantially equivalent program as determined by the board.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**References:**

Please nominate professional referees who can comment on your skills and professional performance in the areas for which you are seeking Scope of Clinical Practice:

**Referee 1**
**Designation:** Nurse/Midwifery Manager

| Name: |
| Current Position: |
| Address: |
| Work Phone: | Mobile: |
| Email Address: |

**Referee 2**
**Designation:** Member of a multi-disciplinary team

| Name: |
| Current Position: |
| Address: |
| Work Phone: | Mobile: |
| Email Address: |

**Applicant’s Declaration:**

Please respond to each of the questions below by ticking the appropriate box in the ‘YES’/’NO’

| 1. Have you ever been the subject of a substantiated claim or complaint or had adverse findings made against you by a nursing registration authority and/or ethical standards/ regulatory complaints authority, or any other professional, disciplinary or similar bodies including those outside Australia? |
|---|---|
2. Have you ever had conditions or undertakings attached to your registration or had your registration suspended or cancelled by a nursing registration authority, or similar body including any overseas?

3. Are you currently under investigation by NMBA, health authority (HQCC) or health service?

4. Is your right to practise and/or scope of clinical practice under investigation and/or ever been denied, restricted, suspended, terminated or otherwise modified by any health care organisation, health facility, or other official body, including any overseas?

5. Do you have any physical or other medical condition or indulge in substance abuse which may limit your ability to exercise the scope of practice for which you have applied?

6. Do you have any disclosable criminal convictions, i.e. convictions as an adult that form part of your criminal history and which have not been rehabilitated under the Criminal Law (Rehabilitation of Offenders) Act 1986? If you are unsure about the status of any criminal convictions which you have, you may wish to seek legal advice in responding to this question.

7. Are you aware of any matters involving offences which are under investigation and which may involve you?

8. Have you ever been convicted, or pleaded guilty to, a drug or alcohol related offence?

9. Do you know of any reason why your application should not be granted?

If you have responded ‘YES’ to any of the above questions, please provide details, including dates, and attach any relevant documentation.

I, ____________________________ authorise ……………………… to obtain information on an annual basis from the registration body/indemnity insurance organisation as nominated in this application, regarding the currency of my registration/membership of that body/organisation.

I authorise ……………………… to have a criminal history check carried out on me.

I declare that the statements contained in this application are correct. In applying for appointment I agree to abide by Queensland Health policies and regulations and any terms and conditions which are attached to my appointment by the Credentialing and Scope of Practice Committee. I undertake to immediately notify the Chair of the Credentialing and Scope of Practice Committee if my clinical privileges are retracted, withdrawn or altered at any other hospital or birthing centre. I authorise Queensland Health, its officers and agents to seek information as to my past experience, performance and current fitness and the validity of my responses to the above questions.

Signed: _______________________________ Date: / /

Witness signature: __________________________

---

**Criminal History Check**

**Pre-Employment screening**

Pre-employment screening, including criminal history and discipline history checks, may be undertaken on persons recommended for employment. Roles providing health, counselling and support services mainly to children will require a Blue Card.
### Statement Of Support From Nursing Midwifery/Director Of Unit

I have reviewed the application from ______________________ to undertake clinical practice at ______________________ Department / Hospital. I have reviewed the application and support the appropriateness of the requested scope of clinical practice.

Signed: ____________________________________________

Print name & designation: __________________________ Date: / /

### STATEMENT OF SUPPORT FROM Director of ______________________

I have reviewed the application from ______________________ to undertake clinical practice at Department / Hospital. I have reviewed the application and advise that the requested scope of clinical practice is within the scope of the facility.

Signed: ____________________________________________

Print name & designation: __________________________ Date: / /

### Recommendation Of The Committee

Application details checked by (name):

Signature: ____________________________________________

Decision of Credentialing and Scope of Practice Committee at its meeting on / /

Re-application:  

- Approved
- Rejected

If re-application rejected, detail reasons:

Letter to applicant advising outcome of application  

- Yes
- Copy attached
Appendix 4 – Example Application for Credentia ling Checklist

When Applications are received please ensure the following documentation is present:

<table>
<thead>
<tr>
<th>Checklist</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Please ensure that all these items are attached present for the credentialing committee</td>
<td></td>
</tr>
<tr>
<td>CV</td>
<td>□</td>
</tr>
<tr>
<td>Scope of Clinical Practice Document</td>
<td>□</td>
</tr>
<tr>
<td>Certified copy of Registration</td>
<td>□</td>
</tr>
<tr>
<td>Certified Copy of qualifications</td>
<td>□</td>
</tr>
<tr>
<td>Continuous Professional Development documentation</td>
<td>□</td>
</tr>
<tr>
<td>Contact details of TWO referees as requested</td>
<td>□</td>
</tr>
<tr>
<td>Evidence of midwifery indemnity insurance</td>
<td>□</td>
</tr>
<tr>
<td>Documentation in relation to answers in the Declaration (Page 3)</td>
<td>□</td>
</tr>
<tr>
<td>Documentation of Medication endorsement (DTP – acceptable in interim)</td>
<td>□</td>
</tr>
<tr>
<td>Google Search</td>
<td>□</td>
</tr>
</tbody>
</table>

Person Checking The Application

Name_________________________________ Designation________________________________

Signature______________________________ Date _____________________________________
## Appendix 5 - Example Referee Check

<table>
<thead>
<tr>
<th>[Logo]</th>
<th>[Insert Health Service Name] Hospital and Health Service [or name of Midwifery Practice] Scope of Clinical Practice Referee Check</th>
</tr>
</thead>
</table>

### Referee Report for Credentialing and Scope of Clinical Practice Application

<table>
<thead>
<tr>
<th>Referee’s Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Referee’s Title:</td>
<td></td>
</tr>
<tr>
<td>Applicant’s Name:</td>
<td></td>
</tr>
<tr>
<td>Scope of Clinical Practice Requested:</td>
<td></td>
</tr>
</tbody>
</table>

### Professional Relationship

<table>
<thead>
<tr>
<th>How long have you known the applicant?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In what professional capacity have you known the applicant?</td>
<td></td>
</tr>
<tr>
<td>When was your last professional contact with the applicant?</td>
<td></td>
</tr>
<tr>
<td>Can you comment on the nature of the practice &amp; patient population (gender, age, range of presentations) encountered in the professional practice of the applicant?</td>
<td></td>
</tr>
</tbody>
</table>

### ANMC’s National Competency Standards for the Midwife

#### Midwifery Knowledge and Practice:

How would you rate the applicant’s ability to provide women centred care in the practice setting?

- [ ] Excellent
- [ ] Good
- [ ] Adequate
- [ ] Poor
- [ ] Not Observed

Comments:

_______________________________________________________________________________________________

______________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

#### Legal and Professional Practice:

How would you rate the applicant’s ability to practice within legal and ethical framework of practice setting?

- [ ] Excellent
- [ ] Good
- [ ] Adequate
- [ ] Poor
- [ ] Not Observed

Comments:
Midwifery as Primary Health Care

How would you rate the applicant’s ability to incorporate primary health care into midwifery practice?

☐ Excellent  ☐ Good  ☐ Adequate  ☐ Poor  ☐ Not Observed

Comments:

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Ethical and Reflective Practice

How would you rate the applicant’s ability to engage in ethical and reflective practice in the midwifery environment?

☐ Excellent  ☐ Good  ☐ Adequate  ☐ Poor  ☐ Not Observed

Comments:

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Employability

Are you aware of any medical condition, mental or physical (including substance abuse or dependence) which might adversely affect the midwives ability to competently and safely deliver Midwifery care.

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Are you aware of any formal complaints, disciplinary or legal action against this Midwife?

_______________________________________________________________________________________________

_______________________________________________________________________________________________
Would you offer this midwife a position in your unit or midwifery practice?
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Please explain any reservations or concerns regarding the scope of clinical practice requested by the applicant?
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Signature: ______________________________ Date: ______________________________
Name: ______________________________

Please return to:

Or

E-mail:
Appendix 6 – Example of confirmation letter to CEO

The Nursing and Midwifery Credentialing and Scope of Clinical Practice Sub-Committee reviewed the application for scope of clinical practice from <Midwife Name> at a meeting held on <meeting date>. The Sub-Committee recommended that you write to advise <Midwife Name> that scope of clinical practice is granted for three years as below. The Credentialing and Scope of Clinical Practice Committee supported and endorsed this recommendation from the Sub-Committee at its meeting on <meeting date>.

<table>
<thead>
<tr>
<th>Scope of Clinical Practice</th>
<th>Provide pregnancy, labour, birth, postnatal care and associated services and order diagnostic investigations required for midwifery practice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credentialing Committee</td>
<td>......................... Credentialing &amp; Scope of Clinical Practice Committee</td>
</tr>
<tr>
<td>Special Conditions</td>
<td>Nil / AHPRA &lt;Date&gt;</td>
</tr>
<tr>
<td></td>
<td>It is a requirement that you practice at all times in accordance with the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral, current edition.</td>
</tr>
<tr>
<td>Notations:</td>
<td>&lt;Midwife Name&gt; is an Medicare eligible midwife competent to provide pregnancy, labour, birth and post natal care and qualified to provide the associated services and order diagnostic investigations required for midwifery practice, in accordance with relevant State and Territory legislation.</td>
</tr>
<tr>
<td>Queensland Health Clinical Services Capability Framework (CSCF)</td>
<td>Your clinical practice must be consistent with your granted Scope of Practice and the [Insert] Health Clinical Services [Insert relevant policy] level(s) for Maternity Services at [insert] Hospital.</td>
</tr>
<tr>
<td>Period (max. 3 year)</td>
<td>Commencement Date: &lt;Date of letter&gt;</td>
</tr>
</tbody>
</table>

Signed:

Click, enter name,

Chair Credentialing Committee [insert] Health Service
Appendix 7 - Example Midwives Notification Letter

[Midwives address details]

Dear [title and name]

Re: Credentialing & Scope of Clinical Practice Nursing and Midwifery [insert] Hospital and Health Service

Please be advised that on the recommendation of the [insert name] Credentialing & Scope of Clinical Practice Nursing and Midwifery Committee, endorsed by the [insert name] Credentialing & Scope of Clinical Practice Committee, I have granted your scope of clinical practice as follows:

<table>
<thead>
<tr>
<th>Scope of Clinical Practice</th>
<th>Provide pregnancy, labour, birth, postnatal care and associated services and order diagnostic investigations required for midwifery practice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Conditions</td>
<td>Nil / AHPRA &lt;Date&gt;</td>
</tr>
<tr>
<td></td>
<td>It is a requirement that you practice at all times in accordance with the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral, current edition.</td>
</tr>
<tr>
<td>Notations:</td>
<td>&lt;Midwife Name&gt; is an Medicare eligible midwife competent to provide pregnancy, labour, birth and post natal care and qualified to provide the associated services and order diagnostic investigations required for midwifery practice, in accordance with relevant State and Territory legislation. Medicare eligible midwife qualified to obtain endorsement under Section 94 of the Health Practitioner Regulation National Law to prescribe Schedule 2, 3, 4 &amp; 5 medicines required for midwifery practice in accordance with State and Territory legislation: <a href="http://www.ahpra.gov.au/About-AHPRA/What-we-do/Legislation.aspx">http://www.ahpra.gov.au/About-AHPRA/What-we-do/Legislation.aspx</a></td>
</tr>
<tr>
<td>Clinical Services Capability Framework (CSCF)</td>
<td>Your clinical practice must be consistent with your granted Scope of Practice and the [insert] Health Clinical Services Capability Framework (CSCF) level(s) for Maternity Services at [insert] Hospital/Health Service.</td>
</tr>
<tr>
<td>Period (max. 3 year)</td>
<td>Commencement Date: &lt;Date of letter&gt;</td>
</tr>
<tr>
<td></td>
<td>End Date: &lt;3 years from date of letter&gt;</td>
</tr>
</tbody>
</table>

The approved scope of clinical practice is subject to any undertakings given to, or conditions which may be imposed on your registration by the Australian Health Practitioner Regulation Agency (AHPRA). Please note that you are required to immediately notify the office of the Executive Director of Nursing & Midwifery Services (EDNMS) of any changes to your Australian Health Practitioner Regulation Agency (AHPRA) registration. This can be done via direct contact with the EDNMS.

Should you wish to appeal the scope of clinical practice granted to you, please provide a written response to this letter within 30 days, providing any further information and evidence you would like me to consider.

Salutations
Appendix 8 - Example Licence Agreement

Continued on next page.
ACCESS LICENCE AGREEMENT

Between

GOLD COAST HOSPITAL AND HEALTH SERVICE

And

(insert name of Licensee)
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5. PERMITTED USE ............................................................................................................ 6  
6. LICENCE TO ACCESS PREMISES AND FACILITIES ................................................. 6  
7. COSTS .............................................................................................................................. 7  
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25. EXECUTION .................................................................................................................. 12  
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ACCESS LICENCE AGREEMENT

BETWEEN Gold Coast Hospital and Health Service (Service)

AND Licensee (Licensee)

RECITALS

A. The Service operates one or more hospitals and other health care facilities.
B. It is the function of the Service to provide, manage and deliver public sector health services and to ensure that public sector health services are of a high quality and delivered equitably.
C. The Licensee has applied to the Service for a licence to use the Premises.
D. The Service has approved the application.
E. The parties wish to record the terms of their agreement.

THE PARTIES AGREE AS FOLLOWS:

1 INTERPRETATION

1.1 In this Agreement, unless the context otherwise requires or the contrary intention appears, the following definitions apply:

Act means the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010.

Agreement means this document and the Schedules to it.

Car Space means the car space described in Item 4 of the Schedule.

Contact Officer means the contact officer for the relevant party specified in Item 13 of the Schedule.

Commencement Date means the date specified in Item 6 of the Schedule.

Committee means the committee specified in Item 10 of the Schedule.

Committee’s Advice means the advice specified in Item 11 of the Schedule.

Credentialing means a formal process undertaken by the Committee which verifies the qualification, experience, professional standing and other relevant professional attributes for the purpose of forming a view about the Licensee’s clinical competence.

Eligible Midwife means a registered midwife who has fulfilled the requirements for eligibility and has been provided registration with endorsement by the Australian Health Practitioners Regulation Agency.

Expiry Date means the date specified in Item 7 of the Schedule.

Guidelines means the guidelines as specified in Item 12 of the Schedule.

Licence Fee means the fee specified in Item 5 of the Schedule.
Licensee means the licensee specified in Item 2 of the Schedule.

Period of Use means the period of use specified in Item 9 of the Schedule.

Permitted Use means the permitted use specified in Item 8 of the Schedule.

Personal Information means information or an opinion (including information or an opinion forming part of a database), whether true or not, and whether recorded in material form or not, about an individual whose identify is apparent or can reasonably be ascertained, from the information or opinion.

Premises means the premises specified in Item 3 of the Schedule.

Relevant Privacy Laws means the Privacy Act 1988 (Cth), Information Privacy Act 2009 (Qld), Right to Information Act 2009 (Qld) and any other legislation, regulation or guideline in relation to the Personal Information of individuals.

Scope of Practice means the scope of clinical practice as specified by the Committee in the Committee’s Advice.

Service means the hospital and health service specified in Item 1 of the Schedule.

Term means the term of the Agreement specified in clause 2.1.

1.2 Headings are for convenience only and do not affect interpretation.

1.3 The singular includes the plural and vice versa.

1.4 Words denoting a given gender include all other genders.

1.5 Where a word or phrase is given a particular meaning in the Agreement, other parts of speech and grammatical form of that word or phrase have a corresponding meaning.

1.6 A reference to a person includes a reference to a corporation and other entities recognised by law.

1.7 A reference to a Schedule bearing a number is a reference to a Schedule to this Agreement that is identified by that number.

1.8 In the case of any inconsistency between a Schedule and a clause, the provisions of the clause will prevail to the extent of any inconsistency.

1.9 A reference to this Agreement or to any other agreement or document includes respectively this Agreement or that other agreement or document as amended, novated, supplemented, varied or replaced from time to time.

1.10 References to any statutes, regulations, ordinances or by-laws will include all amendments, consolidations or replacements of those statutes, regulations, ordinances or by-laws.

1.11 A reference to the Service and any government department or entity or other authority, association or body, whether statutory or otherwise, shall in the event of any such department, entity, authority, association or body ceasing to exist or being reconstituted, renamed or replaced or its powers or functions being transferred to any other department, entity, authority, association or body, be deemed to refer respectively to the department, entity, authority, association or body established or constituted in its place and succeeding, or as nearly as may be, to its powers or functions thereof.
1.12 If a party consists of more than one person, this Agreement binds them jointly and each of them individually.

1.13 Where under or pursuant to this Agreement the day on by which any act, matter or thing is done is a Saturday, Sunday or public holiday in the site of the Premises, such an act, matter or thing may be done on the next proceeding business day in the site of the Premises.

2. TERM

2.1 This Agreement will commence on the Commencement Date and expire on the Expiry Date.

2.2 The parties must review this Agreement at least once during the Term.

2.3 The Service may extend this Agreement by providing at least 30 days written notice to the Licensee.

3. LICENCE FEE

3.1 The Licensee must pay the Licence Fee for the Term of this Agreement.

3.2 The Service must provide the Licensee with a tax invoice for the Licence Fee.

3.3 The Licensee must pay a correctly rendered tax invoice within 14 days of receipt.

4. GOODS AND SERVICES TAX (GST)

4.1 For the purposes of this clause:

(a) ‘GST’ means the goods and services tax which results from the enactment of the GST Acts.


4.2 The parties acknowledge that GST may be payable on the supply of goods and/or services under this Agreement.

4.3 Where GST is payable upon any supply of goods and/or services under this Agreement the Licence Fee payable by the Licensee to the Service for the supply shall be adjusted in accordance with clauses 4.4 and 4.5.

4.4 Subject to the Service issuing a valid GST tax invoice, the Licence Fee payable by the Licensee to the Service for the supply shall be increased by the amount equal to that which the Service is obliged to remit as GST on the supply.

4.5 If it is determined on reasonable grounds that the amount of GST collected from the Licensee under this clause 4 differs, for any reason, from the amount of GST paid or payable by the Service, including by reason of:

(a) any amendment to the GST Acts; or

(b) the issue of a ruling or advice by the Commissioner of Taxation,

the Licensee shall be entitled to a refund of the additional amount, if any, collected from the Licensee, or shall be required to immediately pay any shortfall to the Service.
5. PERMITTED USE

5.1 The Licensee may use the Premises for the Permitted Use provided that the Licensee has:

(a) current unrestricted registration as a midwife with a notation that the Licensee is an Eligible Midwife;

(b) received notification of Credentialing and Scope of Practice by the Committee.

5.2 The Licensee must demonstrate collaboration in accordance with the Guidelines.

5.3 The Licensee must not use the Premises for providing care to public patients.

5.4 The Licensee must not suggest or hold out to any public or private patients at the Premises that any care provided by the Licensee will be provided free by the Service.

5.5 The Licensee may use the Car Space during the Periods of Use for the purpose of parking a motor vehicle and for no other purpose.

5.6 The Service may engage midwives to provide care during labour to public patients who have received shared maternity care by the Licensee. These midwives engaged may include the Licensee by operation of a separate agreement, but this Agreement does not confer any automatic or other right of engagement by the Service.

5.7 The Licensee must not carry on, or permit to be carried on in the Premises any illegal occupation or activity or cause, permit in the Premises anything which may be or become a nuisance, annoyance, danger or cause damage to the Premises, or to any employees, agents, or invitees of the Service.

5.8 The Licensee must not alter or add to the structure, fittings, facilities or equipment of the Premises or perform any work affecting the Premises or the services supplied to the Premises (such as air-conditioning and electricity).

5.9 The Licensee may provide clinical services for public patients as agreed between the Licensee and the Service under a separate employment agreement.

5.10 The Licensee must participate in clinical governance in collaboration with the Service.

6. LICENCE TO ACCESS PREMISES AND FACILITIES

6.1 Subject to the terms and conditions of this Agreement, the Service grants to the Licensee its employees, agents, customers and invitees a non-transferable and non-exclusive licence to occupy, access and use:

(a) the Premises;

(b) the Car Space by the Licensee only;

(c) any general-use amenities within the Premises, such as toilets, lunch facilities, common rooms; and

(d) the roads, walkways and paths necessary to enter and exit the Premises and the Car Space.

6.2 The provision of the Premises to the Licensee is conditional upon the following:

(a) the Licensee must obtain all approvals, licences or permits which are applicable for and necessary for the Permitted Use;

(b) the Licensee must inform patients of their right to choose to be treated publicly or privately including that the Licensee is not able to provide care if the patient elects to be treated publicly;
the Licensee will be solely responsible for billing and other arrangements associated with the business (including Medicare claims), operation and administrative matters relating to the Permitted Use. The Licensee must not use any administrative supplies, staff or resources of the Service for the Permitted Use;

where the Licensee requires other staff of the Service to provide assistance to the Licensee in the performance of the Permitted Use, the Service recognises that such assistance may be required. However the provision of such assistance must not incur additional costs to the Service or cause a loss of midwifery care to public patients.

e the Licensee is not granted an exclusive right to occupy and use the Premises during the Term and any Service officer, employee or agent may enter the Premises as reasonably necessary for the provision of health services provided that such entry causes minimum disruption to the Licensee’s performance of the Permitted Use.

the Licensee must comply with any of the Services’ policies, procedures, Guidelines, workplace instructions and standards in force at the Premises (including infection control, waste management) and the codes of conduct of midwifery and nursing governing bodies;

the Service may enter the Premises at any time during the Term of this Agreement;

the Service may refuse admission to, or cause to be removed from the Premises, any person whose behaviour is, in the opinion of the Service, objectionable, improper or undesirable; and

the Service does not warrant or represent that the Premises, its facilities or equipment will be adequate or fit for the Permitted Use by the Licensee. The Licensee acknowledges that the Licensee had the opportunity to inspect the Premises and the equipment supplied with the Premises.

With the consent of patients, documentation of maternity care will be shared between the Licensee and the Service’s staff and supplied on the Queensland Health pregnancy health record, intrapartum record and clinical documentation,

The management of patient clinical records will be as follows:

The Licensee must keep full and accurate records in relation to each patient treated by the Licensee.

The parties agree that the records of either party relating to patient care are confidential and each party will maintain this confidentiality by not supplying, copying or releasing the records to the other party unless with patient consent and with mutual agreement between the parties.

The parties agree that the Licensee owns all patient records made in connection with the Permitted Use.

The Licensee uses the Premises at their own risk.

The Licensee must comply with all security procedures notified by the Service.

7. COSTS

All episode of care costs involved in the Licensee providing the Permitted Use are payable by the private patient. The Service is not responsible for these episode of care costs.
8. LICENSSEE'S OBLIGATIONS

8.1 The Licensee must:

(a) keep the Premises in good and substantial repair (subject to fair wear and tear) and make good any damage caused by the Licensee, its employees, agents, customers and invitees;

(b) keep the Premises, fixtures, fittings and installations in a clean and tidy condition;

(c) keep the Premises free from litter or accumulation of rubbish;

(d) use the Premises and any fixtures, fittings and installations in the Premises in a safe and proper manner;

(e) use any equipment in the Premises with a standard of care and skill required of the ordinary skilled person exercising and professing to have the skill to operate the equipment;

(f) observe all security and evacuation procedures applicable to the Premises;

(g) comply with the Service's reasonable directions in relation to the Premises;

(h) obtain at its expense and if required, produce evidence of all permits, licences and consents related to its use of the Premises;

(i) ensure that there is no smoking in the Premises;

(j) ensure that all keys and passes relating to access to and security of the Premises given to the Licensee are not duplicated and are returned to the Service at the end of the Term;

(k) ensure that Licensee and all agents wear identification badges when on the Premises and return the same to the Service at the end of the Term;

(l) notify the Service immediately if the Licensee becomes aware of any damage or loss to the Premises, its facilities, equipment or any injury to any person in the Premises; and

(m) properly supervise any persons under the direction or control of the Licensee.

8.2 In addition to the general maintenance obligations contained in clause 8.1, the Licensee must immediately inform the Services' Contact Officer of any damage to or defect in any equipment located in the Premises.

8.3 If any equipment in the Premises requires substantial repair or replacement, the Service is under no obligation to repair or replace such equipment and such equipment shall be deemed deleted from the definition of Premises in this Agreement.

9. TERMINATION

9.1 Either party may terminate this Agreement at any time by providing three months written notice to the other party.

9.2 The Service may immediately terminate this Agreement by notice in writing to the Licensee if the Licensee fails to comply with the requirements of clauses 5.1 and 5.3 of this Agreement.

9.3 The Service shall be entitled to terminate this Agreement by notice in writing to the Licensee if the Licensee fails to observe, comply with or fulfil any of the Licensee's obligations under or arising out of this Agreement, and such failure continues for a period of seven days after the Service has given notice in writing to the Licensee specifying the default and requesting the default to be remedied.
9.4 Immediately upon termination of this Agreement, the Licensee must remove all property of the Licensee, its employees, agents, customers and invitees from the Premises and leave the Premises in the condition required by clause 8.1.

9.5 Termination of this Agreement will be without prejudice to such other rights as either party may have against the other.

10. DISPUTE RESOLUTION

10.1 If a dispute arises out of this Agreement (Dispute) a party must comply with this clause 10 before commencing court proceedings (except proceedings for interlocutory relief).

10.2 A party claiming a Dispute has arisen must give the other party to the Dispute notice setting out the details of the Dispute.

10.3 During the 14 days after a notice is given under clause 10.2 (or longer period if the parties to the Dispute agree in writing), each party to the Dispute must meet and use its reasonable efforts to resolve the Dispute. If the parties cannot resolve the Dispute within that period, they must refer the Dispute to a mediator.

10.4 If the parties to the Dispute fail to agree as to the appointment of a mediator within 7 days after the period specified in clause 10.3, the mediator will be appointed by the Chair of the Australian Commercial Disputes Centre.

10.5 The role of the mediator is to assist in negotiating a resolution of the Dispute. A mediator may not make a binding decision on a party to the Dispute except if the parties agree in writing.

10.6 Each party must provide the mediator with all documents and information necessary to resolve the Dispute.

10.7 Any information or documents disclosed by a party under this clause 10:

(a) must be kept confidential; and

(b) may only be used to attempt a resolution of the Dispute.

10.8 Each party to a Dispute must pay its own costs of complying with this clause 10. The parties to the Dispute must equally pay the costs of any mediator.

10.9 If the parties are unable to resolve the Dispute within 30 days after conducting the mediation either party may commence court proceedings.

10.10 Despite the existence of a Dispute, the parties will (unless requested in writing by the other party not to do so) continue to perform their obligations under this Agreement.

11. NO ESTATE OR INTEREST CREATED

11.1 The rights conferred by this Agreement shall rest in contract only and shall not infer an intention to create or confer upon the Licensee any tenancy, estate or interest whatsoever in or over the Premises.

11.2 This Agreement does not constitute any agreement of employment, partnership or agency between the Licensee and the Service.

12. INSURANCES

12.1 The Licensee must at all times during the Term of this Agreement at the Licensee’s cost and expense, obtain and keep in force and effect the following insurances:

(a) public liability insurance in an amount not less than $20,000,000 per occurrence; and
12.2 The Licensee must at all times during the Term of this Agreement and for the period until the Licensee becomes eligible for the Commonwealth Run Off Cover Scheme under the Act, at the Licensee’s cost and expense, obtain and keep in force and effect professional indemnity insurance for an amount of not less than $2,000,000 per claim.

12.3 The amount of professional indemnity insurance required under clause 12.2 is subject to the Commonwealth contribution provided under the Act.

12.4 Prior to the execution of this Agreement the Licensee must provide evidence to the satisfaction of the Service of the insurances effected and maintained for the purposes of this clause 12.

13. INDEMNITY

13.1 The Licensee will at all times indemnify the Service, its officers, employees and agents (in this clause referred to as “those indemnified”) from and against any loss (including legal costs and expenses) or liability, reasonably incurred or suffered by any of those indemnified arising from any claim, suit, demand, action or proceeding by any person against any of those indemnified where such loss or liability was caused by any wilful, unlawful or negligent act or omission of the Licensee or any servant or agent of the Licensee.

13.2 The Licensee’s liability to indemnify the Service under this clause will be reduced proportionately to the extent that any act or omission of the Service or its officers, employees or agents caused or contributed to the loss or liability referred to in clause 13.1.

14. VARIATION

14.1 This Agreement may be varied at any time by an agreement in writing executed by both parties.

15. SEVERABILITY

15.1 If any provision of this Agreement is held invalid, unenforceable or illegal for any reason, this Agreement shall remain in full force apart from the invalid provision which shall be deemed deleted.

16. INFORMATION PRIVACY

16.1 The parties acknowledge that they each have statutory and common law obligations including under Relevant Privacy Laws to maintain the privacy of Personal Information.

16.2 Nothing in this Agreement allows either party to access Personal Information being held by the other party.

16.3 Each party undertakes to promptly notify the other party if they become aware of a breach of privacy.

17. CONFIDENTIALITY

17.1 The parties must not, except as expressly authorised in writing by the other party or required by law, reveal to any other person any of the confidential operations, dealings or affairs of the other which may come to its knowledge through the carrying out of this Agreement.

17.2 The parties must not use or attempt to use any information or knowledge referred to in subclause 17.1 in any manner which may injure or cause loss either directly or indirectly to the other.

17.3 Notwithstanding the provisions of clause 17.1, the parties may disclose details of this Agreement to their solicitors, auditors, insurers or accountants for the purposes of obtaining advice. Disclosure to a Government Agency to satisfy mandatory requirements is acknowledged and agreed. The Licensee acknowledges that the Service may make disclosure to a Government
Agency or government owned or controlled corporation or to comply with a direction by a Queensland government minister or a Queensland government requirement or policy.

17.4 The parties acknowledge and agree that either party may disclose publicly the fact that it has entered into this Agreement and the general details of this Agreement.

18. **SURVIVAL**

18.1 Clauses 1, 9, 10, 11, 12, 13, 16, 17, 18 and 22 will survive termination or the expiry of this Agreement.

19. **NO PROPRIETARY INTERESTS**

19.1 All liabilities incurred by the Licensee in providing and/or performing the Permitted Use shall remain liabilities of the Licensee and none of such liabilities shall attach to the Service.

20. **WAIVER**

20.1 No right under this Agreement shall be deemed to be waived except by notice in writing signed by each party. The failure of the Service to enforce at any time any clause of this Agreement will in no way be interpreted as a waiver of such clause. The waiver by the Service in respect of any breach of a clause of this Agreement by the Licensee will not be deemed to be a waiver in respect of any other clause or of any subsequent breach of that clause.

21. **COSTS**

21.1 Each party must pay their own costs of and incidental to the negotiation, preparation and execution of this Agreement.

22. **GOVERNING LAW**

22.1 This Agreement will be governed by and construed according to the law of the State of Queensland and the parties agree to submit to the jurisdiction of the Courts of the State of Queensland.

23. **NOTICES**

23.1 Any notice or communication given under or about this Agreement must be:

(a) in writing; and

(b) delivered by hand, sent by ordinary prepaid post or sent by facsimile to the party's address or facsimile number (as the case may be) specified in accordance with clauses 23.2 and 23.3 of this Agreement, or another address or facsimile number notified by the party.

23.2 Any notice given by the Service to the Licensee must be sent to the Licensee’s Contact Officer in accordance with clause 23.1.

23.3 Any notice sent by the Licensee to the Service must be sent to the Service’s Contact Officer in accordance with clause 23.1.

23.4 In this clause 23, business day ('business day') means a day which is not a Saturday, Sunday or a public holiday in Brisbane or the site of the Premises. A notice or other communication given under or about this Agreement is taken to be received (as the case may be):

(a) if delivered personally, on the business day it is delivered;

(b) if sent by ordinary prepaid post, 3 business days after posting; or

(c) if transmitted electronically when the sender receives acknowledgment that the communication has been properly transmitted to the recipient.
24. ENTIRE AGREEMENT

24.1 This Agreement constitutes the entire agreement between the parties in relation to its subject matter. Any prior arrangements, agreements, representations or undertakings are superseded.

25. EXECUTION

25.1 The parties shall execute two copies of this Agreement, with each party retaining an original, fully executed, copy.

26. ASSIGNMENT AND SUBCONTRACTING

26.1 The Licensee must not sublicense, subcontract, assign or deal with any right under this Agreement without the prior written consent of the Service. Any purported dealing and breach of this clause 26 is of no effect.
EXECUTED by the parties as an agreement on the date last appearing:

SIGNED for and on behalf of the Service:

……………………………………………………………………………………………………………………

(Print name and position) …………………………………………………………………………………

In the presence of: ………………………………………………………………………………………

(Print name) ……………………………………………………………………………………………..

(Date) ………………………………………………………………………………………………………
## Schedule

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
</table>
| 1      | Service                            | Gold Coast Hospital and Health Service  
108 Nerang Street  
Southport Q 4215  
ABN 826 169 924 16 |
| 2      | Licensee                           | (insert name, address and ABN for Licensee)                             |
| 3      | Premises                            | The premises means the Gold Coast Hospital and Health Service and includes any equipment in the premises. |
| 4      | Car Space                          | Nil                                                                     |
| 5      | Licence Fee                        | Nil                                                                     |
| 6      | Commencement Date                  | 1 October 2012                                                         |
| 7      | Expiry Date                        | 30 September 2013                                                      |
| 8      | Permitted Use                      | The private practice delivery of antenatal, intrapartum and postnatal midwifery care to private patients. |
| 9      | Periods of Use                     | The Premises are available 24 hours per day during the Term.            |
| 10     | Committee                          | The Credentialing & Scope of Clinical Practice (Midwifery) Committee – Gold Coast Hospital and Health Service. |
| 11     | Committee’s Advice                 | Letter from the Committee to the Licensee attached to this Agreement as Attachment A. |
| 12     | Guidelines                         | Gold Coast Hospital and Health Service Guideline – “Clinical Guideline Eligible Private Practice Midwives with an Access Licence Agreement; Collaborative Practice Guidance” |
| 13     | Contact Officer                    | Licensee  
Name:  
Address:  
Telephone:  
Facsimile:  
Email:  
**Service**  
Position: Chief Operations Officer  
Address: Gold Coast Hospital and Health Service, 108 Nerang Street, Southport Q 4215  
Telephone: 56198222  
Facsimile 55198852  
Email: GCESOCOO@health.qld.gov.au |
Attachment A
Credentialing Letter
Appendix 9 - Example Collaborative Agreement

Continued on next page.
COLLABORATIVE ARRANGEMENT

BETWEEN

(name of eligible midwife)

And

Dr .........................................................
Director of Obstetric Services/Medical Services

On behalf of ...................... HHS

Or

(insert name/s of the specified Medical Practitioner/s)

..............................................
This Collaborative Arrangement (the Arrangement) is made on the day of 20 .

BETWEEN

(name of eligible midwife)

AND

Dr Director of Obstetric/Medical Services On behalf of HHS or

(name of QH specified medical practitioner/s)

PREAMBLE

The National Maternity Services Review (2009) highlighted the need for eligible privately practising midwives to access clinical privileges in public maternity services, to enable women to receive continuity of care by their known midwife in a hospital setting. The development of this document reflects the importance that Queensland Health places on the concept of continuity of carer in the provision of maternity services.

PURPOSE

The purpose of this Arrangement is to meet the requirements of the National Health (Collaboration Arrangements for Midwives) Determination (2010). This Arrangement will provide for collaboration between the Eligible Private Practice Midwife (EPPM) and the Queensland Health collaborative Medical Practitioner.

RECITALS

A. The Eligible Private Practice Midwife (EPPM) and collaborative Medical Practitioner/s acknowledge that each party has respective roles and professional obligations.

B. The EPPM and collaborative Medical Practitioner/s wish to work in co-operation to enable the effective and efficient delivery of health services to pregnant and birthing women.

C. The EPPM and collaborative Medical Practitioner/s agree that this Arrangement does not create any legal relationship between them.

D. Nothing in the Arrangement is intended to affect the obligations that each individual has to maintain the recognised standards as set down by the parties respective professional bodies; the Australian Health Practitioners Registration Board (AHPRA), the Australian College of Midwives (ACM) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

THE PARTIES TO THIS ARRANGEMENT AGREE AS FOLLOWS:
1. DEFINITIONS

1.1 In this Arrangement the following definitions apply:

“Australian College of Midwives (ACM) National Guidelines for Consultation and Referral” means the current publication of the ACM National Guidelines for Consultation and Referral is to be utilised by maternity health practitioners to guide consultation, referral and transfer of an Eligible Private Practice Midwife (EPPM) client to an obstetric specified medical practitioner.

“Arrangement” means this Collaborative Arrangement.

“Associated Staff” means registrars and principal house officers in obstetrics and gynaecology.

“Client” means the pregnant woman and / or neonate.

“Collaboration” means ‘a dynamic process of facilitating communication, trust and pathways that enable health professionals to provide safe, women-centred care. Collaborative maternity care enables women to be active participants in their care.’ (National Guidance on Collaborative Maternity Care, NHMRC 2010)

“Collaborative Medical Practitioner” means a medical practitioner, authorised by the CEO to participate in collaborative arrangements.

“Commencement Date” means the date this Agreement will commence and is listed in item 2 of schedule One.

“Consultation” means when a midwife recommends the client consult a medical practitioner because a variance from normal care has been identified, or where the client requests another opinion of a health care provider.

“Contact Officer” means the Health Service employee who will be primary point of contact with respect to this Agreement listed in item 3 schedule One.

“Director Medical Services” means the person with operational responsibility for medical services at the Hospital

“District/HHS” means the area of Queensland hospital authority, public sector hospital or other public sector facility declared by the Governor in Council, under the Health Services Act 1991 (Queensland).

“Chief Executive Officer” (CEO) means the officer who is appointed or seconded to act as Chief Executive Officer of the HHS/District from time to time to manage the district.

“Credentialed Private Practice Midwife (CPPM)” means a registered midwife who has fulfilled the requirements for eligibility and has been provided with a scope of practice and a license to deliver private midwifery services by the Chief Executive Officer (CEO).

“Eligible Private Practice Midwife (EPPM)” means a registered midwife who has fulfilled the requirements for eligibility and has been provided Registration with endorsement by APHRA

“Hospital” means the hospital listed in item 1 of schedule One.
“National Health (Collaboration Arrangements for Midwives) Determination (2010)” means the determination outlining the collaborative arrangements required for midwives.

“Parties” mean the signatories to this Arrangement.

“Referral” means when the EPPM identifies a variance from normal care that requires medical specialist assessment and collaboration.

“Risk Evaluation Tool” The document listed in item 4 of schedule One.

“Specified Medical Practitioner (SMP)” means a specified medical practitioner, authorised by the CEO to participate in collaborative arrangements.

“Statewide Pregnancy Health Record” means the current Queensland Health developed Pregnancy Health Record.

“Transfer” means when primary care is transferred, temporarily or permanently, from an EPPM to a medical practitioner. The receiving medical practitioner assumes full responsibility during the period they are lead carer.

2. COMMENCEMENT AND DURATION

2.1 This Arrangement will commence on the commencement date.

2.2 Unless otherwise terminated it will continue for 36 months from the commencement date.

3. GUIDING PRINCIPLES

3.1 The parties agree that this Arrangement is based on mutual respect, cooperation and shared principles to ensure that clients of the EPPM are provided with safe maternity care, with the expectation of a birth within the Hospital.

3.2 The parties acknowledge that the shared principles that underlie the Arrangement are agreed as:

(a) care is women centred;

(b) care is provided within a co-operative, collaborative and efficient framework;

(c) all communications between individuals is courteous, respectful, culturally sensitive and professional; and

(d) there is transparency across all care provided to the clients of the EPPM.

4. COOPERATIVE ARRANGEMENTS

4.1 In a spirit of cooperation between the EPPM and Collaborative Medical Practitioner, the parties agree to do the following:
Appendix 3.3 Collaborative Arrangement

(a) to continue to improve knowledge, skills, attitudes and values of the respective staff of both parties in relation to birthing services; and

(b) to document maternity care on the Statewide Pregnancy Health Record (PHR).

5. RESPONSIBILITIES OF THE PARTIES

5.1 The responsibilities of the EPPM are to:

(a) ensure all legislative or other professional requirements are met. This includes maintaining national registration, adequate Private Indemnity Insurance and having a Medicare provider number at all times;

(b) practice at all times in accordance with the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral, current edition;

(c) ensure that the care provided to the pregnant client during pregnancy, labour, birth and the postpartum period accords to the agreed standards of the midwifery profession;

(d) liaise with the hospital clinical staff utilising the principles outlined in the National Health and Medical Research Council (NHMRC) Collaborative Guidelines (2010);

(e) ensure all relevant documentation relating to the client’s care is provided to the Hospital clinical staff and other staff when clinically indicated or at any time when it is required by the SMP or other staff for the care of the client;

(f) acknowledge and understand that this carer collaborative agreement will not apply when the Hospital clinical staff provides the advice to the EPPM as specified in 5.2(g);

(g) ensure attendance at case conferencing meetings and ensure each case subject to this care collaborative agreement is presented at intake and as clinically indicated and provide the completed risk evaluation tool as listed in item 4, schedule One;

(h) to abide by relevant Queensland Health policies and the Queensland Health Code of Conduct while in attendance at Queensland Health facilities;

(i) ensure that when the care required is a variance from normal care that consultation occurs in accordance with the ACM National Midwifery Guidelines for Consultation and Referral in a timely manner.

(j) ensure that when the care required is a variance from normal care that the appropriate referral of a client to an appropriate medical staff &/or Hospital clinical staff occurs in accordance with the ACM National Midwifery Guidelines for Consultation and Referral in a timely manner;

(k) ensure that when the care required is a variance from normal care that the transfer of a client’s care to an appropriate medical staff &/or Hospital clinical staff directly or via associated staff occurs in
accordance with the ACM National Midwifery Guidelines for Consultation and Referral;

(i) work in partnership with an appropriate medical staff and Associated Staff when recommendation is to temporarily or permanently transfer a patient's care to a appropriate medical staff member consistent with ACM National Midwifery Guidelines for Consultation and Referral;

(m) understand that when the care is transferred from primary to secondary care this may require the mother to birth in the birthing suite or operating theatre;

(n) provide supportive education for health professionals and students working in the Hospital if and when requested by the Hospital; and

(o) ensure collaboration between EPPM and Hospital staff when dealing with complaints about client care or the operation of this Agreement.

5.2 The responsibilities of the collaborating hospital medical staff are to:

(a) Acknowledge the professional framework of midwifery practice including:

   i. Current codes & standards of midwifery practice

   ii. Australian College of Midwives (ACM) National Guidelines Consultation and Referral, current edition

   iii. Other relevant professional guidance

(b) engage in a timely manner with the EPPM when consulted to provide medical advice;

(c) engage in a timely manner with the EPPM when asked to accept a referral;

(d) facilitate the transfer of a client's care when required;

(e) consider the continuation of midwifery care being provided by the EPPM if the client's care is temporarily or permanently transferred;

(f) attend case conferencing with the EPPM as agreed and scheduled or arrange a proxy of another Collaborative Medical Practitioner;

(g) Ensure the Dispute resolution escalation processes is followed if issues arise; as listed section 9

(h) Promptly advise the EPPM and Director of O & G and then Director of Medical Services in a case where a hospital staff clinician considers any care provided under this agreement to be in breach of guidelines or otherwise.
6. **EXCHANGE OF INFORMATION**

6.1 The parties acknowledge that exchanges of information in relation to this process may involve information that is confidential and/or subject to privacy laws. The parties acknowledge that they are bound by their respective confidentiality and privacy laws or obligations.

6.2 The parties agree to:

(a) ensure security measures are in place to protect any information provided by the other party from unauthorised access, use or disclosure;

(b) restrict any person from accessing or using information, unless that person is legally authorised to do so;

(c) recognise and observe the confidentiality of information and agree that the collection, release and use of information will comply, so far as they apply to the relevant party, with all applicable Queensland Government policy and legislative requirements; and

(d) comply with any other reasonable confidentiality restrictions agreed between the parties in respect of the handling or disclosure of information.

7. **VARIATION AND REVIEW**

7.1 This Arrangement may be varied by agreement between the parties in writing. Any proposed alterations shall be raised and addressed through the EPPM and the contact officer listed in item 3 of schedule One.

7.2 The parties agree that this Arrangement will be reviewed within 12 months of the date of its taking effect, and thereafter on the 2 year anniversary of the initial review, or at such other time as may be agreed between the parties.

8. **TERMINATION**

8.1 Either party may terminate this Arrangement by giving the other party 21 days prior notice in writing of its intention to terminate.

8.2 Where this Arrangement is terminated under Clause 8.1, the parties agree to provide all reasonable assistance and cooperation necessary to ensure a smooth transition of woman’s care to a new working arrangement.

9. **DISPUTE RESOLUTION**

9.1 For any matter in relation to this Arrangement that may be in dispute, the parties:

will attempt to resolve the matter at the workplace level between the EPPM and the medical officer listed in item 3 of schedule one.; Utilising QH dispute resolution processes.

(a)
(b) Guide to the resolution of informal complaints at the local level


The Guide for the resolution of complaints at the local level provides guidance to staff and managers on how to promptly and informally resolve administrative complaints and workplace conflict before issues are escalated to a formal grievance. Some situations require immediate escalation of a complaint to a formal grievance or notification to another entity.

(c) agree that, if the matter is not resolved at the local workplace level, the matter will be referred to Director of Nursing & Midwifery and Director of Medical Services for discussion with Chief Executive Officer, of the Health Service for resolution; and

(d) agree that, during the time when the parties attempt to resolve the matter, the parties continue to comply with the Arrangement.

10. NOTICES

10.1 Any notice or communication given under clauses 7 or 8 of this Arrangement must be delivered, sent by registered post, sent by ordinary prepaid post or sent by facsimile to the addressee’s address or facsimile number (as the case may be) notified by the addressee from time to time.

10.2 A notice or other communication given under or about this Arrangement is taken to be received (as the case may be):

(e) if delivered personally, on the business date it is delivered;

(b) if sent by registered post, the date the notice is signed for;

(c) if sent by ordinary prepaid post, three business days after posting; or

(d) if sent by facsimile, when the sender receives confirmation that the facsimile has been transmitted in its entirety to the addressee’s facsimile number.

10.3 Unless otherwise advised in writing, addressees for each party being:

Party A:

(address)

Party B:

(address)
Name

**SIGNED:** ___________________________ Date: ___________________________

For and on behalf of Eligible Private Practice Midwife in the presence of:

Signature of Witness

Name: ___________________________ Signature: ___________________________
Date: ___________________________

For and on behalf of Collaborative Medical Practitioners:

**Director of Medical Services on behalf of ……………………………………hospital authority**

Name: ___________________________ Signature: ___________________________
Date: ___________________________

Signature of Witness

Name: ___________________________ Signature: ___________________________
Date: ___________________________

**OR**

Collaborative Medical Practitioners:

Name: ___________________________ Signature: ___________________________
Date: ___________________________

Name: ___________________________ Signature: ___________________________
Date: ___________________________
### Schedule 1

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<tr>
<th>Item 1</th>
<th>Hospital</th>
<th>Eg Toowoomba Hospital</th>
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<td>Item 2</td>
<td>Commencement Date</td>
<td>Eg 1 January 2012</td>
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<tr>
<td>Item 3</td>
<td>Officer</td>
<td>Eg Executive Director Medical Services</td>
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<tr>
<td>Item 4</td>
<td>Risk evaluation tool</td>
<td>Eg First midwife interview risk evaluation Appendix 1</td>
</tr>
</tbody>
</table>
Appendix 10 - Example Communications Pathway

Continued on next page.
Appendix 11 – Example of Models Options

Antenatal Care Options

The Medicare eligible midwife can provide women with private primary midwifery care in the community. The midwife will use the Australian College of Midwives’ National Midwifery Guidelines for Consultation and Referral to determine when obstetric or other medical care is required. When women have complex needs, the midwife continues to provide primary midwifery care in collaboration with hospital staff clinicians, taking a care coordination role. Medicare eligible midwives have the option of bulk-billing women who are uninsured and do not have the ability to self-fund fees above the rebate.

Medicare eligible midwives can provide named referrals for antenatal obstetric (or other medical) consultations, enabling the public hospital to bulk bill Medicare for antenatal visits if doctors have “option A” contracts.

Labour and Birth Care

Normal Birth, Private Care with Medicare eligible Midwife:

Women with private health insurance, or the ability to self-fund, may employ an Medicare eligible midwife for intrapartum care in hospital. The woman is admitted to hospital by the midwife, and receives midwifery care in labour and birth from the Medicare eligible midwife. A second private midwife with credentialing from the private practice may attend at birth, or a staff midwife may be asked to attend. The woman and/or her insurer are billed by the Medicare eligible midwife for care and by the hospital for the bed fee.

Women without private health insurance may choose this option if they are able to self-fund, as the cost is limited when birth remains normal. These women may need to have other options available if complexities develop.

A HS may also choose to allow women without insurance and unable to self-fund to be admitted as private patients and to waive some or their entire bed fee. This may be to the HS’s financial advantage in several ways: savings are made by private antenatal and postnatal care being provided by the Medicare eligible midwife; intrapartum midwifery care is at no cost to the HS; reductions in acute care demand are achieved by the continuity of midwifery care model; the HS will receive the same ABF DRG payment under state ABF or a slightly reduced ABF payment under national ABF, as it would receive for a public patient.

Normal or Complex Birth, Public Care with Medicare eligible Midwife:

If women are uninsured or unable to self-fund, they may still receive continuity of midwifery care if the Medicare eligible midwife who provides them with private antenatal and postnatal care is also employed by the hospital to provide public labour and birth care. Some women will have the resources to self-fund a private normal birth, but have complex clinical needs they are unable to fund.

Fractional FTE employment under the caseload award is currently considered the most flexible and effective employment model. This enables attendances of varying time periods (no minimum shift length), and is administratively simple. For example, Toowoomba Base Hospital employs several Medicare eligible midwives at 0.1 FTE to facilitate continuity for women receiving private antenatal and postnatal care but who are not able to fund private intrapartum care. Employing Medicare eligible midwives in casual arrangements is another option.

This model can be expected to be to the HS’s financial advantage in several ways: savings are made by antenatal and postnatal care being provided privately by the Medicare eligible midwife; on-call intrapartum midwifery care is a cost-effective staffing strategy responding directly to demand; reductions in acute care demand are achieved by the continuity of midwifery care model.

Complex Birth, Private Care with Medicare eligible Midwife:
When the client of an Medicare eligible midwife requires complex intrapartum care, the midwife will consult and/or refer to an obstetrician (or other doctor) according to guidelines and hospital protocols. If the woman is privately insured or is able to self-fund, and doctors are able to provide private care (e.g. staff doctors under option A contract), the woman may be/remain admitted as a private patient and receive private medical care. The hospital may bulk-bill Medicare for medical services of option A medical staff.

If the woman is not insured and unable to self-fund, she may need to be admitted/change admission status to public. In this case it is highly desirable that the woman is able to receive continuity of midwifery care. However, the Medicare eligible midwife must not provide midwifery care to public patients in her private capacity, as this would breach her professional indemnity insurance. To facilitate continuity, Medicare eligible midwives may be employed with a fractional FTE under the caseload award, or as a casual, so that the midwife may change employment status to staff when the woman changes admission status to public.

If the woman is not insured and unable to self-fund, and staff doctors are able to provide private care, the HS has the option of allowing the woman to retain private admission status, and waive all or most fees. This may be to the HS’s financial advantage, as it will not need to pay the Medicare eligible midwife, it may bulk-bill Medicare for medical services, and it will receive the same ABF DRG payment under state ABF or a slightly reduced ABF payment under national ABF, as it would receive for a public patient.