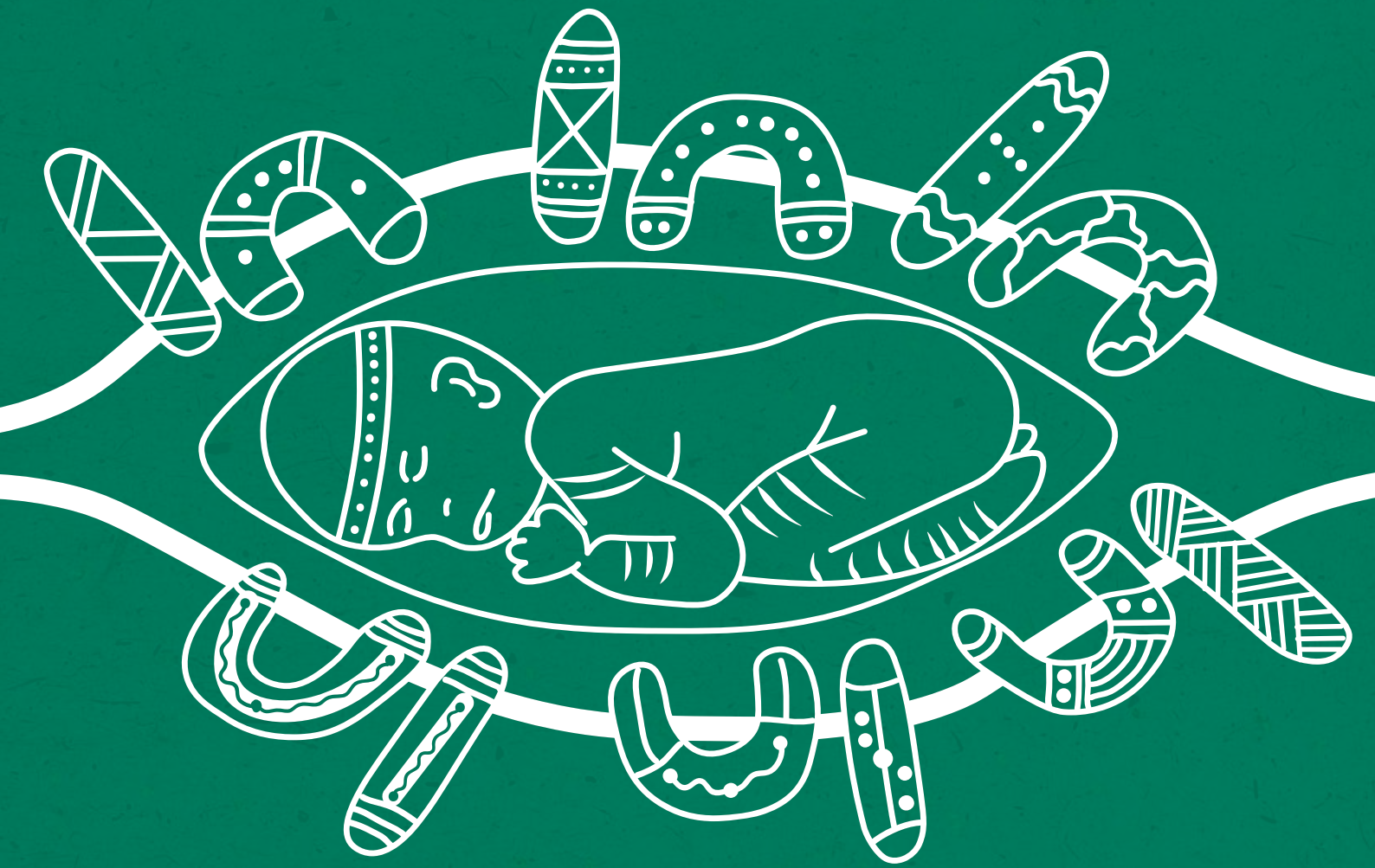
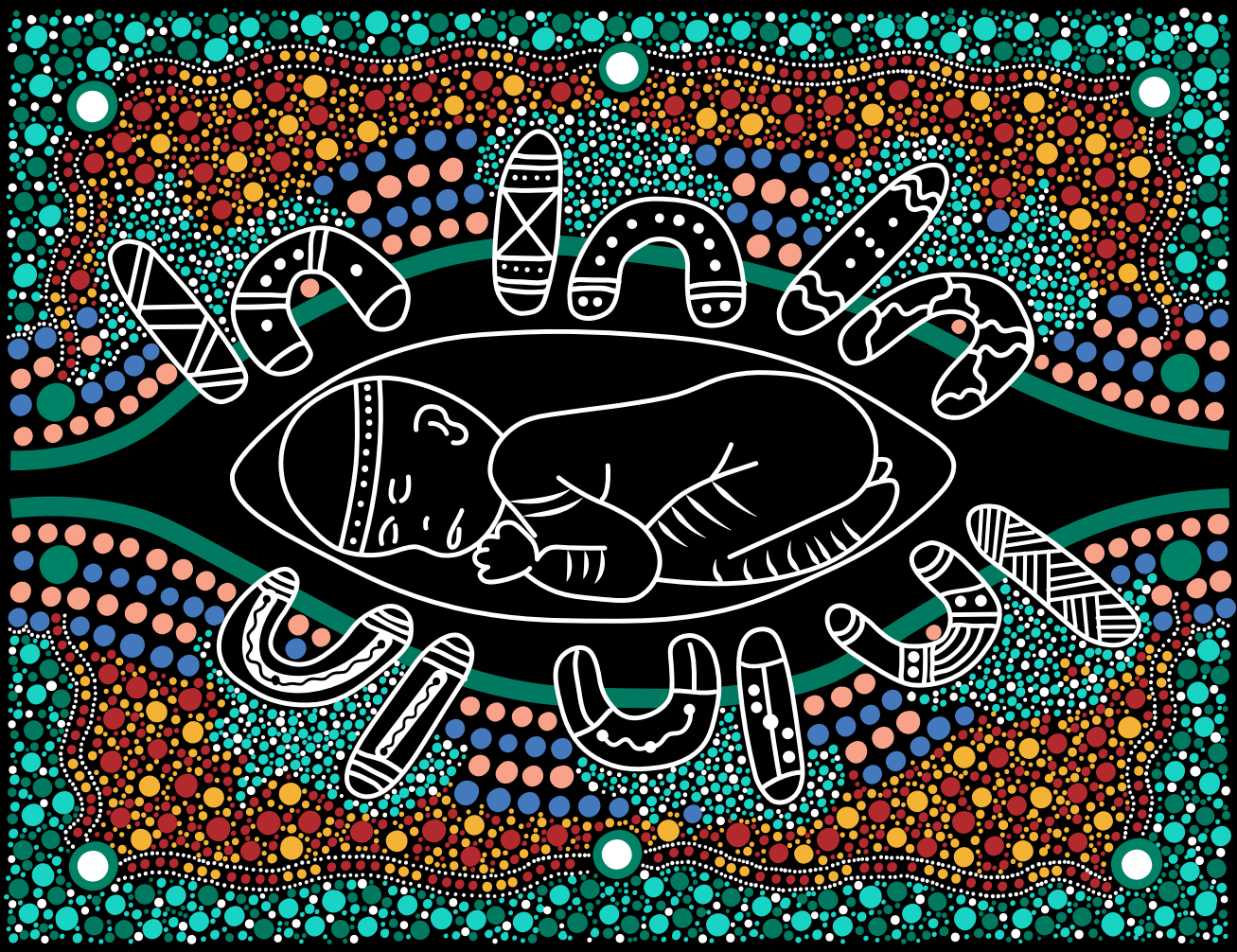
Maternity Services Integration Project (MSIP)

Place-based Integration Activities Evaluation Report



QAIHC

Queensland Aboriginal and Islander Health Council



Birthing Story © Samantha Neilson, 2020. *This painting is my story. It talks about how all my children have made a great impact on my life. It shows the baby/children in the middle of my world. The women sitting around the baby represent all the Mothers, Sisters, and Aunties, but most of all the midwives and doctors that helped in making the birthing process an enjoyable experience. The journey lines are the appointments that I and the family members attended for the health of our baby girl and myself. The bold dots symbolise the strong women and men about to become parents and/or extending too. The smaller dots around the women are the people in their lives encouraging them with their journey. The ochre red and yellow dots stand for the land that we all walk on. The blue and green dots are the waters that flow and change with the tides. The baby is outlined for some are walking among/beside us in the spirit world.*

Acknowledgement

QAIHC acknowledges the Traditional Owners of the lands throughout Queensland. We respect and acknowledge the Elders that walked before us, and those who walk beside us today to continue to guide the birthing practices for women who are birthing Aboriginal and Torres Strait Islander babies.

QAIHC would like to acknowledge the contributions of the following people to MSIP: Wyomie Robertson, Margaret Cashman, Karen Francisco, Dr Lucy Morris, Rachel Doolan, Angela Young, Dr Kelly Dingli, Dr Rebecca Soole, Jenny Gillett, Georgina Chelberg, Stacey Giles, Dr Stephen Lambert, Prof Gregory Phillips

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About QAIHC

The Queensland Aboriginal and Islander Health Council (QAIHC) is a leadership and policy organisation. It was established in 1990 and is the peak organisation body representing Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) in Queensland at both a state and a national level.

QAIHC membership is comprised of ATSICCHOs located throughout Queensland which deliver holistic care that is patient and family centred, at no cost to the patient and at a single location. In delivering comprehensive primary health care, ATSICCHOs also provide treatment, prevention and early intervention, rehabilitation and recovery services. There is flexibility in providing services, and many services include home visits, outreach, telehealth and family care plans. The values and perspectives of the local communities shape the design and delivery of services, evaluation, cultural policies, engagement mechanisms and the physical attributes of the medical services. Empowering Aboriginal and Torres Strait Islander people to take charge of their own health advancement is a core element of the ATSICCHO Model of Care.

Collectively, QAIHC's Members have established more than 70 clinics across Queensland, focussed on providing culturally appropriate primary health care services to their communities and improving Aboriginal and Torres Strait Islander peoples' health status.

About ATSICCHOs

In Australia, community-controlled health services embody a model of self-determination. The core of community-controlled primary health care is the initiation and operation of holistic, comprehensive and culturally appropriate health care to the community which controls it. Governance is led by a locally elected board.

One hundred and forty-three community-controlled health organisations across Australia are represented by the national peak organisation, the National Aboriginal Community Controlled Health Organisation (NACCHO). Community controlled health organisations are referred to by a variety of names throughout Australia, which are determined by the relevant state. In Queensland, community-controlled health services are known as Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs).

Executive Summary

1

Globally, Australia has some of the best maternal health outcomes worldwide, evidenced by low maternal and infant mortality rates. However, there are persistent disparities in maternal and perinatal health outcomes for Aboriginal and Torres Strait Islander women compared with non-Indigenous women.[1-2]

Maternal health services play a vital role in creating a healthy foundation through supporting women during pregnancy, birth and the postpartum period.[3] Moreover, child and maternal health feature as a priority in the many national and Queensland policies and strategies addressing Aboriginal and Torres Strait Islander health outcomes.This support is vital for helping close the gap in Aboriginal and Torres Strait Islander maternal health outcomes. Creating safe birthing journeys for women birthing Aboriginal and Torres Strait Islander babies is the foundation required to ensure the best possible outcomes for women, and their babies. To improve the outcomes for women birthing Aboriginal and Torres Strait Islander babies, we must first understand their journey.

The Growing Deadly Families Strategy 2019–2025 (the Strategy)[4] is the Queensland Government's commitment to action that improves the patient journey and promotes strong outcomes for women birthing Aboriginal and Torres Strait Islander babies, and their babies. Under the Strategy, the Maternity Services Integration Project (MSIP) was funded. MSIP incorporates three main components to improve health outcomes for Aboriginal and Torres Strait Islander mothers and babies:

- a state-wide review of maternity service models used across the ATSICCHO sector to deliver maternity services
- delivery and evaluation of local placed-based integration activities
- the co-design and distribution of maternal health promotional products.

This report is the evaluation of the place-based component of the MSIP. Eight sites participated in this component. The aim of the evaluation was to examine the effectiveness of the site-specific activities in improving the integration of maternity service delivery between ATSICCHOs and their respective HHSs and to inform embedded and sustainable, culturally safe maternal health models of care appropriate for Aboriginal and Torres Strait Islander mothers and babies.

This report demonstrates both have been achieved. The evaluation was informed by review of program documentation and background reading, review of the monthly progress reports from each of the eight sites, a questionnaire for each participating HHS, and focus groups and interviews with key stakeholders from participating sites. The evaluation team also attended the two virtual forums held in September and December 2020 designed to showcase and share learnings from participating sites.

The place-based activities occurred in the context of the health system's need to focus on the urgent and immediate threat of COVID-19.[5] The public health response to COVID-19 has strongly impacted the ability of this project to gather the data required to fully evaluate the project and to fully understand the impact of place-based activities. It has also revealed much about how services and systems cope under pressure and how adaptable services and personnel are to a changing environment. Through this, COVID-19 has revealed vulnerabilities in existing systems and there are lessons to take forward to strengthen these systems. One key lesson has been a reinforcement of the model of care and service delivery of ATSICCHOs and how this assisted to minimise the spread of COVID-19 within Aboriginal and Torres Strait Islander communities across Australia.[6]

Within Australia's health system there is a tension between provision of services in primary and secondary care and this tension was evident in this project. Barriers to effective integrated services found in this project mirror the structural barriers (and much needed reform) more broadly. Success in resolving this tension through learnings from these place-based activities will provide evidence of ways forward for other parts of the health system that continue to grapple with challenges of integration of services across primary and secondary levels of care.

Effective integrated models of care require formal partnerships to support informal collaboration. Communication is key. There is a need for formal communication mechanisms as well as structures and activities to support relationships for effective informal communication.

This evaluation shows genuine co-design was successfully undertaken and offers suggestions for future co-design efforts as a key element in an integrated approach to the care of mothers and babies.

The co-design of site activities was predominately led by ATSICCHOs and HHS personnel involvement was positive overall. Place-based activities were most successful when the co-design was collaborative and involved personnel from the HHS.

A long history of effective information sharing between some ATSICCHOs and HHSs exists and was illustrated in this evaluation. Where formal structures for information sharing exist, they support maintenance of relationships and information sharing. The strong need for systems and formal approaches cannot be overemphasised. Turnover of staff in both HHSs and ATSICCHOs was evident. This was exacerbated by COVID-19 impacts as staff were redeployed. Staffing turnover highlighted how information sharing suffers without formal systems in place.

Integration of services is complex. For services with many variables, like maternity, this complexity is compounded. For integration to be successful, a full understanding of the service offering of one partner, by the other partner is essential. Where this is achieved, integration of service to fully support mothers and babies is more successful. HHSs must recognise the important role of ATSICCHOs in the transition between the primary and secondary health systems for achieving an integrated experience for the mother and Aboriginal and Torres Strait Islander baby.

The implications that arise from the evaluation of the eight place-based activities focus on a shared understanding of services, policy and context; a shared understanding of the required breadth of maternity services; the role of the Aboriginal Health Worker; capacity building, including staffing levels; cultural safety; communication; and suggestions for future evaluation steps.

This evaluation reveals there is passion, dedication and an abundance of goodwill from individuals who aim to provide quality care to mothers and babies. The place-based activities particularly highlight the dedication of ATSICCHO maternal care staff to facilitate cross-sector collaboration to support women birthing Aboriginal and Torres Strait Islander babies. The leadership offered by QAIHC across the implementation of place-based activities was highlighted as critically important by ATSICCHO sites. As a coordinating body working across multiple HHSs and with several ATSICCHOs, QAIHC was able to bring an additional perspective and offer solutions that were not always readily available at the local level.

This report outlines key lessons learnt from this project and implications for shared maternity care, which, if actioned, would support the achievement of the aim and priorities of Growing Deadly Families Aboriginal and Torres Strait Islander Maternity Services Strategy 2019–2025.[4]

2

About the Maternity Services Integration Project

QAIHC secured funding from the Aboriginal and Torres Strait Islander Health Division (ATSIHD) and the Clinical Excellence Division of Queensland Health to deliver the Maternity Services Integration Project (MSIP) in 2019. The overarching aim of the MSIP was to improve the maternity services journey of women birthing Aboriginal and Torres Strait Islander babies in Queensland across primary and tertiary health care settings—working together to provide one system of culturally safe care.

This project aimed to facilitate the establishment of partnerships and improve the integration of maternity services between ATSICCHOs and HHSs across the state of Queensland.

2.1 Project components

MSIP incorporates three main components to improve health outcomes for Aboriginal and Torres Strait Islander mothers and babies.

2.1.1 State-wide component

A reflective case study of maternity services throughout Queensland was undertaken. This included a comprehensive review of the literature, a critical appraisal of current maternity services and integration models for women birthing Aboriginal and Torres Strait Islander babies in Queensland, and in-depth consultation with ATSICCHOs and HHSs.

The State-wide component of MSIP was completed in January 2021. The report, Maternity Services Integration Project (MSIP) State-wide Review of Models of Maternity Service[7], provides background and policy context to highlight what models are available and how they are enhanced using programs aimed at improving cultural support. It also explores any system and policy barriers that prevent women from experiencing an efficient, effective and culturally safe maternity journey. The report provides six practical recommendations aligned with the Growing Deadly Families Strategy.[4]

2.1.2 Place-based component

The place-based component has a site-specific focus on the implementation of a co-designed integration activity by participating ATSICCHOs and their local HHS for mothers birthing an Aboriginal and Torres Strait Islander baby.

2.1.3 Resource development

The MSIP activity also included the co-design and distribution of maternal health promotional products. These were designed to support women birthing Aboriginal and Torres Strait Islander babies, and to resource ATSICCHOs in the important maternal and child health work they do.

The resource component of MSIP was completed and evaluated in April 2021. The report, Evaluation of Maternal Health Promotion Materials: As part of the Maternity Services Integration Project[8], outlines the key findings and implications to inform future design, delivery and sustainability of health promotion activities aimed at improving maternal health care for women birthing Aboriginal and Torres Strait Islander babies. The overall aim of this evaluation was to undertake a process and implementation evaluation of the MSIP maternal health promotion material and gain insight into the integration of maternal health care delivery in ATSICCHOs and their local HHS.

3 Context

3.1 COVID-19

This project was delivered during the global COVID-19 pandemic.[5] COVID-19 has had impacts in all areas of life, work and society. For organisations and individuals in the healthcare system, the impact was significant.

COVID-19 required ATSICCHOs and the broader health system to develop multifaceted prevention and response activities across the breadth and depth of the sector. The MSIP project occurred in the context of the health system's need to focus on the urgent and immediate threat of COVID-19.

The public health response to COVID-19 has strongly impacted the ability of this project to gather the data required to fully evaluate the project and to fully understand the impact of place-based activities. However, it has also revealed much about how services and systems cope under pressure, including how adaptable services and personnel are to a changing environment. The impacts on the project are discussed in Section 7.6.

3.2 Policy context

Aboriginal and Torres Strait Islander Maternal and Child health outcomes are a priority in national and state policy documents, which highlight the need for focused and effective efforts to create positive change.

3.2.1 National

The National Agreement on Closing the Gap (agreed in July 2020) identifies four priority reform areas which are designed to change and measure the way governments work with Aboriginal and Torres Strait Islander peoples and communities. It also identifies 16 socio-economic targets focused on areas including education, employment, health and wellbeing, justice, safety, housing, land and waters, and Aboriginal and Torres Strait Islander languages.[9] Targets of specific relevance to maternity services include:

- **Target 1:** Close the Gap in life expectancy within a generation, by 2031.
- **Target 2:** By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91 per cent.
- **Target 4:** By 2031, increase the proportion of Aboriginal and Torres Strait Islander children assessed as developmentally on track in all five domains (physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, (school-based) communication skills and general knowledge) of the Australian Early Development Census (AEDC) to 55 per cent.

In 2008, the Council of Australian Governments agreed to prioritise 'Closing the Gap' through the *National Indigenous Reform Agreement (NIRA)*. The *National Agreement on Closing the Gap* (2020)[9] builds upon those concerted efforts to improve the health outcomes of Aboriginal and Torres Strait Islander peoples.

3.2.2 Queensland

In Queensland, the efforts, investment and priorities for the health of Aboriginal and Torres Strait Islander peoples is guided by the *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033: Policy and Accountability Framework* ("Making Tracks").[10]

Making Tracks involves a revision of the investment and direction of efforts every three years and aims to provide current, evidence-based decisions that support improved outcomes. Making Tracks has a whole-of-life view, with interventions focused across the life course, but specifically identifies early life as a priority area: "A healthy start to life—Giving Aboriginal and Torres Strait Islander children 0–8 years a healthy and safe start to life through effective women's health services, antenatal and infant care, improved education outcomes and child protection services". [10]

In November 2019, Queensland's Minister for Health announced the launch of the *Growing Deadly Families Strategy*[4]. The Strategy was informed by a Clinical Senate Forum held in 2017, which was attended by maternity service health professionals, policy writers, senior government advisers, and consumers. As documented in the Strategy, there was an overwhelming recurrence of three themes:

1. *We want a say in how maternity services are designed and delivered.*
2. *We don't want to keep telling our same story to different people.*
3. *We want more of our people providing our maternity care.*

The Strategy aims to prioritise locally developed solutions to support better integrated care through the sharing of information processes and improved professional relationships between the ATSICCHO Sector and Queensland HHSs.

In August 2020, the *Health Legislation Amendment Act 2020* was assented by Queensland Parliament following reports by Queensland Human Rights Commission (QHRC) and QAIHC.[11-13] The Act sets out a range of amendments to the *Hospital and Health Boards Act 2011*, which includes a now-legislated requirement for all HHS to have a Health Equity Strategy and a position on the Board of Directors specifically designated for a person who identifies as Aboriginal and/or Torres Strait Islander. The *Health Legislation Amendment Act 2020* is part of a wider health reform agenda across Queensland which seeks to ensure there are Aboriginal and Torres Strait Islander voices and guidance across all levels of HHS governance.

4

Evaluation Framework

QAIHC developed an Evaluation Framework (approved by ATSIHD), presented in the report Maternity Services Integration Project: Development of an Evaluation Framework through Co-Design[14] *to provide overall guidance to the evaluation.*
The framework includes three components:

1. *Evaluation approach, including aims, key evaluation questions, scope, domains, and methodology.*
2. *Probity and ethical considerations, including data protection, storage, confidentiality and retention, and ethics approval.*
3. *Significance, including anticipated benefits and dissemination of findings.*

4.1 Framework

4.1.1 Aim

The overall aim of the evaluation is to examine the effectiveness of the site-specific activities in improving the integration of maternity service delivery between ATSICCHOs and their respective HHSs.

The evaluation also aims to inform an embedded and sustainable maternal health model of care, which is culturally appropriate to Aboriginal and Torres Strait Islander mothers and babies.

4.1.2 Approach

The evaluation framework outlines an approach that is:

- Underpinned by the NHMRC guidance framework on *Ethical Conduct in research with Aboriginal and Torres Strait Islander peoples and communities: Guidelines for researchers and stakeholder*.[15]
- Focused on ensuring research activity is for the direct benefit of Aboriginal and Torres Strait Islander peoples, communities, and community-controlled organisations
- Built on a foundation of respect, rights, consultation, mutual understanding, partnership and agreement
- Includes recognition of, and respect for, Aboriginal and Torres Strait Islander peoples' right to self-determination as being fundamental to all Australian Indigenous research
- Recognises the active engagement of Aboriginal and Torres Strait Islander peoples in research affecting them and their communities as a core principle
- Fosters action research processes to ensure the active participation of Aboriginal and Torres Strait Islander peoples and genuine collaboration in the co-design of key research components.

4.1.3 Key evaluation questions

The key evaluation questions ask:

- How are site-specific activities improving maternity service delivery and integration being implemented across participating ATSICCHOs?
- What are the enablers and inhibitors for implementing the site-based maternal health activities?
- What changes are happening as a result of these site-specific activities including:
  - collaboration and formal partnerships
  - co-design
  - information sharing
  - service integration?
- What else may be needed to improve maternal health delivery between ATSICCHOs and their respective HHSs?
- Are there learnings that are transferable for improving other health services delivery and integration for Aboriginal and Torres Strait Islander Peoples?

4.1.4 Evaluation domains

The MSIP and associated project activities focussed on five evaluation domains. These were used to ensure standardisation across the eight participating sites and provided clear parameters for local integration activities. Table 1 outlines the domains, and the terms used to describe domain-specific features of the evaluation.

These five domains are aligned with the outcomes of the Queensland Health Clinical Senate held in August 2017 (see Section 3.2.2) and are reflected in the deliverables and performance measures of the Service Agreement between QAIHC and the project funding body, Queensland Health.

Table 1. Evaluation domain terminology

Collaboration and formal partnerships	Steps to strengthen relationships and the establishment of formal partnerships between the ATSICCHO and the HHS
Enablers and inhibitors	Identified existing, potential and perceived barriers and strengths of the ATSICCHO and the HHS
Co-design	Evidence of co-design of integrated maternity services between the ATSICCHO and the HHS
Information sharing	Plan to improve information sharing processes and protocols between the ATSICCHO and the HHS as implemented
Integration	Local solutions to overcome existing barriers and promote better integration across the ATSICCHO and the HHS

4.1.5 Domain indicators

The following indicators were measured for each domain:

- inputs
- outputs: results of activity
- outcomes: short- or medium-term effects of outputs
- influence: longer-term influence of outputs.

Where appropriate, consideration was also given to progress made in future planning related to each domain, both strategic and operational. Areas where progress has been made and are yet to be completed will be denoted as 'in development.'

4.2 Methodology

The evaluation employed a combination of quantitative and qualitative methods to ascertain the success of place-based activities in improving the integration of maternity services between the ATSICCHOs and respective HHSs.

A combination of data sources were used in this evaluation, combining interviews, focus groups and surveys as well as reviewing the available evidence from progress and final reports. The evaluation also reviewed meeting documentation as evidence to support key findings.

The evaluation was informed by:

- A review of program documentation and background reading to understand the evolution of the MSIP objectives and activities across the State.
- Reviews of the monthly progress reports that collated site-specific information from each site, with a focus on the evaluation domains and site-specific data (see Section 10.1 and 10.2).
- Questionnaires for each participating HHS. This was sent to all sites in the form of a final report during the final month of their MSIP activities (see Section 10.1).
- Focus groups or interviews with key stakeholders involved with the participating sites directly involved in the integration activity.
- The evaluation team also attended the two virtual forums held on 16 September and 9 December 2020, which were designed to showcase and share the learnings of participating sites.

Further details regarding the methodology, including the evaluation scope, ethical approvals, and data collection and management are provided in Section 10.1.

4.3 Data limitations

There are several limitations to the data that were analysed to identify the findings and implications during the evaluation process.

First, eight sites for the place-based activities were a sample of sites from across Queensland and while diverse, did not represent all ATSICCHOs or HHSs. As every ATSICCHO and every HHS is unique and has evolved its services and models of service delivery to suit local circumstances, there is caution in moving from a discussion about specific circumstances—which may be unique to a particular site or location—to a broader, more generalised discussion that may be applied across the State. Acknowledging this limitation, the breadth of diversity within the eight place-based sites suggests that where there are common themes across multiple sites, these may be translatable to a broader context.

Second, the emergence of COVID-19 impacted both the completion of some activities and the ability to collect data and further evidence. This restricted the quantitative analysis that was possible due to the lack of statistical power for certain data sets. No attempt has been made to use data that did not generate significance to draw conclusions.

It is acknowledged there may be some bias in the discussion and conclusions as those who responded with evaluation data and information, including through the emergence and impact of COVID-19, were those that may lean toward those who desire an integrated approach in maternity care. This potential bias does has not impacted on the evaluation report as those with expressed interest have been constructive in their approach.

Overview of place-based activities

5

Place-based activities with QAIHC Members focused on the integration of maternity service delivery for women birthing Aboriginal and Torres Strait Islander babies who were accessing antenatal and postnatal care.

Maternal health staff at each ATSICCHO worked with their corresponding HHS to develop local activities to support culturally safe care pathways for Aboriginal and Torres Strait Islander babies and their mothers.

QAIHC undertook a facilitation role between service providers to develop the planned activities in alignment with the five domains.

The place-based MSIP activities took place at eight QAIHC Members in partnership with three Queensland HHSs. Table 2 lists participating QAIHC Member and respective HHSs. While these local ATSICCHOs and HHSs all provide maternal health services, there is variation in service delivery models and levels of integrated care.

5.1 Participating QAIHC Members

Table 2. Participating QAIHC Members and respective HHSs

QAIHC Members	Hospital and Health Service (HHS)
1. Apunipima Cape York Health Council	Cairns and Hinterland HHS
2. Gurriny Yealamucka Health Service Aboriginal Corporation	
3. Mamu Health Services	
4. Mulungu Aboriginal Corporation Primary Health Care Service	
5. Wuchopperen Health Service	
6. Darling Downs Shared Care Incorporated t/a *Carbal Medical Services*	Darling Downs HHS
7. Goondir Medical Services	
8. Girudala Community Co-operative Society Ltd.	Mackay HHS

Each place-based MSIP site is described in detail in Section 6. The results are grouped into the three regions of Queensland where the Members and associated HHS are based.

In each section, a regional overview of maternal care services is provided, along with a description of the eight QAIHC Members, the maternity demographics, and the integration activity. For each site, additional data (see Section 10.2) is provided that details the joint maternal services prior to MSIP and data collected from each site in line with the evaluation framework. This data includes the five domains that are documented with project indicators and site-specific data and challenges.

5.2 Timeline

QAIHC's philosophy of fostering strong relationships through meaningful engagement underpinned all the MSIP activities. Whilst this timeline represents the key milestones of the project, consultation between QAIHC and participating Members was ongoing.

Figure 3. Timeline

August 2017	Growing Deadly Families: A Healthy Start for Mums and Bubs Forum
2018–2019	Comprehensive feedback on QH Draft Maternity Services Action Plan
Feb–March 2019	QAIHC consultation with Members
March 2019	Establishment of MSIP
March 2019	Development of Evaluation Framework
June 2019	Funding allocation
June–August 2019	Recruitment and orientation of Apunipima, Gurriny, Mamu, Mulungu, Wuchopperen
18 July 2019	Cairns and Hinterland ATSICCHO and HHS stakeholder meeting
20 September 2019	Cairns and Hinterland, Darling Downs and Townsville HHS Stakeholder meeting
December 2019	Growing Deadly Families: A Healthy Start for Mums and Bubs strategy launch
9 January 2020	Far North Queensland Human Research Ethics Committee ethics approval
March 2020	Global COVID-19 Pandemic declared
March 2020	Expansion of MSIP
March–April 2020	Recruitment and orientation of Carbal, Goondir, Girulada
March–August 2020	MSIP 1 Activity period
16 September 2020	MSIP 1 Forum
21 April 2020	The Townsville Human Research Ethics Committee ethics approval
May–October 2020	MSIP II Activity period
18 November 2020	Presentation at POCHE Indigenous Health Network 9th Annual Aboriginal Research Showcase
1 December 2020	MSIP Presentation at First Nations Child Health Working Group
9 December 2020	MSIP II Forum
December–February 2021	Data compilation and analysis
February–April 2021	Bespoke follow-up with Members re: evaluation report
March–April 2021	Place-based evaluation report finalised

Results from participating Members

6

QAIHC's philosophy of fostering strong relationships through meaningful engagement underpinned all the MSIP activities and a wide range of engagement and data collection tools were utilised, including:

HHS information

One-on-one consultations

Group sessions

Online responses

Opportunistic discussions

MSIP Forums

The evaluation is informed by:

40 Place-based monthly reports (eight sites, five months)

8 Final place-based reports

8 Place-based discussions (eight sites)

8 Place-based presentations (eight sites)

Queensland Place-based Activities

Cairns and Hinterland Region

The Cairns and Hinterland region has five ATSICCHOs providing culturally safe health and social care to Aboriginal and Torres Strait Islander peoples. These include Apunipima Cape York Health Council, Gurriny Yealamucka, Mamu Health Service Limited, Mulungu Aboriginal Primary Health Care Service and Wuchopperen Health Service Limited. Each of these Members offer maternal health care and participated in the place-based component of the MSIP.

This region is serviced by the Cairns and Hinterland Hospital and Health Service (CHHHS), which covers seven local government areas (LGAs). Cairns Hospital (CH) is the primary site for women associated with Apunipima, Wuchopperen, and Gurriny ATSICCHOs to birth their babies. The Cairns Birth Centre is also available to women who elect to have care provided within the Midwifery Group Practice model of care for birthing. Particular characteristics of this region include:

- In 2019, there were 3096 babies born in the CHHHS region across the seven LGAs including Cairns (2114), Cassowary Coast (338), Mareeba (266), Tablelands (233), Douglas (132), Etheridge (7), and Croydon (6).[16]
- In 2019, there were 2310 babies born at CH.[17]
- 33 per cent of women who birthed at CH in 2019 identified as Aboriginal and/or Torres Strait Islander.
- Women from The Cape and Torres Strait HHS travelled to CH to birth.

Innisfail Hospital is the primary site for women accessing care through Mamu, to birth their babies. In 2019, there were 191 births at Innisfail Hospital.[17]

Women accessing maternal health care through Mulungu, primarily birth at Mareeba Hospital—although some travelled to CH. In 2019, there were 167 births at Mareeba Hospital.[17]

Further information regarding the CHHHS maternal health care services is available in the associated report entitled "State-wide Review of Models of Maternity Service".[7]

6.1 Site One: Apunipima

6.1.1 About Apunipima

Apunipima was officially established on 14 September 1994 as a health advocacy organisation, mandated to inform the Cape York Land Council and the ATSIC Regional Council about health issues on Cape York.

In the two decades since its inception, Apunipima has grown from a small advocacy organisation to the largest Aboriginal Community Controlled Health Organisation in Queensland. Apunipima delivers a comprehensive primary health care service to 11 Cape York communities. With more than 150 staff, offices in Cooktown, Mapoon and Coen, the Mossman Gorge health centre and the Kowanyama Mums and Bubs clinic, Apunipima is continuing with its mission to eliminate health inequality on the Cape. Apunipima adheres to a family-centred model of comprehensive primary health care, which sees clients as people embedded in families and communities.

apunipima.org.au

6.1.2 Maternity demographics

No data was available at this site, at the time of reporting.

6.1.3 Integration activity summary

Project title: Improving collaborative midwifery clinical care between Apunipima and Cairns Hospital.

This project aimed to expand the maternity service delivery for Apunipima Cape York clients who travel to Cairns at 36 weeks gestation to await delivery at Cairns Hospital. The Apunipima Midwife and Aboriginal Health Worker delivered on-site visits with mothers at their temporary residence in Cairns. For many women, this was at Mookai Rosie Bi-Bayan accommodation, a safe and respectful environment for Aboriginal and Torres Strait Islander women and their babies located in Edmonton, south of Cairns. In addition, Apunipima staff liaised with CH staff to ensure all health service providers were aware of the health status of the clients.

6.1.4 Further data

See Section 10.2 for further information about Apunipima's joint maternal services prior to MSIP, and data collected from each site in line with the evaluation framework, including the five domains that are documented with project indicators, site-specific data, and challenges.

6.2 Site Two: Gurriny Yealamucka

GURRINY YEALAMUCKA
HEALTH SERVICE ABORIGINAL CORPORATION

6.2.1 About Gurriny Yealamucka

Gurriny Yealamucka is a local Gungganghi name which means 'Good Healing'. Gurriny Yealamucka Health Services Aboriginal Corporation ('Gurriny') is an Aboriginal Community Controlled Health Service delivering primary health care services within the Yarrabah Aboriginal Shire in Far North Queensland.

Gurriny's role in health services began in the 1980s when Yarrabah Aboriginal Council commissioned a community health assessment and the development of a five-year plan to have Aboriginal health in the hands and care of their own people. Significant developments in the 1990s and early 2000s saw funding opportunities used for innovative programs, a feasibility study and lobbying for Gurriny to become community-controlled. Delivery of primary health care commenced in 2009, and community control of all health services to Yarrabah people was finalised in 2014.

Gurriny Yealamucka now operates multiple clinical services and programs that address health issues in Yarrabah and employs up to about 80 staff, of whom 70 per cent are local people. The core business of Gurriny is to provide a culturally sensitive, multipurpose primary health care service for the community with the primary focus being on preventative health care, including strategies that target early intervention.

gyhsac.org.au

6.2.2 Maternity demographics*

41

Babies per year

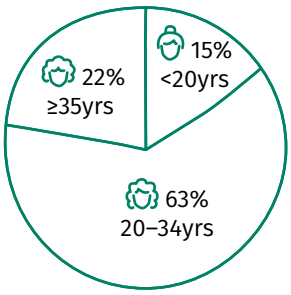
Approximate number of women birthing Aboriginal and Torres Strait Islander babies per year = 41 (50–70 per year).

6

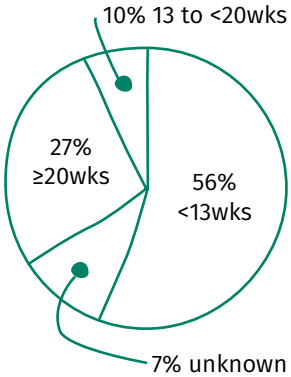
Antenatal visits

Average number of antenatal visits = approximately six per client.

Age of patients



Gestation at first presentation



**Maternity demographics data reported for 1/7/201 to 30/6/2020*

6.2.3 Integration activity summary

Project title: Connecting Communities: Journeying Safely, Returning Strong.

Gurriny Yealamucka and the CH Antenatal, Birthing and Maternity Services designed a project to address workforce development. The activities aimed to address continuity of care, discharge planning and CH clinicians' understanding of the context of care for women birthing Aboriginal and Torres Strait Islander babies. A site visit by Gurriny Maternal Health worker (MHW) to the CH birthing suite and collaborative work on a Memorandum of Understanding (MOU) were key aspects of the project.

6.2.4 Further data

See Section 10.2 for further information about Gurriny's joint maternal services prior to MSIP, and data collected from each site in line with the evaluation framework. This includes the five domains that are documented with project indicators, site-specific data and challenges.

6.3 Site Three: Mamu

6.3.1 About Mamu

Mamu Health Service Limited ('Mamu') has been incorporated since 1 May 1990. Prior to this, Mamu were a branch of Wuchopperen Medical Service in Cairns, which was established in July 1981. Basic clinics began operating in Innisfail in 1984.

Mamu became autonomous from Wuchopperen in 1990 and in 1992 established an outreach clinic in Ravenshoe. This now extends into the Mount Garnet communities. In 2011, Mamu established primary health care outreach clinics in Babinda, Tully and Cardwell and relocated the Ravenshoe clinic into a new purpose-built, multi-disciplinary clinic.

Mamu Health Service Limited provides culturally appropriate and comprehensive primary health care programs for Aboriginal and Torres Strait Islander People and communities in the Innisfail and surrounding areas.

mamuhsl.org.au

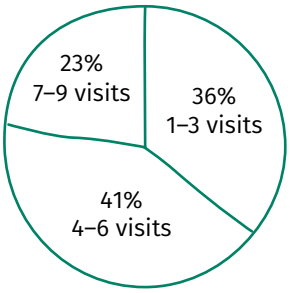
6.3.2 Maternity demographics*

40

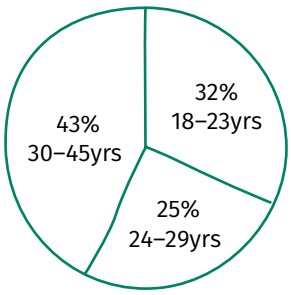
Babies per year

Number of women birthing Aboriginal and Torres Strait Islander babies = 40.

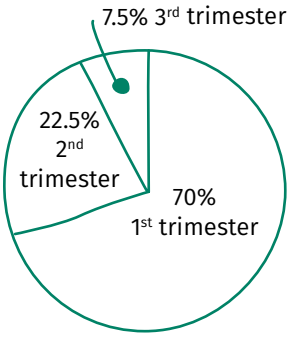
Antenatal visits



Age of patients



Gestation at first presentation



**Maternity demographics data reported for 2018–2019*

6.3.3 Integration activity summary

Project title: Innisfail Hospital Maternity Unit Midwives to work at Mamu Mum and Bubs clinic.

Mamu Health Service Limited collaborated with Midwives from the Maternity Unit at Innisfail Hospital to create and utilise a designated, culturally safe antenatal room at Mamu Clinic for antenatal appointments. In addition, Mamu staff attended the Innisfail Antenatal clinic staff meetings and were able to support women birthing Aboriginal and Torres Strait Islander babies within the mainstream hospital setting.

6.3.4 Further data

See Section 10.2 for further information about Mamu's joint maternal services prior to MSIP, and the data collected from each site in line with the evaluation framework, including the five domains that are documented with project indicators, site-specific data and challenges.

6.4 Site Four: Mulungu

6.4.1 About Mulungu

Mulungu Aboriginal Corporation Primary Health Care Service

Mulungu Aboriginal Primary Health Care Service ('Mulungu') is run by the Aboriginal community of Mareeba, located in the Tablelands region. Mulungu is an Aboriginal Community Controlled organisation working to improve health outcomes and wellbeing for the Indigenous population of Mareeba. Mulungu achieves this through providing comprehensive primary health care services that respond to the physical, spiritual, cultural, emotional, and social wellbeing needs of the community and by empowering the community to manage their own health and wellbeing.

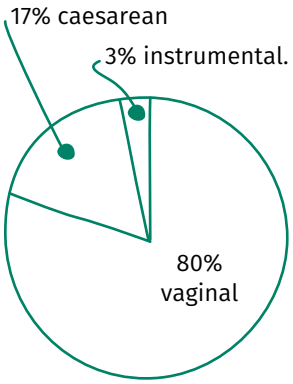
Mulungu strives to provide high quality medical services and support to the Aboriginal and Torres Strait Islander communities by providing culturally appropriate health care for people of all ages in the community. Mulungu has 80 staff members, with 95% identifying as Aboriginal and Torres Strait Islander.

mulungu.com.au

6.4.2 Maternity demographics*

19.5%
Women identified as Aboriginal or Torres Strait Islander

Type of birth



**Maternity demographics Data from Mareeba Hospital Midwives Group Practice (CHHHS) for the 2018/19 period*

45%
Women attended their first antenatal visit during the first trimester

97%
Women attended five or more antenatal visits

44%
Smoked at some time during the pregnancy

37%
Were smoking after 20 weeks

1.4%
Babies were of low birth weight

1.4%
Babies were pre-term deliveries

6.4.3 Integration activity summary

Project Title: Prenatal and postnatal care co-ordination between Mulungu and Mareeba Hospital.

Mulungu Aboriginal Primary Health Care Service worked with Cairns and Hinterland Hospital and Health Service (CHHHS) to develop a shared care model so that women could opt to receive antenatal care at either Mareeba Hospital, Mulungu, or both. Staff from both services were committed to the significance of culturally appropriate care for women and their babies. A key component of this project was to review the quality of information flow between organisations.

6.4.4 Further data

See Section 10.2 for further information about Mulungu's joint maternal services prior to MSIP, as well as the data collected from each site in line with the evaluation framework, including the five domains that are documented with project indicators, site-specific data and challenges.

6.5 Site Five: Wuchopperen

6.5.1 About Wuchopperen

Wuchopperen Health Service Limited ('Wuchopperen') was established in 1979 and began providing primary health care services in 1981. Their main aim is to improve quality of life for Aboriginal and Torres Strait Islander peoples. Wuchopperen has primary health care facilities in Manoora and Edmonton and a child service in Atherton.

The organisation provides a range of services addressing the physical, social, emotional and spiritual wellbeing of individuals and families. Wuchopperen also provides child wellbeing services including foster and kinship care and a Family Wellbeing service, which supports at-risk families. Wuchopperen is a not-for-profit, membership-based ATSICCHO that delivers an integrated, holistic primary health care service to Aboriginal and Torres Strait Islander peoples in the greater Cairns area.

The organisation is governed by a 10-person Board of Directors elected annually by Wuchopperen members. The organisation has around 200 staff with approximately 70 percent identifying as Aboriginal and/or Torres Strait Islander. Wuchopperen offers culturally appropriate, comprehensive primary health care which includes medical and social and emotional wellbeing services.

wuchopperen.org.au

6.5.2 Maternity demographics

No data for maternity demographics at this site was available at the time of the report.

6.5.3 Integration activity summary

Project Title: Working better with Cairns Hospital Antenatal Clinic.

This co-designed project aimed to establish weekly case-conferencing between Wuchopperen Health Service and the Cairns Hospital Antenatal Clinic Staff. A Terms of Reference (TOR) agreement formalised the process and regular meetings were scheduled to achieve the project goals. Wuchopperen and CH also aimed to develop a number of hand-held information resources for birthing mothers.

6.5.4 Further data

See Section 10.2 for further information about Wuchopperen's joint maternal services prior to MSIP, and data collected from each site in line with the evaluation framework. This includes the five domains that are documented with project indicators, site-specific data and challenges.

Darling Downs Region

The Darling Downs region has four ATSICCHOs providing culturally safe health and social care to Aboriginal and Torres Strait Islander People. Two QAIHC Member Services that offer maternal health care opted into the place-based component of MSIP. These were Goondir Health Services and Carbal Medical Services.

This area is serviced by the Darling Downs Hospital and Health Service (DDHHS), which has four sub-regions. Toowoomba Hospital (Toowoomba region) and Dalby Hospital (Western Downs region) are the primary birthing sites for women accessing care through Carbal and Goondir. However, some clients with high-risk pregnancies are required to birth in Brisbane. In 2019, the following information was documented in the Darling Downs region:

- There were a total of 3797 babies born in the DDHHS region including Toowoomba (2214), Western Downs (464), Southern Downs (384), South Burnett (386), Goondiwindi (149), Cherbourg (29) and Banana (171).[16]
- There were 2046 babies born at Toowoomba Hospital[17]
- 12.3% (251) women who birthed at Toowoomba Hospital identified as Aboriginal and Torres Strait Islander.
- 228 babies were born at Dalby Hospital.[17]
- 11.0% (25) women who birthed at Dalby Hospital identified as Aboriginal and Torres Strait Islander.

Further information regarding the maternal health care services in the Darling Downs region is available in the associated report, "State-wide Review of Models of Maternity Service".[7]

6.6 Site Six: Carbal

6.6.1 About Carbal

Carbal Medical Services ('Carbal') operates in the Darling Downs, Goondiwindi and Southern Downs regions of Queensland.

Carbal provides a high quality, sustainable and comprehensive primary health care service with a balance of clinical and population health programs that are culturally safe, responsive to community needs, and integrated with other complementary service providers.

Carbal has a holistic approach to caring for the individual and exploring all factors that contribute to wellbeing. Their team of General Practitioners (GPs), Nurses and Aboriginal Health Workers (AHWs) deliver a wide range of medical services and health programs including: primary health care, women's health, chronic disease management, hearing health, Integrated Team Care, Carbal Support Services (e.g. NDIS and Continuity of Support), Carbal Addiction Support Services, Strong Fathers, Strong Mothers, Strong Families, and Marlu Youth Program, as well a range of allied health services.

Carbal's maternal and child health services are designed to provide holistic support for mothers and families during pregnancy and the first five years. They bridge the gap between General Health Practitioners and the Darling Downs Health Service (DDHS). They provide services including health checks, pregnancy care, and advice on health issues including breastfeeding, immunisations, social support, transport, child development, and a support group for new mothers. The 'New Directions' program supports women throughout the maternal journey (antenatal to postnatal), with regular support and health checks. Women may also receive maternal health checks and support by attending the Carbal clinic—but they do not necessarily need to enrol in the 'New Directions' Program.

carbal.com.au

6.6.2 Maternity demographics

~60

per year

Number of women birthing Aboriginal and Torres Strait Islander babies through the **'New Directions' Program**

~3

Average number of antenatal visits per client

79

Births during 2020 (not all were part of the New Directions program)

Age of patients

~20–30

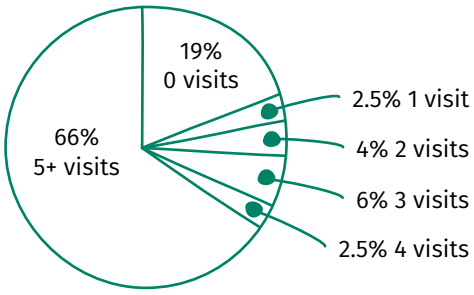
years old

Gestation at first presentation

~13

weeks

Number of antenatal visits



6.6.3 Integration activity summary

Project title: Mubal-Yaal Yarnin

Carbal Medical Services and DDHHS collaborated on the design and delivery of culturally safe antenatal classes for women in the Toowoomba and Warwick regions. Formalisation of the project with a contract and the commitment of staff from both services to the project enabled good communication and strengthening of professional relationships between the services. The content and inclusions for the antenatal classes were informed by a visit to an HHS sister-site (Moree), co-design meetings and feedback from community. The classes aimed to provide culturally appropriate and engaging education and support to women birthing Aboriginal and Torres Strait Islander babies.

6.6.4 Further data

See Section 10.2 for further information about Carbal's joint maternal services prior to MSIP, and data collected from each site in line with the evaluation framework. This includes the five domains that are documented with project indicators, site-specific data and challenges.

6.7 Site Seven: Goondir

6.7.1 About Goondir

Goondir Aboriginal and Torres Strait Islander Corporations for Health Services ('Goondir') was incorporated on 19 April 1994 to provide primary health care and related services to the Aboriginal and Torres Strait Islander communities.

Goondir operates across a region that spans 160 000 square kilometres from Oakey in South-East Queensland to St George in South-West Queensland. With more than 60 employees, health services are delivered to more than 5,000 clients through Goondir's medical clinics located in the townships of Dalby, St George and Oakey. Communities including Jandowae, Surat, Dirranbandi, Thallon, Chinchilla and Tara are supported by Goondir. Goondir operates in a region serviced by several Darling Downs Health and Hospital Services (DDHHS), primarily the Western Downs Region (including Dalby Hospital) but also within the Toowoomba region (including Toowoomba Hospital).

Although Goondir's core business activity involves the delivery of primary health care services, Goondir actively promotes interventions and educational programs including: Maternal and Child Health, Sexual and Reproductive Health, Social and Emotional Wellbeing, Dental Health, Diabetes Care and Hearing Health. Maternal and Child Health services at Goondir is staffed by a Registered Nurse with qualifications in Midwifery. The Nurse is qualified to provide health checks, pregnancy care, and advice on health issues including breastfeeding, immunisations, and child development.

goondir.org.au

6.7.2 Maternity demographics*

89
Aboriginal and Torres Strait Islander babies

10
Average number of antenatal visits per client

Average age of patients
26
years old

Average gestation at first presentation
14
weeks

**Maternity demographics data summary for 2020 calendar year from the Western Downs region (serviced by Dalby Hospital)*

6.7.3 Integration activity summary

Project Title: Maternal Care Navigation

Goondir Health Service and the Darling Downs Hospital and Health Service (DDHHS) partnered to streamline referral pathways for women birthing Aboriginal and Torres Strait Islander babies from the regions of St George, Dalby and Oakey. More specifically, this project sought to appoint a 'Maternal Care Navigator' to assist cross-sector communication and address gaps in processes. Project partners saw the potential for this integration to increase early referral to the Midwifery Group Practice (MGP) and lift attendance rates of women birthing Aboriginal and Torres Strait Islander children for maternal care appointments.

6.7.4 Further data

See Section 10.2 for further information about Goondir's joint maternal services prior to MSIP. It also outlines data collected from each site in line with the evaluation framework, including the five domains that are documented with project indicators, site-specific data and challenges.

Mackay Region

The Mackay region has three ATSICCHOs providing culturally safe health and social care to Aboriginal and Torres Strait Islander People. Girudala Community Co-Operative Society Ltd participated in the place-based component of MSIP.

This region is serviced by the Mackay Hospital and Health Service (MHHS) across three LGAs. Mackay Base Hospital and Proserpine Base Hospital are the key sites for women associated with Girudala to birth their babies. Women birthing Aboriginal and Torres Strait Islander babies in the Bowen and Whitsunday region attend Bowen Hospital for antenatal care and postnatal care provided by midwives and obstetricians. However, women must travel to birth at (their preference) Ayr, Proserpine, Mackay or Townsville hospitals, as Bowen is not generally a birthing hospital. A summary of maternity data from 2019 in the Mackay region include:

- There were 2324 registered births in the MHHS region across the 3 LGAs including Mackay (1609) Whitsunday (367) and Isaac (348).[16]
- 1434 births were at Mackay Hospital.[17]
- There were 210 births at Proserpine Hospital.[17]
- 113 births were at Ayr Hospital (Queensland Government, 2021b).[17]
- 7 births were recorded at Bowen Hospital (Queensland Government, 2021b).[17]

Further information regarding the maternal health care services in the Mackay Region is available in the associated report entitled "State-wide Review of Models of Maternity Service".[7]

6.8 Site Eight: Girudala

6.8.1 About Girudala

Girudala Community Cooperative Society Ltd ('Girudala') is a grass-roots community organisation that leads programs in the area of health, wellbeing, family support, housing and home care for the Bowen, Proserpine and Collinsville regions of Queensland.

The Herbert Street Family Medical Centre located in Bowen offers a range of consultations and assistance to clients with GP appointments, health checks and vaccinations, plus visiting specialists in diabetes education, hearing and podiatry.

girudala.com.au

6.8.2 Maternity demographics

No data for maternity demographics at the Bowen Hospital were available at the time of the report.

6.8.3 Integration activity summary

Project title: Mums and Bubs

Girudala Community Cooperative Society Ltd and the Health and Hospital Services in Proserpine and Mackay commenced a project to develop a formalised MOU in their provision of culturally appropriate care. The project sought to appoint a MSIP Project Officer at Girudala, transport assistance for clients, and collaboration to map client journeys through maternal care pathways that involve both the ATSICCHO and HHS.

In the future, Girudala would like to provide strong cultural support and maternal services for women of the Bowen region at the Herbert Street Clinic.

6.8.4 Further data

See Section 10.2 for further information about Girudala's joint maternal services prior to MSIP, and data collected from each site in line with the evaluation framework. This includes the five domains that are documented with project indicators, site-specific data and challenges.

Key evaluation findings

7

This section presents key findings from the eight place-based activities. The five evaluation domains provide the framework and structure for this discussion, with a focus on inputs, outputs, outcomes and influences. The key findings provide a response to the evaluation framework's key evaluation questions. Feature boxes highlight selected quotes from the ATSICCHO sites' evaluation data to illustrate findings.

The impacts of COVID-19 on this project and health systems and services more broadly are also discussed.

Two overarching themes are apparent through all aspects of the evaluation. First, there is a universally strong desire by personnel, across all services, to improve the system. There is passion, dedication and an abundance of goodwill from individuals who aim to 'go above and beyond' to provide quality care to mothers and babies. The MSIP place-based activities, in particular, highlight the dedication of ATSICCHO maternal care staff to facilitate cross-sector collaboration to support women birthing Aboriginal and Torres Strait Islander babies.

Second, within Australia's health system, there is a tension between the provision of services in primary and secondary care. This tension was evident in the MSIP. Barriers to effective integrated services found in this project mirror structural barriers (and much needed reform) more broadly. There is opportunity here. Success in resolving this tension in maternal care will provide evidence of a way forward for other parts of the health system that continue to grapple with challenges of integration of services across primary and secondary levels of care.

Each place-based activity was structured uniquely and was designed to suit the needs and complexities of that site, and of the mothers and babies in that area. While a particular key finding may have emerged from one site or activity, that theme was also often reflected in discussion and findings from other sites. There are common themes even though each activity was unique. The following themes were consistent across most sites.

7.1 Collaboration and formal partnerships

Individual team member commitment, determination and goodwill was a primary and essential input that supported the effective integration of services between ATSICCHOs and HHSs. This commitment was demonstrated by personnel from both ATSICCHOs and HHSs. While this was admirable, it underpinned the need for formal partnership arrangements. Staffing changes in organisations across a number of place-based activities caused strain because the relationship was individually-based rather than system-based. The introduction of COVID-19 and the mitigation efforts to reduce its spread added to these strains because of the lack of opportunity to meet and discuss ideas and approaches.

Some ATSICCHOs and HHSs did develop formal links that were not driven by individual approaches or personal networks. This included Memorandum of Understanding (MOU) and Service Level Agreements (SLAs), regular formal meeting schedules, and protocols for feedback. Where these existed, they worked and supported the place-based activities, integration approaches, and reinforced networks during the advance of impacts of COVID-19.

> *"Carbal already had a formal partnership with the hospital but it did bring the two teams together for more formal meetings. This has probably enabled us to have more of an equal relationship with the hospital and health service"*

This is not to say informal networks and relationships based on history are not important. In truth, they are essential. The ability to make contact with a colleague at the HHS or ATSICCHO to discuss an approach or an assumption is an important component of a partnership. This ability is facilitated by previous and existing relationships and is especially important in high turnover environments where relationships assist to embed a culture of collaboration. Relationship development, along with both formal and informal partnerships, is essential to effective integration of service delivery.

> *"The Gurriny Yealamucka maternal health worker received a full orientation to the clinical areas of Cairns Hospital Maternity, birth suite and special care nursery, and the opportunity to gain confidence in extending her clinical expertise within this environment."*

In some instances, site visits by personnel from one service (e.g. the HHS) to the partner service (the ATSICCHO) were organised as part of the place-based activity. Acknowledging COVID-19 limitations, this evaluation demonstrates that, where they were able to occur, these were effective. They provided partner organisations with exposure to the circumstances and environment of the partner service and created opportunity for informal questions and discussion. Some site visits were designed specifically as site visits, for orientation, meeting team members, and viewing facilities. Other site visits were structured around specific purposes, such as joint meetings and case discussions. The evaluation shows that site visits which support relationship building are a key structure for embedding integration. This becomes particularly pertinent when coupled with higher staff turnover rates in both partner organisations.

> *"Relationships [are] ongoing and both ways. Most people now know our midwife and greet her by name—this is a marked improvement, and our midwife is now happy to go [to the HHS], rather than apprehensive."* **Wuchopperen**

Communication is key to effective collaboration and partnership. This evaluation illustrates the need for formal communication mechanisms as well as structures and activities to support relationships for effective informal communication.

> *"Communication between ATSICCHO midwife and doctors with usual HHS antenatal clinic staff is very positive."* **Wuchopperen**

The leadership offered by QAIHC across the implementation of place-based activities was highlighted as critically important by ATSICCHO sites. As a coordinating body working across multiple HHSs and with several ATSICCHOs, QAIHC was able to bring an additional perspective and offer solutions that were not always readily apparent at the local level. This was particularly evident with the emergence of COVID-19. Where barriers emerged at one site, QAIHC was able to bring state-wide, cross-site knowledge, solutions and perspectives. Additionally, where multiple organisations experienced similar barriers or complexities, QAIHC was able to work across organisations to provide guidance and solutions.

"Regular meetings between HHS, QAIHC and ATSICCHO were valuable, with QAIHC leading negotiations around ethics challenges and project re-design."
Girudala

7.2 Co-design

Co-design of strategy, operation and resources can be difficult in the context of full workloads, busy clinical caseloads, and the emergence of COVID-19. Despite these challenges, this evaluation shows co-design was attempted and undertaken with success. These examples offer suggestions for the future of co-design as key element in an integrated approach to the care of mothers and babies. The co-design of site activities was predominately led by ATSICCHOs and HHS personnel involvement was strong and positive. Place-based activities were most successful when the co-design was collaborative and involved personnel from the HHS.

Co-designing resources:

"Mamu's Midwife and Aboriginal and Torres Strait Islander Health Worker have attended meetings at Innisfail Hospital. In addition, Innisfail Hospital maternity midwives have attended Mamu's Mum's and Bub's clinic to specify which maternity equipment would be required in the room."

As well as co-design of the integration activities undertaken in the place-based component, there were examples of co-design of local resources and materials. Engagement through co-design enabled unplanned and informal discussion about maternal priorities and MSIP activities. While this was not the intended benefit of co-design, it aided in the development of effective integrated service delivery.

Importantly, for a co-design approach to be effective, all parties involved in need to come to the co-design discussion with respect and value for the other partners involved.

Through the co-design process, each organisation was able to learn about the other. This is especially important where the organisations cross the primary care-secondary care divide.

"The project intends to provide culturally appropriate antenatal sessions to mothers and their partners at a culturally appropriate location... One of the main discussion points [in our collaborative meetings] was to get a general feel of the context for Indigenous women and their families, and hopefully to make the antenatal learning objectives have the right cultural accent to it, in a way that will let the participants feel that part of them is being acknowledged and feels personal."
Gurriny

7.3 Information sharing

A long history of effective information sharing between some ATSICCHOs and HHSs exists and was illustrated in this evaluation. Where formal structures for information sharing exist, they support the maintenance of relationships and information sharing. This evaluation demonstrates the strong need for systems and formal approaches e.g. MOU or SLA.

Turnover of staff in both HHSs and ATSICCHOs was evident. This was exacerbated by COVID-19 impacts as staff were required to be redeployed. Staffing turnover highlighted how information sharing suffers without formal systems in place. Personality-based systems fail when staff move on.

Information sharing also needs to occur outside standard working hours. This evaluation shows that opportunities to share information were lost when birthing occurred unexpectedly or outside of standard business operating hours (Monday to Friday, 9am–5pm). An integrated approach to maternity care requires that both services—ATSICCHOs and HHSs—have the ability to share and receive information across all time periods, including out-of-hours. There are examples of lost information simply because the opportunity to share the information was not present, even though the desire to share existed. The busy nature of HHS maternity wards, the handover of shifts, and the constant movement of patients meant that desired information sharing did not occur if team members at the ATSICCHO were not able to receive the information at the time it was able to be shared. This is a practical structural reform required to enhance the success of integrated projects.

"We are happy to report the continuation of collaborations between Maternity Services, Mareeba Hospital, QLD Health and Mulungu, despite the current pandemic situation. Weekly tele links were essential in continuing communication between each participating service providing birth notifications, other essential information, including discharge and high-risk clients needing to attend specialist's appointments in Cairns. We are now able to meet face to face one again with social distancing measures in place and we are endeavouring to advance forward to completion of the project as required."

It is evident that the place-based activities in the MSIP increased the quality of information sharing systems and methods. Prior to involvement in the place-based activity, some ATSICCHOs were involved in ad-hoc case conferencing with HHS personnel. MSIP enabled a formalised and structured approach to case conferencing.

In addition to increasing the quality of information sharing systems, this evaluation reveals that the quality of the information shared also was improved. In some HHSs, once an understanding of the role and purpose of the ATSICCHO was better understood, the improved quality of the information provided to the ATSICCHO to better support the mother and baby was evident. This information flow was improved across the mother and baby's care continuum and in their transitions between HHSs to ATSICCHOs. This includes ancillary services coordinated by the ATSICCHO, of which transport and accommodation are key services provided.

"Communication and working relationships [were] much improved with direct and regular visits [and] contact with the antenatal unit... Calling or emailing directly has kept this going... Contact is made at least 2–3 times per week between the Wuchopperen Midwife, various GPs, and the Antenatal Unit . [Overall there has been] better communication, better relationships and understanding and respect for each other's settings and issues."

Many examples of effective information sharing are demonstrated through this evaluation, including formal case conferencing, regular phone check-ins, and discharge summaries. In addition, information sharing was facilitated by reciprocal site visits and orientation at the beginning of the place-based activity. A formal structure to ensure regular orientation and updates through reciprocal site visits is vital due to staff turnover rates in both partner organisations.

A particularly effective approach to information sharing revealed in this evaluation is that of cross-sector approaches to data sharing. Not all systems allowed for electronic data sharing or data entry by team members from both HHSs and ATSICCHOs; however, where this is able to occur, it was an effective mechanism to ensure data was both shared and accurate.

"The MSIP activities at Goondir enabled quality improvement in referral pathways and data flow for women birthing Aboriginal and Torres Strait Islander babies. Information technology resourcing supported remote access to shared software."

This evaluation also revealed that the place-based activities provided the opportunity to improve information technology platforms that facilitated secure, accessible data sharing (e.g. Communicare and Kiteworks) and virtual meetings (e.g. Microsoft Teams and Zoom). This was one of the positive consequences of the overall impact of COVID-19, where organisations were required to move to electronic and 'no touch' systems.

"Innisfail Hospital have sent us a new Cassowary Coast Midwifery Group Practice referral form, which has been uploaded into our medical database and the doctors have been completing this form for all our Antenatal clients who are currently referred to the Innisfail hospital—Cassowary Coast Midwifery Group Practice midwives... The referral seems to be making the Antenatal referral a lot more streamlined." **Mamu**

This evaluation highlighted the different approaches to supporting patients between ATSICCHOs and HHSs. ATSICCHOs are grounded in local values and culture, governed and operated by local communities, and provide healthcare based on Aboriginal and Torres Strait Islander concepts of holistic health and wellbeing for the whole community.[18] The HHS approach does not have this community and whole-of-patient care approach. An effective integrated maternity service needs to acknowledge and accommodate these different approaches to working with mothers and families.

This evaluation illustrates that improved information flows resulted in improved service delivery and better health outcomes.

"Wuchopperen's belief is that... better communication means fewer high-risk women slip through the net. [There has been an] improvement through shared care... with regular meetings, frequent contact ongoing, and improved contact lines."

7.4 Integration

Integration of services is complex. For services with many variables, as is the case for maternity services, this complexity is compounded. For integration to be successful, a full understanding of the service offerings of one partner by the other partner is essential. Where this is achieved, the integration of the service to fully support mothers and babies is more successful. This evaluation provides examples that work and examples where further work is needed.

"[To improve maternity services, we would like to see] every Yarrabah woman [who is] admitted to hospital in pregnancy followed up by our maternal health worker. Ideally, two health workers undergo 'doula' training facilitated by our midwives and provide 24 hour support to women in labour... Ultimately a hybrid agreement [could be] established with CHHHS that clearly identifies the credentialing required by Gurriny Midwives. A collaborative agreement allowing Gurriny midwives the opportunity to accompany Yarrabah women intrapartum."

It is important to acknowledge that this is an integration exercise between two different models of care, being a primary health care model (ASTICCHO) and a secondary care model (HHSs), both with different models, ways of working, and funding structures.

The recognition by HHSs of the important role of ATSICCHOs in the transition between these systems is essential for achieving an integrated experience for the mother and Aboriginal and Torres Strait Islander baby.

The evaluation revealed that quality discharge summaries are a critical tool to support integration. When HHSs understand the role of ATSICCHO, discharge summaries can be prepared in a way that best supports the mother and baby.

It also demonstrated that the increased presence of ATSICCHO Maternal Health Workers (MHWs) within mainstream health care setting was an effective way to enhance an integrated service experience.

"[We discussed with the HHS the] goal of 'integration' and supporting families in their journey from Yarrabah to Cairns and back again—safely, with understanding, respect and returning strong to begin their next journey as a family unit... We also discussed providing greater education and awareness for CHHHS staff about Yarrabah as a community, our services, model of care, supports available, and who to call for assistance and/or handover." **Gurriny**

There was one example of a key person who worked across both the ATSICCHO and the HHS. This dual role was one element that enabled integrated service delivery in that location. Another mechanism revealed in this evaluation is the embedding ATSICCHO staff into the HHS maternity care services. This assisted the HHS to provide culturally appropriate care and demonstrated how ATSICCHOs can assist in the integrated service delivery model.

"Cairns hospital clinical staff engage in collaborative discharge planning with maternal health worker... [This resulted in] increased confidence expressed by women anticipating the support of an Indigenous Health Worker whilst hospitalised. We hope this translates into improvements in postnatal attendance and exclusive breastfeeding rates" **Gurriny**

Another practical approach that supported an integrated service between HHSs and ATSICCHOs was the attention to record-keeping, including minutes and follow-up emails between the two services. Where the partner organisations were able to maintain good record-keeping and action monitoring practices, the model of integrated service delivery was better supported. For an integrated model of care to be fully realised, this needs to include a commitment to action the timeframe agreed and is required from all parties if an integrated model of care is to be fully realized.

These practices are skills requiring time and resourcing to be developed. A properly integrated model of care acknowledges the need for these practices to be part of the systemic embedding of integration.

Understanding the transition phases from community to HHS and HHS to community, and identifying the role of ATSICCHO in this transition, is essential in supporting the move to an integrated service. How this is recognised (or not) by HHS is a determiner of the success of integration.

7.5 Enablers and inhibitors

As part of standard reporting, each ATSICCHO involved with a place-based activity was asked to identify enablers for, and inhibitors of, an effective integrated service. Many common themes arose, which could be classified as both an enabler or an inhibitor, depending on their presence or absence. As such, themes are discussed below in the context of both enablers and inhibitors.

"The appointment of a Maternal and Child Health Nurse with knowledge of both the ATSICCHO and HHS sectors created an 'MSIP champion' who could drive discussion and identification of gaps and referral pathways." **Goondir**

An enthusiastic, committed, skilled workforce is an enabler. This includes trained team members, team members who are knowledgeable about partner services, and an understanding of responsiveness and adaptability.

An integrated approach needs to be supported by the systems of operations within each organisation involved. This evaluation demonstrates that integrated

services require structure and resourcing and, where these are in place, they are true enablers. In contrast, situations where these structures do not exist and there is a reliance on goodwill, extra effort, and determination to 'get the job done' act as inhibitors. This evaluation shows that when key personnel change position, any integration gains are lost.

Formal partnership agreements and opportunities and systems for communication between ATSICCHOs and HHSs, when present, are enablers. One example of an effective communication system is high quality discharge summaries.

"Lack of provision of discharge summaries to the secure fax/email line [by HHS]—[it is] difficult to follow up with women and babies in the postnatal period without a discharge summary. An incident occurred during this reporting period which highlighted the importance of providing discharge summaries."

Apunipima

The evidence from this evaluation shows that the combination of the two points above—goodwill and personnel commitment to 'get the job done,' coupled with lack of system support—leads to an overcommitted and under-resourced workforce in both ATSICCHOs and HHSs. Ultimately, this leads to stress and burnout. For integration to be effective, time to build, support and maintain the relationship needs to be part of the system approach to an integrated maternity service.

"[We have] very professional, senior expert clinicians who are supportive and caring to staff and public. [We are] a strong advocate for women and families."

Mulungu

An understanding of the sector and the workday of a team member in the alternate service is an enabler and the lack of understanding is a strong inhibitor. This was evident from both sides of an integrated service between HHSs and ATSICCHOs.

This evaluation revealed that some team members did not fully comprehend how the partner service actually worked, what services they provided, or how they related to their own patients or clients. The lack of understanding led to missed opportunities because individuals did not know about the breadth of services or the role of particular team members in the partner service. For integration to be effective, education about, and possible immersion into, partner services is needed. The development of both formal and informal supports to the relationship will assist this understanding.

"Initially Antenatal Unit were very busy—possibly too busy to meet regularly—the value for both now appreciated and time is made regularly to catch up. [We also had] limited communication with the Midwifery Group Project regarding shared clients they see. Unfortunately, clients seem to 'disappear' and we do not have up to date information to action when they do present to Wuchopperen which can lead to delays in important follow-up.

This evaluation found that, in some cases, the barrier to integration was more than a simple lack of understanding and was underpinned by racism. This assessment is supported by evidence that interpersonal and institutional racism continues to be experienced by Aboriginal and Torres Strait Islander peoples with regard to healthcare, and there are important opportunities for HHSs to address these determinants of health.[12,13]

"[We want to] expose the hospital to the model of care Yarrabah women have described as acceptable to them and extend an invitation to hospital staff into that space."

Gurriny

There were many examples across the place-based activities where respect for the services provided by the ATSICCHO and cultural safety underpinned the success of an integrated model of service delivery.

This evaluation shows that an understanding of this model of care and service delivery by ATSICCHOs is an enabler and a lack of understanding is an inhibitor. Aboriginal and Torres Strait Islander definitions of health are holistic and intimately understand the complex integration and balance of physical, environmental, emotional, social, spiritual and cultural wellbeing. This complexity is not reflected or well understood within the Australian health care system's biomedical approach.

This lack of understanding can translate in some individuals not realising what services partner organisations can provide and why comprehensive information is needed by the partner organisations. These misunderstanding can lead to team members poor quality information sharing and feelings of frustration.

"The biggest learning for Carbal staff was not to make changes just because hospital staff could not attend. We wanted to get the classes started but the hospital kept pushing the date back because they were busy. In the end, the date for the first class was set and the hospital staff either made it work or did not attend (they were there on the day!)."

The lack of understanding of the ATSICCHO Sector by HHS staff resulted in low value being placed on advice offered by ATSICCHO team members. In some place-based sites, this lack of value was evident in the evaluation and is an inhibitor of developing an integrated model of care for maternity. Strengthening information sharing and developing networks leads to stronger understandings, which this leads to greater valuing of the advice offered and as a result this leads to better outcomes for mothers and babies.

As a specific example, an accurate understanding of the role of the Aboriginal and Torres Strait Islander Health Worker (ATSIHW) is a strong enabler, and a lack of understanding is a strong inhibitor. This evaluation showed the complete breadth of understanding, which correlated with the effectiveness of an integrated model between HHSs and ATSICCHOs. ATSIHWs provide a range of clinical and non-clinical primary health care services. They are an Aboriginal and Torres Strait Islander workforce that is vocationally trained (against a national training curriculum) in comprehensive primary health care and provide access to culturally safe health care and services, along with a deep understanding of the communities they serve.[19] When this is understood, the potential of these roles to comprehensively support greater integration is recognised. The evaluation shows that training is required where these roles are not well understood within the HHS.

Isolation of clinical team members is an inhibitor to integration. It is noted that in some sites, maternity clinicians for the HHS and ATSICCHO work in isolation rather than in a coordinated manner. A coordinated case-based approach is desired and, in the locations where this occurred, it was an enabler of an integrated approach.

Finally, the hours of work for some ATSICCHOs meant there were no services to support maternity activity on weekends or overnight. This resulted in clients being unable to access the ATSICCHO system. The variance between work hours of the HHS and the ATSICCHO was an inhibitor. Some partner organisations designed 'work arounds,' however a lack of coordination for out-of-hours activity was common. Adequate resourcing for ATSICCHOs involved in an integrated model is an enabler.

"We don't provide a service on weekends, therefore women cannot contact us. This can be an issue where a woman births on the weekend and we aren't notified therefore we are unable to follow up with them postnatally."

Apunipima

7.6 Impact of COVID-19

This project was delivered during the global COVID-19 pandemic. COVID-19 has had impacts in all areas of life, work and society. For organisations and individuals in the healthcare system, the impact was significant. Health services were required to immediately re-orientate to new circumstances.

COVID-19 required ATSICCHOs and the broader health system to develop multifaceted prevention and response activities across the breadth and depth of the sector. The MSIP project occurred in the context of the health system need to focus on the urgent and immediate threat of COVID-19.

The public health response to COVID-19 has strongly impacted the ability of this project to gather the quantitative data required to fully evaluate the project and to fully understand the impact of place-based activities. However, it has also revealed much about how services and systems cope under pressure and how adaptable services and personnel are to a changing environment.

Through this, COVID-19 has revealed vulnerabilities in existing systems and there are lessons about strengthening these systems which can be drawn from these revelations. One of these lessons has been a reinforcement of the model of care and service delivery of ATSICCHOs, and their role in assisting to minimise the spread of COVID-19 within Aboriginal and Torres Strait Islander communities across Australia.

7.6.1 Direct impact on this project and its evaluation

MSIP was directly impacted by the emergence of COVID-19 and by the consequent public health responses. The findings show that COVID-19 not only impacted on the evaluation component of the project but on the local place-based activities themselves.

The MSIP Evaluation Framework was designed prior to the declaration of the pandemic and included multiple methods for data collection. COVID-19 impacted a number of these methods due to travel and movement restrictions being introduced during a key face-to-face data collection stage. While the team at QAIHC were responsive and changed approaches quickly, the uncertainty arising from the pandemic impacted the opportunity to gather timely information in line with the original evaluation framework.

Additionally, some team members at both ATSICCHOs and at HHSs were unavailable to participate in the evaluation. Three primary reasons were provided by sites, including reassignment to prevention and response activities, deployment to crisis management teams, and movement and travel restrictions (including individual quarantining).

Examples of this reprioritisation was highlighted in the evaluation where ATSICCHOs were required to deliver additional services, including administering medicines, because hospitals in their local area were closed. In one example, the Cairns Hospital was closed with little notice. Community members then turned to Apunipima, the local ATSICCHO, for assistance.

Additionally, grants were made available to ATSICCHOs to address and research impacts of COVID-19. The priority focus on these projects resulted in MSIP being deprioritised for a time, including the reassignment of MSIP staff at some sites.

On 12 June 2020, Queensland's Chief Health Officer, in accordance with emergency powers arising from the declared public health emergency, declared that entry to remote Aboriginal and Torres Strait Islander communities (designated areas) in Queensland was restricted under the Commonwealth Biosecurity Act 2015 (Cth). This directive mandated that everyone must go into quarantine for 14 days before entering or re-entering a designated area, effectively closing off 20 of Queensland's Aboriginal communities to the rest of the state.[20]

This directly impacted the projects. Gurriny, as one example, is an ATSICCHO located in a remote community. They were required to support the medical needs of the community during the period of the emergency declaration. In addition, the closure severely impacted their ability to deliver an integration project with their respective HHS, whose facilities were situated outside of their community boundary.

In response to COVID-19, QAIHC and ATSICCHOs changed aspects of the project, including the evaluation data collection, to accommodate and mitigate the impacts. New questions were built into the reporting template for place-based activities and adjustments were made to the requirements for participation in evaluation activities.

There were also changes to systems for information exchange and this, in some cases, had a positive effect on the ability to share information. Not all impacts of COVID-19 were negative as the responses led to improved systems and operations.

7.6.2 Revealing existing vulnerabilities

The impact of COVID-19 revealed and/or further highlighted vulnerabilities within the health system in terms of both primary and secondary care. These already existed, however, were not as obvious due to the goodwill, determination and effort of team members and those who wished the MSIP to succeed. COVID-19 simply exposed these because the systems were put under pressure.

"[The biggest challenge for the project was] communication with and within MHHS. Internal organisational re-structure at MHHS made organising meetings difficult. Staff leave and changes also made communication difficult... internal delays and hierarchy... delayed [the] start to the project and MHHS seemed to have very little information or awareness of MSIP. Ethics approval was not an easy process, and subsequently, the project had to be completely changed to reflect a new substituted outcome." **Girudala**

The most obvious vulnerability to a fully integrated effective service that was exposed by COVID-19 was in staffing levels. For this project to be effective, appropriate staffing is required. Where this was not the case, this evaluation reveals team members 'jumping in and getting the job done'. However, with the emergence of COVID-19 and the redeployment of resources and staff, the level of staffing became stretched and MSIP was deprioritised.

Another vulnerability exposed by COVID-19 was the reliance on informal contact and discussions. When the opportunity for that informal contact was removed, formal systems needed to be in place to allow the exchange of information. In some instances, this was enhanced due to COVID-19 as teams moved to online platforms, allowing the bridging of geographic distances. However, in most instances, the lack of formal system supports was evident when informal interactions became limited or impossible.

7.6.3 Highlighting the ATSICCHO Model of Service Delivery

When COVID-19 first arrived in Australia, there was fear that it would spread rapidly among Aboriginal and Torres Strait Islander peoples and communities. Reasons for this fear included higher rates of chronic disease and because of the complexity of messaging required to engage with communities about COVID-19 prevention. This spread did not eventuate, in fact, rates of COVID-19 among people who identify as Aboriginal and/or Torres Strait Islander were lower than rates of COVID-19 during the first wave than among the rest of the population in Australia.

There are lessons to note from this success and many of these relate to the ATSICCHO model of service delivery. These lessons are translatable to the development of integrated services with an ATSICCHO.

Communication on social media is laden with misinformation and it is difficult to discern trustworthiness. The COVID-19 response by Aboriginal and Torres Strait Islander communities, including those in Queensland, demonstrate that members of the community trust the voice of ATSICCHOs. Messages were spread quickly. The structure and existing communication networks of ATSICCHOs enabled the rapid production and distribution of key messages that were developed locally to suit local populations. This localisation of the intervention was key to ensuring those with chronic conditions who were more susceptible to COVID-19 impacts were able to manage their own transmission risks. The ability to provide quick messages that are locally suited is an asset for any integrated model of service delivery.

Messages were embedded in the context of culture. Information and education "material reflected Aboriginal and Torres Strait Islander People's kinship structures by promoting self-isolation and good hygiene as a way of taking care of family and community"[6]. This is also a lesson about the value and effectiveness of ATSICCHOs and the role of team members in assisting with the development of an integrated model of care for maternity services.

The conversation about COVID-19 was with community members rather than at community members. Information was not told to communities but rather communities were engaged in conversation. This is another strength of the ATSICCHO model of service delivery. ATSICCHOs employ members of the community, underpinning community control. This fosters the connection between the community and the health service, further instilling the value of ATSICCHOs to the development of an integrated model of maternity care, so they know the local community, how it operates, and know the local context. This is the essence of health promotion at the community level and underpins the value of ATSICCHOs to the development of an integrated model of maternity care.

Implications

8

This section is to be read in conjunction with MSIP State-wide Review of Models of Maternity Service.[7] Each section references an issue highlighted through the evaluation of the place-based activities (see section 6), discusses implications for the strategy, and suggests potential solutions aligned to the Growing Deadly Families Aboriginal and Torres Strait Islander Maternity Services Strategy 2019–2025.[4]

These potential solutions provide:

a) options for models of shared maternity care

b) opportunities identified for innovation and co-designed maternity services across the HHSs and QAIHC Members.

8.1 Shared understanding of services, policy and context

8.1.1 Issue

Among the majority of HHS personnel and maternity teams, there is a lack of awareness, and a lack of understanding, of the essential purpose and role of ATSICCHOs. This includes a lack of knowledge of the model of care in maternity services provided by ATSICCHOs. Some HHSs demonstrated strong relationships and awareness, fully utilising the skills and services of team members at ATSICCHOs. However, a minimum level of awareness and understanding was not uniformly met for an integrated service to fully and effectively take place.

8.1.2 Implication

A continued lack of understanding and awareness of the purpose and role of ATSICCHOs as well as the model of care for maternity services will result in ATSICCHOs and HHSs working in isolation. In addition to poorer outcomes for mothers and babies, key elements of how Growing Deadly Families[4] aims to deliver implemented strategies will be greatly impacted. More specifically:

Priority 2—Strategy 2.2: Integrated health and other support services

a) Support the integration, extension or co-location of primary maternity health services with social and emotional wellbeing services, allied health services and child health and early childhood services in a culturally safe environment.

8.1.3 Solutions

1. Develop minimum standards for maintenance of the relationships between ATSICCHOs and HHSs that include an understanding of partnering organisations.
2. In the development of an integrated maternity model of care, explore, design, fund, develop, implement and evaluate the requirement that HHS teams and personnel learn about the ATSICCHOs (with which they are to partner) to develop an integrated model.
3. Include formal orientation about the ATSICCHO in any funding model.
4. Include regular site visits by team members from each partnering organisation to the other organisation in any funding model. This may include occasions for other purposes (for example, team meetings) or to job share and learn.
5. Include activities and resourcing to support cross-fertilisation and learning about the partner organisation's models of care and systems as part of the ongoing structure of an integrated approach.
6. Formalise and fund the leadership role of QAIHC working across ATSICCHOs and HHS boundaries to ensure minimum standards of relationship and partnership-building, and maintenance are met.

8.2 The role of the Aboriginal Health Worker

8.2.1 Issue

While not uniform across all place-based sites, there was a general lack of awareness and understanding of the Aboriginal Health Worker (AHW) in the context of maternity care among HHS personnel and maternity teams. Again, this was not uniform across the place-based activities. This led to the expertise and services of AHWs being underutilised or not accessed and in some cases, exclusion of Aboriginal Health Workers from fulfilling their role with mothers and babies while they were in the care of the HHS.

82.2 Implication

Mothers and community members rely on AHWs to ensure a culturally safe environment and to assist with navigating a complex health system. Underutilising this resource and these skills results in suboptimal care.

Specifically, this would directly impact:

Priority 1—Strategy 1.1: Partnerships and collaborative woman-centred maternity care

c) Ensure clinical governance of maternity care supports the development and implementation of collaborative woman-centred maternity care models and remove barriers to accessing culturally competent and safe maternity and birthing services

Priority 2—Strategy 2.2: Integrated health and other support services

c) Ensure women have choice to access Aboriginal and Torres Strait Islander health workers, practitioners or family support workers, working alongside midwives, to provide socio-cultural support.

In addition, the state-wide report notes that the Queensland ATSICCHO Model of Care involves an Aboriginal and Torres Strait Islander Health Worker/Practitioner (ATSIHW/P) whose role is to provide patient support and coordination of services. The integration of the ATSIHW/P role into service delivery in maternity service models of care is essential to improve the experience for women birthing Aboriginal and Torres Strait Islander babies in Queensland.

8.2.3 Solutions

7. Develop minimum standards for maintenance of the relationship between ATSICCHOs and HHSs that include an understanding of the role of the AHW.
8. Fund the opportunity for AHWs to be embedded in the maternity services of the local HHS for specific blocks of time.
9. Include in any funding model the requirement and resourcing for maternity teams to participate in and complete education in cultural safety.

8.3 Mutual understanding of the breadth of maternity services

8.3.1 Issue

This evaluation revealed that not only do HHSs and ATSICCHOs having different models of care for maternity services; personnel from each service have different understandings of what is required within a comprehensive Model of Care for a mother birthing an Aboriginal or Torres Strait Islander baby. Acknowledging that this was not uniform across place-based sites, there was an incomplete understanding of the requirements of the mother and baby across the complete timeline of perinatal care, birthing and postnatal care.

8.3.2 Implication

Without this complete understanding, not only was a coordinated and fully integrated approach to care unachievable. Optimal care could also be compromised as allocation of, and communication about 'who should be doing what' was not aligned to the complete breadth of care required. Additionally, who was best placed to provide elements of care may not have been discussed, which may have also compromised care. Compromised care means that key elements of the delivery of Growing Deadly Families[4] being unable to be achieved. Specifically, this would directly impact:

Priority 1—Strategy 1.1: Partnerships and collaborative woman-centred maternity care

b.) Develop tools to inform the planning, design and implementation of collaborative woman-centred maternity services.

c.) Ensure clinical governance of maternity care supports the development and implementation of collaborative woman-centred maternity care models and remove barriers to accessing culturally competent and safe maternity and birthing services.

8.3.3 Solutions

10. Using the existing statewide report, provide a map of all services required for a mother and baby across the continuum of maternity care, with acknowledgement that this may already be completed.
11. Using this map, each partner HHS and ATSICCHO entering into a relationship to provide integrated care, including an implementation plan and specification of the role that each organisation will have across the journey of care for the mother and baby. Include meetings and workshops to develop this plan in any funding model. Include the role of QAIHC to oversee standardisation across ATSICCHOs in any funding model.
12. Write MOU in light of this mapping exercise and discussion.

8.4 Capacity building with the ATSICCHO

8.4.1 Issue

The varying levels of engagement among different ATSICCHOs and HHSs revealed in this evaluation demonstrated the variance in capacity to fully and effectively participate in an integrated model of maternity care. Some ATSICCHOs have existing coordinated systems and others are newly entering into this area of care. However, current levels of engagement suggest there is a willingness by HHSs to involve ATSICCHOs. This is due, in part, to the types of services and supports that HHSs ask from ATSICCHOs rather than the services ATSICCHOs are able to offer and be involved with.

8.4.2 Implication

A system where the HHS determines the involvement of an ATSICCHO in an integrated maternity care model is a culturally unsafe environment and results in the provision of sub-optimal levels of care. This impacts clinical safety. A clinically safe model of care is one in which cultural safety is integral to clinical safety and partnership. Co-design is integral to cultural safety. Lack of genuine partnership in determining roles of each organisation means key elements of how Growing Deadly Families[4] will be delivered may not be achieved. Specifically, this would directly impact:

Priority 1—
Strategy 1.1: Partnerships and collaborative woman-centred maternity care

a) *With community endorsement, establish or strengthen formal partnerships between HHSs and primary health care providers (such as midwives, general practitioners and ATSICCHOs to support collaborative woman-centred maternity care services.*

b) *Develop tools to inform the planning, design and implementation of collaborative woman-centred maternity care services.*

Priority 2—
Strategy 2.1: Continuity of Care

a) *Facilitate a collaborative approach to maternity care, with women having access to continuity of care with the care provider(s) of their choice, including midwifery continuity of carer.*

Priority 2—
Strategy 2.2: Integrated health and other support services

c) *Ensure women have choice to access Aboriginal and Torres Strait Islander health workers, practitioners or family support workers, working alongside midwives to provide socio-cultural* support.

8.4.3 Solutions

13. HHS and ATSICCHOs to enter into a formal partnership to determine the best approach to an integrated model of care.
14. Once the division of roles between the local ATSICCHO and the HHS has been determined, conduct a gap analysis of the ATSICCHO to determine the upskilling and resourcing required to enable the ATSICCHO to fulfil its role in the local integrated maternity model of care.
15. As part of the overall funding model, create a pool of funds available to ATSICCHOs to specifically upskill and resource to fill gaps identified in the above analysis.
16. QAIHC lead the process to develop, implement and oversee minimum standards for involvement of ATSICCHOs in any stage or aspect of the maternity model of care. This should include minimum staffing, communication and quality assurance levels.
17. Queensland Health, in collaboration with QAIHC, lead the process to develop, implement and oversee minimum standards for the partnership and decision making of HHSs in their engagement with ATSICCHOS while developing an integrated maternity model of care.

8.5 Staffing levels reflect service delivery need

8.5.1 Issue

This evaluation revealed team members from all organisations contributed to the success of the place-based activities relying on goodwill, determination and extra effort. This is unsustainable and a move to an integrated model of maternity service delivery requires appropriate levels of staffing at both the ATSICCHOs and the HHS. An integrated Model of Care requires coordination, engagement and partnership, and this requires team member time.

An additional key finding from this evaluation is the need for ATSICCHOs involved in an integrated Model of Care to have the capacity to after-hours capacity. For effective transfer of information and for effective collaborative communication, access to ATSICCHO personnel is needed at the time of care and this is sometimes dictated by things other than usual opening hours.

8.5.2 Implication

Inadequate staffing levels result in burnout, stress and inability for the ATSICCHO to effectively complete its tasks. This leads to compromised culturally safe care for mothers and babies, and results in key elements of how Growing Deadly Families[4] will be delivered not being achieved. Specifically, this would directly impact:

Priority 2—Strategy 2.2: Integrated health and other support services

a) Support the integration, extension or co-location of primary maternity health services with social and emotional wellbeing services, allied health services and child health and early childhood services in a culturally safe environment.

8.5.3 Solutions

18. ATSICCHOs partnering in an integrated model of maternity care are adequately resourced for all aspects of the activities of their agreed role including collaboration, communication and partnership activities and including appropriate resourcing to facilitate involvement in core business hours of work.
19. Resource QAIHC to act in an overall governance coordinating role to support the capacity and capability of ATSICCHOs to assist with continuity of care and follow up.

8.6 Cultural safety

8.6.1 Issue

Team members from multiple participating ATSICCHOs expressed a lack of understanding of the role of the ATSICCHO, the role of the Aboriginal Health Worker and the ATSICCHO Model of Care. This translated into provision of care that was culturally unsafe for not only mothers and babies but also for team members in ATSICCHOs.

8.6.2 Implication

A culturally safe workplace and culturally safe clinical care for mothers and babies is at the centre of Growing Deadly Families Strategy.[4] All elements of the strategy are affected by a lack of appropriate clinical care because of the missing element of culturally safe care. In addition, this would directly impact:

Priority 3—Strategy 3.1: A culturally capable corkforce

e) Develop Aboriginal and Torres Strait Islander maternal and child health guidelines to support cultural capability of staff.

8.6.3 Solutions

20. Develop a cultural safety framework, associated resources and tools for maternity health services in Queensland.
21. Use lessons learned from the MSIP place-based activities to inform the development of this framework.
22. Once this framework and associated tools and resources have been developed, include in any proposed funding model education activities that bring together each local ATSICCHO and relevant team members and leaders in maternity services at the local HHS to move through a comprehensive cultural safety training and exploration activity.

8.7 Communication

8.7.1 Issue

This evaluation demonstrates that formal and informal systems for communication are essential to any integrated Model of Care. Where the timing and requirement of the care itself, in this case maternity and neonatal care, is unpredictable and sometimes requires responsivity, those requiring care are sometimes subject to things that impact on their care, for example racism. In these instances, communication becomes even more important. While integrated models of care are about systems, they are also about partnership, collaboration and teamwork. This can only occur within the safety of effective communication.

8.7.2 Implication

Communication is key. Without formal systems for communication and without allowance for informal systems to develop through relationships, sharing and trust building; key elements of the strategy to deliver Growing Deadly Families[4] may not be achieved. Specifically, this would directly impact:

Priority 2—
Strategy 2.1: Continuity of Care

a) *Facilitate a collaborative approach to maternity care, with women having access to continuity of care with the care provider(s) of their choice, including midwifery continuity of carer.*

b) *Support the maternity workforce to work across organisational boundaries to facilitate continuity of midwifery and maternity care.*

Priority 2—
Strategy 2.5: Information sharing, referral and follow-up

a) *Enable formal clinical handovers and timely sharing of personal health information (particularly referrals and discharge summaries) for women and their babies across all service providers through pregnancy, birth and the postnatal period to ensure appropriate referral and follow up.*

8.7.3 Solutions

23. As part of any future funding model, require that both partners need to have formal mechanisms of communication in place and appropriately resourced. Examples in this evaluation include a formal MOU or SLAs, orientation activities, development of templates and tools to assist formal communication, regular set shared meetings and formal steps to take when communication does not occur.
24. As part of any future funding model, acknowledge the necessity of informal communication based on partnership, sharing and trust. Build into the model mechanisms to develop these informal methods of communication.
25. Acknowledge and resource that co-design means those involved are equal partners with equal decision making.
26. Stage co-design workshops specifically about the information needed in discharge summaries and as part of that discussion, work through steps to ensure how discharge summaries are completed and what happens with them.

8.8 Community of Practice

8.8.1 Issue

This evaluation has highlighted that there are many new ideas being worked on and lessons learnt about how best to integrate maternal services in the primary and secondary health systems. QAIHC is well placed to facilitate sharing of this information so advances can be made in integration of maternity care beyond the current geographical scope of MSIP to across the state. However, the localised nature of ATSICCHOs and HHSs means that information and lessons learnt along with novel ideas developed in one area are not necessarily fully embraced or utilised in another.

8.8.2 Implication

A Community of Practice is, of its nature, driven and maintained by its members. It has the ability to share ideas, generate discussion and solve problems. Its success rests on its membership and the commitment and enthusiasm of these members. In this way, a Community of Practice that is included as a support to those working in maternity will greatly assist in achieving integration goals. Without it, the work is

still able to be undertaken and outcomes achieved, however some key elements of how Growing Deadly Families[4] will be more difficult to achieve. Specifically, this would impact:

Priority 2—
Strategy 2.1: Continuity of Care

a.) Facilitate a collaborative approach to maternity care, with women having access to continuity of care with the care provider(s) of their choice, including midwifery continuity of carer.

b.) Support the maternity workforce to work across organisational boundaries to facilitate continuity of midwifery and maternity care.

8.8.3 Solutions

27. As part of any future funding model, resource the establishment and yearly maintenance of a Community of Practice for ASTICCHO and HHS staff who are working in an integrated model of maternity care.

8.9 Future Evaluation

8.9.1 Issue

An evaluation framework was developed as part of this project, however COVID-19 greatly restricted the ability to conduct elements of this evaluation framework. The pandemic also restricted some of the activities of the project to be evaluated. Many elements in this framework remain useful and could be employed with future place-based activities or to follow-up with existing sites as they continue to do the work that evolved from the place-based activities undertaken as part of this project. There is opportunity to study the longer-term impacts of this work.

8.9.2 Implication

Future evaluation of the efforts that have evolved out of existing place-based activities and of any additional place-based activities will provide the data and analysis to respond to the question in the Growing Deadly Families Strategy: "How will we know if we succeed?"[4] While any data and analysis will help find answers to all the points noted, there are some outcomes that may be useful indicators of success:

a) Maternity services provided in partnership between community, primary, secondary and tertiary services.

b) Aboriginal and Torres Strait Islander leadership is evident in the delivery of maternity services in Queensland Health facilities.

c) Maternity services are integrated or co-located with wrap-around social support services.

d) More Aboriginal and Torres Strait Islander people working in maternity care.

e) More Queensland Health maternity staff participating in cultural capability training.

8.9.3 Solutions

There are opportunities to further extend the insights of this evaluation, including:

28. Extend the evaluation of the existing place-based activities, using the existing evaluation framework, to gather information to assist with impact evaluation.

29. As part of any future development of services, include resourcing to evaluate activities against the measures of impact in the Growing Deadly Families Strategy.[4]

8.10 Continuation of the Place-Based Activities Component of the MSIP

8.10.1 Issue

While the place-based activities of the overall MSIP highlighted issues and implications noted in this report, they also enabled capacity building, exploration of systems and approaches, and developed partnerships and collaboration. The emergence of COVID-19 and the measures to mitigate its spread curtailed some place-based activities. A continuation of these local activities will provide further evidence for effective integrated models of maternity care overall and will provide specific support and assistance to local ATSICCHOs and HHSs in the development of their own local relationships.

8.10.2 Implication

There is more to learn. This evaluation shows the local approach to place-based activities revealed lessons and ideas applicable to the broader implementation of integrated services. Non-continuation of further place-based activities as part of further exploration of integrated maternity models of care misses an opportunity to further reveal any vulnerabilities and key elements which might compromise or prevent Growing Deadly Families[4] from being achieved. Specifically, this would directly impact:

Priority 1—
Strategy 1.1: Partnerships and collaborative woman-centred maternity care

a.) With community endorsement, establish or strengthen formal partnerships between HHSs and primary health care providers (such as midwives, general practitioners and ATSICCHOs) to support collaborative woman-centred maternity care services.

b.) Develop tools to inform the planning, design and implementation of collaborative woman-centred maternity services.

8.13.3 Solutions

30. Fund those place-based activities that were curtailed by the impacts of COVID-19 to enable full implementation of locally co-designed projects.
31. Develop a further round of six to ten place-based activities to be completed over an 18-month period, utilising the same governance structures as the previous round. This should include QAIHC as the leadership and governance organisation.

Conclusion

9

The place-based integration activities were one component of the overall Maternity Services Integration Project, with the other two being a State-wide Review of Maternity Service Models[7] used across the ATSICCHO sector to deliver maternity services, and the Co-Design and Distribution of Maternal Health Promotional Products.[8] Together, these three components aimed to improve the maternity services journey of women birthing Aboriginal and Torres Strait Islander babies in Queensland across primary and tertiary health care settings, working together to provide one system of culturally safe care.

The place-based component had a site-specific focus on the implementation of a co-designed integration activity by participating ATSICCHOs and their local hospital for mothers birthing an Aboriginal and Torres Strait Islander baby. Maternal health staff at each ATSICCHO worked with their corresponding HHS to develop local activities to support culturally safe care pathways for Aboriginal and Torres Strait Islander babies and their mothers.

Of note, this project was delivered during the global COVID-19 pandemic. COVID-19 has had impacts in all areas of life, work and society. For organisations and individuals in the healthcare system, the impact was significant, and this project and the organisations involved were not immune.

This report provides details of the evaluation structure, process and findings. The aim of the evaluation of place-based activities was to examine the effectiveness of the site-specific activities in improving the integration of maternity service delivery between ATSICCHOs and their respective HHSs. The evaluation also aimed to inform embedded and sustainable maternal health model of care, which is culturally appropriate to Aboriginal and Torres Strait Islander mothers and babies.

This evaluation report of the eight place-based integration activities, illustrate that much has been learned to support the development of a fully integrated model of maternity services between Hospital and Health Services and Aboriginal and Torres Strait Islander Community Controlled Health Organisations. Learning has centred on the five domains of collaboration and formal partnerships, co-design, information sharing, integration, and enablers and inhibitors.

There are implications for The Growing Deadly Families Strategy 2019–2025 (the Strategy)[4] in the findings from this evaluation. The Strategy is the Queensland Government's commitment to action that improves the patient journey and promotes strong outcomes for women birthing Aboriginal and Torres Strait Islander babies, and their babies. The findings from this evaluation offer solutions that may assist in the achievement of goals in the strategy and may assist with measuring the success of actions from the strategy.

10 Appendices

10.1 Evaluation Framework: Additional background

Evaluation scope

This evaluation focuses on activities aimed at enhancing the integration of maternal services between the eight participating sites and the HHS. As such, the scope of this evaluation relates to:

- pregnant women intending to birth Aboriginal and Torres Strait Islander babies at a hospital in the participating HHS catchment
  - the period of maternity service delivery is defined as confirmation of pregnancy to six weeks post-delivery
  - women considered high risk or with severe complications who are unable to receive antenatal care at an ATSICCHO are excluded.
- staff of participating ATSICCHO sites: Apunipima Cape York Health Council, Carbal Medical Services, Girudala Community Co-operative Society Ltd, Goondir Medical Services, Gurriny Yealamucka Health Services Aboriginal Corporation, Mamu Health Service Limited, Mulungu Aboriginal Corporation Health Centre and Wuchopperen Health Service
- staff of participating HHS sites: Cairns and Hinterland, Darling Downs and Mackay
- though Apunipima delivers health services to clients within the Torres and Cape Hospital Health Service (TCHHS) catchment, the TCHHS will not be included in this evaluation. This evaluation is specifically focused on women birthing Aboriginal and Torres Strait Islander babies in hospitals in the ATSICCHOs and respective HHSs as outlined in Section 5.1.

Probity considerations

Ethics approval

Ethical clearance for MSIP, including the evaluation, was obtained from:

- The Far North Queensland Human Research Ethics Committee on 9 January 2020 (Protocol Number HREC/2019/QCH/58819 – 1397; see page. 48) and
- The Townsville Human Research Ethics Committee on 21 April 2020 (Protocol Number HREC/QTHS/61002; see page. 49).

Several amendments were made. Specifically, these included the addition of an investigator to project team, change in scope of one set of site-based integration activities to ensure the activity was achievable during the COVID-19 response, and the inclusion of evaluation specifics as they pertain to the resource component.

Data collection and management

Data/information obtained from key personnel at participating Members contained in monthly reports, forum presentations, final report questionnaires, and individual site discussions were compiled together in a spreadsheet for each site.

Analysis of the data involved multiple read-throughs of the spreadsheet and viewing of audio/visual content. Recurring themes were drawn from the free text as they related to each of the elements of the evaluation framework, namely the domains and the key questions outlined above.

Members involved in the place-based component were provided with an opportunity to preview and discuss the summary statements and findings of the MSIP evaluation prior to finalisation of the report.

Ethical Clearance Certificate Far North Queensland HREC

HREC/2019/QCH/58819 - 1397
Further information received – Study Approved
33.10 ES:jld
Telephone: (07) 4226 5513
Email: Cairns_Ethics@health.qld.gov.au

Queensland Government
Far North Queensland
Human Research Ethics Committee

6 December 2019

Email: Wyomie.Robertson@qaihc.com.au; Margaret.Cashman@qaihc.com.au

Mrs Wyomie Robertson
Policy and Research Department
Queensland Aboriginal and Islander Health Council
Third Floor, 36 Russell St
South Brisbane QLD 4101

Dear Ms Robertson,

Review Reference: HREC/2019/QCH/58819 - 1397
Project Title: QHAIC Maternity Services Integration Project

Thank you for submitting the above research project for ethical and scientific review. This project was considered by the Far North Queensland Human Research Ethics Committee (FNQ HREC) (EC00157) as a new application on the 31 October 2019. Your response to FNQ HREC queries dated 15 November 2019 was received by the FNQ HREC on 5 December 2019.

I am pleased to advise you that the above research project meets the requirements of the National Statement on Ethical Conduct in Human Research (2007) and **ethical approval for this research project has been granted** by FNQ HREC.

This letter constitutes ethical approval.

The nominated sites for the project are:

- Cairns and Hinterland Hospital and Health Service

This project cannot proceed at any Queensland Health site until separate research governance authorisation has been obtained from the CEO or Delegate of the institution under whose auspices the research will be conducted at that site.

Please contact: Margaret Grasso, CHHHS Research Governance Officer
A: William McCormack Place, Level 7, 5B Sheridan Street, Cairns
E: RGO_Cairns@health.qld.gov.au | T: (07) 4226 5512

The nominated non-Queensland Health sites for the project area:

- Queensland Aboriginal and Islander Health Council (QAIHC)
- Apunipima Cape York Health Council
- Gurriny Yealamucka Health Service Aboriginal Corporation
- Mamu Health Service Limited
- Mulungu Aboriginal Corporation Primary Health Care Service
- Wuchopperen Health Service

William McCormack Place
Level 7, 5b Sheridan St
PO Box 902
Cairns QLD 4870

Ethical Clearance Certificate Townsville HREC

HREC/2019/QCH/58819 - 1397
Further information received – Study Approved
33.10 ES:jld
Telephone: (07) 4226 5513
Email: Cairns_Ethics@health.qld.gov.au

Queensland Government
Far North Queensland
Human Research Ethics Committee

6 December 2019

Email: Wyomie.Robertson@qaihc.com.au; Margaret.Cashman@qaihc.com.au

Mrs Wyomie Robertson
Policy and Research Department
Queensland Aboriginal and Islander Health Council
Third Floor, 36 Russell St
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- Gurriny Yealamucka Health Service Aboriginal Corporation
- Mamu Health Service Limited
- Mulungu Aboriginal Corporation Primary Health Care Service
- Wuchopperen Health Service

William McCormack Place
Level 7, 5b Sheridan St
PO Box 902
Cairns QLD 4870

Monthly progress report template

The Maternity Services Integration Project (MSIP) monthly reporting is due the 15th of each month.
Final report is due 15 November 2020.
Please complete and send to policyteam@qaihc.com.au

1. MSIP site name:

2. Project title:

3. Project team:

	Name	Position
ATSICCHO		
Hospital and Health Services		
Other		

3.1 Have there been any project team changes?

Completed by:

Signature:

Date:

4. Project summary

How would you describe the progress of the project to date? Please tell us the status of the project and any challenges, wins and learnings.

5. Reporting measures

Reporting measures		Responses
5.1 Collaboration and formal partnerships	Three steps taken to strengthen relationships and any establishment of formal partnerships between the HHS and ATSICCHO	
	How many face-to- face meetings have you held in the last month? Please provide details *(who have been involved in these meetings? e.g. Practice Manager, HHS DON, HHS Midwife)*	
	Have there been any other types of engagement or collaboration? Please provide details	
5.2 Enablers and inhibiters	Potential barriers	
	Perceived barriers	
	Strengths	
	Other	
5.3 Co-design	What joint activities were delivered this month?	
	What planned joint activities are planned for the upcoming month or to occur later in the project? How will this occur?	
5.4 Information sharing	What integration improvement activities in relation to information sharing processes occurred this month?	
	Please attach any examples if appropriate e.g. documents describing new processes for sharing information	
5.5 Integration	How will these activities overcome existing barriers and streamline care?	

6. Data report (site-specific data items)

Reporting measures	Responses
6.1 Percentage of mothers attending an early antenatal care visit	
6.2 Percentage of pregnant women attending five antenatal visits per pregnancy with the first visit less than 14 weeks gestation	
6.3 Percentage of women with a Failure to Attend antenatal care appointment at Darling Downs HHS	
6.4 Percentage of women with birth weight recorded by Goondir	
6.5 Percentage of Newborn Health checks conducted	
6.6 Percentage of babies with a low birth weight recording	
6.7 Percentage of babies born less than 37 weeks gestation	

7. COVID-19

7.1 Please describe if COVID-19 has impacted the project in the following areas:

	Yes	No	If yes, please provide further detail
Change to commencement date			
Change to project team			
Change to recruitment processes			
Change in performance measures			
Change to resources (financial and/or equipment)			
Change to anticipated end date			

7.2 Please describe contingency planning for government restrictions on meeting, travel and movement in the ongoing management of activities:

7.3 If your planned place-based activity requires physical proximity with participants please describe how this risk will be managed and will comply with government requirements:

Final report template

MSIP site name:

Project title:

Project's Hospital and Health Service Partner:

Project Summary

What were the outputs of the project? (what was done)

What were the outcomes of the project? (what did it lead to)

What were the biggest challenges with the project?

What were the biggest learnings from the project?

What must happen next to improve maternity services delivery?

Please provide feedback on QAIHC's facilitation of this project and contract management

Please describe what and how the project achieved the following:

Collaboration and formal partnerships:

Enablers and inhibiters

Co-design

Information sharing

Integration

COVID-19

Please describe if COVID-19 impacted the project in the following areas:

	Yes	No	If yes, please provide further detail
Change to commencement date			
Change to project team			
Change to recruitment processes			
Change in performance measures			
Change to resources (financial and/or equipment)			
Change to anticipated end date			

Please describe how the project and your maternal health services were affected by COVID-19 and how you responded, particularly in regards to; patient care, community wellbeing, government restrictions, meetings and travel.

10.2 Evaluation: Additional data

APUNIPIMA DATA

Joint services prior to MSIP

It is understood that no joint maternity services were delivered by Apunipima and the CHHHS prior to MSIP.

Evaluation domains: Apunipima

Table 3: The evaluation framework included five project domains that are documented with project indicators for the Apunipima MSIP site in the following table.

Table 3. Evaluation domains: Apunipima

Domains	Inputs	Outputs	Outcomes	Influence
Collaboration and formal partnerships	Building structured communication: • quantity of meetings. • quality of meetings. • efficiency of communication.	• MOU between CH Midwifery Unit and Apunipima Midwifery Team. • Strength of relationship between CH Antenatal clinic and extended Midwifery Team. • MOU between Mookai Rosie Bi-Bayan and Apunipima Midwifery Team.	• Strengthened working relationships between Cairns Home Visiting Team and CH Antenatal clinic. • Strengthened working relationships between Mookai Rosie Bi-Bayan and Apunipima Midwifery Team.	Culturally safe continuation of care to the women of Cape York.
Co-design	Active engagement with HHS wherever opportunity.	Presence and continuity of culturally appropriate and safe care for women and babies within CH and with Mookai Rosie Bi-Bayan.		
Information sharing	• Structured communication enabled flow between HHS and Apunipima. • New communication pathway through social media.	• Cross-team approach to data entry and client record/history. • Two-way communication between clients and Apunipima Midwifery Team.	• Increase in data efficiency for client pathway. • Increase touchpoints for clients with services and flow of information.	
Integration	Role definition of HHS and ATSICCHO.	Refined processes of referral re: clinical practice.	Streamlined handover process within Apunipima for women transitioning through CH Antenatal clinic.	

Table 3. Evaluation domains: Apunipima (continued)

Domains	Inputs	Outputs	Outcomes	Influence
Enablers and inhibitors	**Enablers**: • Apunipima staff strengths. • Respectful, inter-sector relationships. • Open communication channels. • Transport for client access. • Adaptability for continued service delivery.		**Inhibitors**: • COVID-19 pandemic • Consent impact on client participation. • Clinic capacity (weekdays only). • Time management/priorities. • Clinical readiness.	

Key site-specific challenges

- Workforce capacity—single midwife with no replacement for leave; weekday clinic availability only, potentially 'missing' women who birth on weekends, and no communication between Apunipima is shared.
- Information sharing processes:
  - Lack of process for discharge summaries from CH for referral services including Apunipima.
  - Casual-based handover from CH Maternity Ward AHW to Cairns Home Visiting Team (Apunipima) sometimes creates gaps in information flow to provide necessary care to clients.
- Consent—Project participation required women to complete consent forms, of which many were hesitant. The number of clients impacted by the project will not be a true reflection of the clients who received services from Apunipima.

Site-specific data: Apunipima

Site-specific data for Apunipima focused on documenting the attendance rates for antenatal appointments and birthing information of Apunipima Cape York clients. COVID-19 restrictions significantly impacted in-person appointments at this site.

Table 4. Site-specific data: Apunipima

	March	April	May	June	July
Antenatal care attendance	4	14	16	4	9
Length of stay in postnatal ward (days)	1.5	1.5*	n/a*	n/a*	3-5*
Number of spontaneous vaginal births	1	7	11	3	4

**Insufficient information provided to Apunipima*

GURRINY DATA

Joint services prior to MSIP

- Regular case conferencing between CHHHS and Gurriny midwives.
- Far North Regional Obstetric Services (based at Cairns) visiting Gurriny and providing regular case conferencing and review of high-risk antenatal patients.
- Support from Cairns Hospital Indigenous Liaison Officer (ILO) for Yarrabah women admitted to hospital.
- Indigenous childbirth education services provided by Cairns Hospital.

Evaluation domains: Gurriny

Table 4: The evaluation framework included five project domains that are documented with project indicators for the Gurriny MSIP site in the following table.

Table 5. Evaluation domains: Gurriny Yealamucka

Domains	Inputs	Outputs	Outcomes	Influence
Collaboration and formal partnerships	Initiative and persistence enabled: • regular communication between parties. • collaborative meetings. • invitation for clinical site visit.	• Clinical site visit to CH birthing suite by Gurriny Maternal Health Worker. • MOU between CH and Gurriny. • Enhanced reciprocal understanding of care services by each organisation. • Established relationships between Gurriny MHW and CH Director of Nursing (DON), Midwifery staff.	• Strengthened professional relationships between organisations. • Enhanced professional/ clinical experience of Gurriny MHW.	Culturally safe continuation of care to the women of Yarrabah. "Journeying Safely, returning Strong".
Co-design	• Intentional and active collaboration with HHS wherever opportunity allowed. • Adaptability with project activities given impacts of COVID-19.	Resource development: • to advertise Gurriny MHW services including calendar, brochures and posters. • new mobile phone number for client contact with Gurriny MHW. • consent form, protocol for MHW role with clients in CH. • discharge planning template. • evaluation form.	• Raised awareness of Gurriny MHW services in CH and community. • Single point of contact (mobile number) to simplify client/clinical staff access to Gurriny MHW. • Streamlining of care including mitigation of lost appointments and discharge issues. • Ethical considerations. • Feedback on MSIP—client experience.	

Table 5. Evaluation domains: Gurriny Yealamucka (continued)

Domains	Inputs	Outputs	Outcomes	Influence
Information sharing	• Regular communication enabled information flow between HHS and Gurriny Yealamucka. • Communications identified opportunities including resources, client access and official paperwork.	• New communication pathway with mobile phone. • As above (other resource development).	• Increase in maternal and infant health data efficiency for client pathways. • Additional simple touchpoint for clients/clinical staff to access information and services.	Culturally safe continuation of care to the women of Yarrabah. "Journeying Safely, returning Strong".
Integration	Project partners committed to creating better knowledge transfer within system.	• Gurriny MHW ability to attend CH and engagement with CH clinical staff to enhance understanding of Gurriny models of care, cultural context, and service strengths. • Gurriny MHW partnership with ILO, DON, Nursing staff at CH. • Shared official documents (as above) to streamline professional care and data accuracy. • Collaborative discharge planning.	• Culturally appropriate care and support for women birthing Aboriginal and Torres Strait Islander babies within mainstream clinical setting. • Better management of discharge for client and infant safety and support.	
Enablers and inhibitors	**Enablers**: • Gurriny staff commitment and persistence to project. • Quality staff members with capacity for MSIP from both parties. • Existing respectful relationships. • Adaptability for continued service delivery.		**Inhibitors**: • COVID-19 pandemic—impacts to logistics with community lockdown and difficulty accessing CH services for clients, and CH staff for collaboration. • Some staff illness reduced capacity for Gurriny.	

Key site challenges

- Yarrabah Community abrupt lockdown due to COVID-19 prevented staff and client travel to Cairns for appointments, meetings etc.
- Gurriny staff time and resources re-directed away from MSIP to COVID-19 taskforce work for the Community.
- CH staff time and resources prioritised for COVID-19 demands and planning.
- Some staff illness reduced capacity for MSIP progress.
- Resignation of key staff member at CH—Nursing and Midwifery Director Women's Health.

Site-specific data: Gurriny Yealamucka

Site-specific data for Gurriny was to follow cross-sector engagement, discharge planning and workforce development. As reflected in the following data table, COVID-19 restrictions significantly impacted data collection.

Table 6. Site-specific data: Gurriny Yealamucka

	March	April	May	June	July
Number of information sessions	0	0	0	0	1
Number of contacts by CHHS with Gurriny ILO	0	0	2	0	2
Number of planned discharged communicated in advance to Gurriny Maternal Health Team	0	0	0	0	0
Number of Gurriny Midwives' supernumerary shifts	0	0	0	0	0

MAMU DATA

Joint services prior to MSIP

- Yabu Njalngga—existing Mums & Bubs Program offered at Mamu (not joint delivery)
- Antenatal and postnatal care
- Shared antenatal care with Cassowary hub maternity
- General Practitioner consults
- Annual Health Checks (715), GP management plan/ Team Care Assessment
- Child health and developmental checks
- Childhood Immunisation Program
- Health promotion/prevention
- Smoking cessation
- Mental Health Practitioner
- Healthy Hearing Screening
- Visiting Speech & Occupational therapist
- Social Emotional Well-Being and Family Support Referrals
- Reading Group
- Transport

Evaluation domains: MAMU

Table 5: The evaluation framework included five project domains that are documented with project indicators for the Mamu MSIP site in the following table.

Table 7. Evaluation domains: Mamu

Domains	Inputs	Outputs	Outcomes	Influence
Collaboration and formal partnerships	Collaborative approach by both partners enabled: • regular communication. • invitation for reciprocal site visits. • progress towards a MOU.	• Collaborative meetings. • CHHHS visit to Mamu. • Mamu visit to CHHHS and ongoing Mamu attendance at meetings where possible. • MOU between CHHHS and Mamu developed. • Respectful working relationships.	• Strengthened professional relationships between organisations. • Commitment to the project by partners for health of Mums and Bubs. • MOU established.	Culturally safe space and interagency health networks for the care of mothers and babies in Innisfail and surrounds.

***Table 7. Evaluation domains: Mamu** (continued)*

Domains	Inputs	Outputs	Outcomes	Influence
Co-design	Active collaboration and presence at HHS with meetings to discuss: • project • MOU • resource needs for room • possibilities for future services.	• Collaborative work to complete fit out of Mums and Bubs room at Mamu. • MOU between CHHHS and Mamu • Identification of maternal/postnatal service gaps and solutions e.g. postnatal care classes at Mamu.	• Culturally safe and consistent space for Mums and Bubs to receive care—enhancing access and appropriateness of care. • Ongoing maternity service improvement and responsiveness.	Culturally safe space and interagency health networks for the care of mothers and babies in Innisfail and surrounds.
Information sharing	Regular communication enabled site invitations and information flow between CHHHS and Mamu.	• Reciprocal site visits between partners—enhanced understanding of care services by each organisation. • Attendance and presence of Mamu within mainstream health care setting. • MOU solidifies this information flow between partners. • Referral form for Innisfail Hospital (Cassowary Coast MGP) added to Communicare and used by ATSICCHO GPs.	• Ongoing maternity service improvement and responsiveness through knowledge transfer. • Streamlining of referrals to MGP.	
Integration	Join up of partners committed to project outcomes.	• Advice and knowledge transfer to enable culturally safe space and personnel networks for maternity care. • Access and presence of Mamu within mainstream antenatal care.	• Culturally appropriate care and support for women birthing Aboriginal and Torres Strait Islander babies across inter-agency pathways, including mainstream clinical setting.	

Table 7. Evaluation domains: Mamu (continued)

Domains	Inputs	Outputs	Outcomes	Influence
Integration		• Identification of service opportunities to increase access to care e.g. transport.		Culturally safe space and interagency health networks for the care of mothers and babies in Innisfail and surrounds.
Enablers and inhibitors	**Enablers**: • Mamu staff commitment and persistence to project. • Enthusiasm and engagement of CHHHS staff (including ILO) to project. • Resource commitment to project (funding and needs assessment) for medical and information technology equipment. • Existing respectful relationship and maternal service delivery alongside CHHHS.		**Inhibitors**: • COVID-19 pandemic—impacts to logistics with service delivery for Mamu and also staff ability to meet with CHHHS. • Some staffing changes/issues that reduced capacity for MSIP follow through.	

Site-specific challenges

- COVID-19 pandemic impacted logistics with service delivery for Mamu and also cross-sector meetings for staff.
- Project members expressed concern regarding lack of staff continuity and how this would impact capacity of staff to be able to follow through on MSIP objectives. Organisational changes at Mamu were also taking place during the project.

Site-specific data: Mamu

Mamu's site-specific data intended to track the cross-sector engagement, client referrals and attendance at antenatal, postnatal clinics and education sessions. As clearly reflected in the site-specific data for Mamu, COVID-19 restrictions significantly impacted in-person appointments.

Table 8. Site-specific data: Mamu	March	April	May	June	July
Number of meetings held/attended	6	0	0	0	
Number clinics conducted	Nil	Nil	Nil	Nil	
Number antenatal clients seen	53*	0	0	0	
Number of postnatal clients seen	31	0	0	0	
Number follow ups with FTA antenatal/postnatal	n/a	0	0	0	
Number of home visits made to antenatal/postnatal clients	n/a	0	0	0	
Number women presenting for follow-up and review	31	0	0	0	
Number of antenatal/postnatal clients on register	53	0	0	0	

Table 8. Site-specific data: Mamu (continued)

	March	April	May	June	July
Number of referrals for counselling and support	n/a	0	0	0	
Number of antenatal clients provided with education	53	0	0	0	
Number of group educations sessions conducted including participants	0	0	0	0	
Number of postnatal clients seen whilst inpatients at Innisfail hospital	0	0	0	0	

**Period 01/09/2018-01/09/2019 n/a = not available*

MULUNGU DATA

Joint services prior to MSIP

While there was an existing positive relationship between Mulungu and Mareeba Hospital, there were no joint-delivered maternal services prior to MSIP.

Evaluation domains: Mulungu

Table 9: The evaluation framework included five project domains that are documented with project indicators for the Mulungu MSIP site in the following table.

Table 9. Evaluation domains: Mulungu

Domains	Inputs	Outputs	Outcomes	Influence
Collaboration and formal partnerships	Committed and enthusiastic senior clinicians at Mareeba Hospital and Mulungu staff created opportunity for positive relationships and collaboration.	• Committed and enthusiastic senior clinicians at Mareeba Hospital and Mulungu staff created opportunity for positive relationships and collaboration.	• Strengthened professional relationships between organisations. • Commitment to the project by partners—strong advocates for health of mothers and babies.	Building a culturally safe, shared model of care for mothers and babies in Mareeba and surrounds.
Co-design	Active collaboration with meetings to discuss: • maternal needs. • beliefs and considerations for antenatal care. • cultural awareness.	• Collaborative work to develop a shared Model of Care. • Collaborative work to develop client resources and communications during COVID-19.	• MOU in progress. • Ongoing maternity service improvement and responsiveness through shared activities.	

Table 9. Evaluation domains: Mulungu (continued)

Domains	Inputs	Outputs	Outcomes	Influence
Co-design *(continued)*	• Recognition of skill set across teams for project. • Potential for memorandum of understanding (MOU).	• Team approach to development and presentation of MSIP report with QAIHC. • Transport options for high-risk clients.	• Maintaining access to culturally safe and consistent care and support during challenging times. • Continuity of care for high-risk clients.	Building a culturally safe, shared model of care for mothers and babies in Mareeba and surrounds.
Information sharing	Regular communication enabled information flow and mutual agreements between CHHHS and Mulungu.	• Mutual agreement for information flow re: Birth notices (via KiteWorks software and email) including key data and discharge summaries. • Timeliness of referrals and support for complex cases (e.g. teleconference for antenatal and postnatal care). • Site visit by Nurse Unit Manager to Mulungu with report to all CHHHS midwives. • Weekly case conferencing. • IT platforms facilitated secure and easily accessible data sharing and virtual meetings.	• Maternity service improvement and responsiveness through knowledge transfer with streamlining of processes. • Secure and accessible data sharing. • Continuity of knowledge exchange despite COVID challenges.	
Integration	Join up of skilled partners committed to project outcome of shared Model of Care.	• Strengthened communication. • Shared knowledge. • Collaborative outputs: client resources and supports. • Mutual agreements and Model of Care.	Streamlining of culturally appropriate care and support for women birthing Aboriginal and Torres Strait Islander babies.	Building a culturally safe, shared model of care for mothers and babies in Mareeba and surrounds.

Table 9. Evaluation domains: Mulungu (continued)

Domains	Inputs	Outputs	Outcomes	Influence
Enablers and inhibitors	**Enablers**: • Mulungu staff commitment and strength of advocacy role for women and babies. • Engagement and professionalism of CHHHS staff to project. • Partnership approach throughout MSIP. • Flexibility to adapt service delivery, communication and access during impacts of COVID-19. • Resources available to project operations e.g. Kiteworks software, IT platforms for virtual communications.		**Inhibitors**: • COVID-19 pandemic—impacts to logistics with service delivery for clients and also staff ability to meet with CHHHS. • COVID-19 pandemic—impacts to client follow-up re: flow-on effect for social and emotional wellbeing of clients. • Concerns re: Mulungu staffing capacity for MSIP.	

Site-specific challenges

- COVID-19 pandemic had specific impacts on project logistics—regarding service delivery and cross-sector meetings.
- The COVID-19 pandemic impacted clients' social and emotional wellbeing due to isolation and resulted in loss to follow-up for clients who moved to other locations, leaving no contact details.
- Staff capacity to work on MSIP at Mulungu was a concern for staff.

Site-specific data: Mulungu

Site-specific data for Mulungu was focused on documenting the antenatal appointments delivered at the partnering organisations in line with the project goal to support women with culturally safe maternal care at both sites. Data shown here reflects the impacts of COVID-19 restrictions on in-person consultations.

Table 10. Site-specific data: Mulungu

	March	April	May	June	July
Number antenatal appointments delivered onsite at Mulungu	23	5	6	9	17
Number antenatal appointments delivered onsite at Mareeba hospital	23	5	7	n/a	n/a
Number of joint-delivered antenatal education sessions	–	0	0	0	0

**n/a= not available at time of reporting*

WUCHOPPEREN DATA

Joint services prior to MSIP

It is understood no joint maternity services were delivered by Wuchopperen and the CHHHS prior to MSIP.

Evaluation domains: Wuchopperen

The evaluation framework included five project domains that are documented with project indicators for the Wuchopperen MSIP site in the following table.

Table 11. Evaluation domains: Wuchopperen

Domains	Inputs	Outputs	Outcomes	Influence
Collaboration and formal partnerships	Initiative and commitment of Wuchopperen Staff and advocacy of QAIHC created opportunity for positive relationships and collaboration.	• Respectful working relationships. • Drafting of Terms of Reference (TOR). • Regular communications at collaborative meetings, case conferencing. • Wuchopperen staff visits to CHHHS.	• Strengthened professional relationships and role clarity between organisations. • Appreciation for each other's professional context. • Professional and personal acknowledgement of Wuchopperen staff within CHHHS (mainstream setting).	Culturally safe model of care for mothers and babies in Cairns and surrounds.
Co-design	Commitment to MSIP goals by project partners.	Collaborative meetings to discuss: • project activities. • resource development e.g. possibility of client-held record. • drafting of Terms of Reference. Case-conferencing re: considerations for high-risk clients.	• Service improvement with (TOR) and regular communications. • Continuity of care for high-risk clients.	
Information sharing	Regular communication enabled information flow between CHHHS and Wuchopperen.	• Case conferencing. • CHHHS meetings attended by Wuchopperen. • TOR drafted. • Better information flow with Communicare software.	• Streamlining of processes. • Improved shared care. • Continuity of knowledge exchange despite COVID challenges e.g. phone, email.	

***Table 11. Evaluation domains: Wuchopperen** (continued)*

Domains	Inputs	Outputs	Outcomes	Influence
Integration	Project partners committed to outcome of better communication.	• Strengthened communication processes. • Better data sharing. • Improved trust between organisations and respect for professional contexts.	Streamlining of communication and care processes across HHS and ATSICCHO for maternal/antenatal care.	Culturally safe model of care for mothers and babies in Cairns and surrounds.
Enablers and inhibitors	**Enablers**: • QAIHC advocacy for term of project, especially at beginning. • Wuchopperen staff commitment to MSIP. • Engagement of CHHHS staff to project. • Professional and personal acknowledgement of Wuchopperen staff within CHHHS. • Flexibility to adapt during impacts of COVID-19. • Resources available to project operations e.g. Communicare software, IT platforms for virtual communications.		**Inhibitors**: • COVID-19 pandemic—abrupt closure of hospital with women presenting to Wuchopperen for antenatal care. • COVID-19 impacts on logistics (e.g. social distancing) with service delivery for clients and also staff ability to meet with CHHHS. • COVID-19 pandemic—impacts for client social and emotional wellbeing presenting at CHHHS (or lost to follow-up). • Wuchopperen staffing losses. • CHHHS staffing losses. • Initiating regular meetings and regular contact with stakeholder groups.	

Key site challenges

- Early indications from antenatal clinic were that they were too busy to meet regularly for MSIP.
- Communication and information flow between Midwifery Group Project limited—results in 'lost' clients and difficulty in advocacy for additional care needs, particularly regarding mental health.
- COVID-19 pandemic had specific impacts on project logistics—e.g. social distancing altered in-person service delivery and cross-sector meetings.
- COVID-19 pandemic impacts to loss of in-person visits and travel created social and emotional issues for clients.
- Staff losses at both the HHS and ATSICCHO impacted the progress of MSIP e.g. loss of two MOs from the antenatal clinic at CH.

Site-specific data: Wuchopperen

Wuchopperen's data collection tracked cross-sector engagement (e.g. TOR, case conferences) and information flow, in line with the overall project goal of working better together to deliver culturally safe maternal care. Cessation of some CH services during the project due to COVID-19 impacted antenatal attendance rates and data accuracy.

Table 12. Site-specific data: Wuchopperen

	March	April	May	June	July
Terms of Reference development (TOR)	Draft	Draft	Finalised	Finalised	Finalised
Antenatal attendance (percentage)	70% of bookings	80%*	80%*	70%	60%
Classification of clients as high risk (percentage)	Continuing	10%	10%	15%	18%
Number of Case Conferences	17	15	20	16	12
Number of cases discussed at Case Conference	17	17	24	20	21
Contacts between staff	4–8 staff at weekly Wuchopperen high-risk AN meetings				
Number of referral letters	10	13	25	20	19
Number of discharge summaries	12	9	10	14	10
Numbers of high-risk antenatal clients discussed	28	25	25	20	20

**Possibly underestimated as a result of closure Category 3 services at Queensland Health*

CARBAL DATA

Joint services prior to MSIP

Historically, Carbal 'New Directions' and 'Boomagam Caring' (DDHHS) have worked together to ensure that Indigenous women and their families residing in the Toowoomba and Warwick districts receive high quality care during the antenatal and postnatal periods. Client cohort often miss appointments and/or often switch between service providers, so the working relationship between Carbal and DDHHS is important to help support women who may otherwise fall through the cracks. Joint meetings were held to discuss client and services. However, prior to MSIP, no joint services were provided to Toowoomba's Indigenous Community. Antenatal education sessions were provided by DDHHS on an individual basis with a low number of Aboriginal and Torres Strait Islander attendees. However, no joint antenatal education classes were provided.

Evaluation domains: Carbal

The evaluation framework included five project domains that are documented with project indicators for the Carbal MSIP site in the following table.

Table 13. Evaluation domains: Carbal

Domains	Inputs	Outputs	Outcomes	Influence
Collaboration and formal partnerships	Existing relationships and formalisation of MSIP contract facilitated early collaboration.	• Project meetings to plan and progress antenatal classes. • Consistent communication between services. • Visit to Moree HHS for education and connection with sister-site.	• Strengthened and equalised existing professional relationships between organisations. • Navigation of challenges between services e.g. staff availability.	Culturally safe antenatal classes for care and support of mothers and babies in Toowoomba and Warwick.

Table 13. Evaluation domains: Carbal (continued)

Domains	Inputs	Outputs	Outcomes	Influence
Co-design	Commitment to MSIP goals by project partners.	• Collaborative meetings to discuss: – antenatal classes – content, presenters, style, engagement, resources across two sites. – shared commitment to culturally safe programs and settings. – advertising to reach clients. – concern regarding Community interest in classes. • Visit to Moree HHS to observe classes and reflect on MSIP objectives for local clients. • Co-design allowed for negotiation re: elements of the antenatal classes e.g. Carbal Nutritionist vs DDHHS Dietitian presenter.	• Informed design of antenatal classes for culturally safe content and setting. • Delivery of antenatal classes (at two sites) for women birthing Aboriginal and Torres Strait Islander babies.	Culturally safe antenatal classes for care and support of mothers and babies in Toowoomba and Warwick.
Information sharing	Communication enabled information flow between DDHHS and Carbal.	• Regular meetings between DDHHS and Carbal staff. • Use of phone, Zoom software to facilitate ongoing contact. • Consistent record-keeping with minutes and follow-up emails between services.	• Good information flow between services regarding project.	

Table 13. Evaluation domains: Carbal (continued)

Domains	Inputs	Outputs	Outcomes	Influence
Integration	Project partners committed to MSIP goals.	• Strengthened relationship and communication processes e.g. Carbal staff visits to DDHHS. • Commitment and formal plans for co-delivery of classes with culturally safe content and settings.	• Confidence and value in Carbal staff working in mainstream setting at DDHHS. • Establishment of antenatal classes delivered in partnership—with ongoing quality improvement.	Culturally safe antenatal classes for care and support of mothers and babies in Toowoomba and Warwick.
Enablers and inhibitors	**Enablers**: • Existing professional relationship between services. • Commitment of both services to collaborate on MSIP goals—particularly to ensure culturally safe content and settings. • Observation and reflection on antenatal activities of sister-site. • Resources available to project operations e.g. Communicare software, IT platforms for virtual communications.		**Inhibitors**: • COVID-19 pandemic—direct impacts for this site were less than other MSIP projects, however DDHHS deferred timelines and project actions . • DDHHS pushback re: workflow capacity/ staffing—rescheduling of meetings and deferral of start date for classes. • Staffing capacity within Carbal was also a limitation.	

Key site challenges

- DDHHS staff capacity for attendance and contribution to antenatal classes—pushback from HHS regarding start date.
- COVID-19 did not have as much direct impact on project logistics; however, there were competing funded programs within Carbal (due to COVID-19) that made staff ability to focus on MSIP difficult at times.
- Workflow pressures re: COVID-19 on the DDHHS may have contributed to deferral of work on MSIP.
- Community interest in classes was a concern for this site, however despite 'low' numbers attending the first set of classes, the project team feel more confident in class delivery and engagement and will continue to provide these sessions.

Site-specific data: Carbal

Carbal opted to track the formal cross-sector meetings, delivery of antenatal classes, and client numbers for site-specific data. Data levels reflect the impacts of COVID-19 restrictions on in-person consultations and the opportunity to commence the antenatal classes.

Table 14. Site specific data: Carbal

	March	April	May	June	July
Number of meetings with DDHHS re: classes	2	2	3	1	2
Number joint-delivered antenatal classes	0	0	0	0	2
Number clients attending antenatal classes	0	0	0	0	5
Number feedback forms completed by clients attending antenatal classes	0	0	0	0	5

GOONDIR DATA

Joint services prior to MSIP

Prior to the MSIP activities there were no jointly delivered maternal services by Goondir and the DDHHS. However, there were existing relationships that enabled some information flow and referral of women to existing programs such as Queensland Health's 'Bridging Antenatal Care, Indigenous Babies, Smoking Cessations' (BAIBS) project. This was launched in 2019 in partnership with several QAIHC Member Services and other medical providers in the Darling Downs Region. Midwives from DDHHS were also in contact with Goondir to enquire about client assistance with social support, transport, Closing the Gap (CTG) scripts, birth certificate receipt and other communication about service needs.

Evaluation domains: Goondir

The evaluation framework included five project domains that are documented with project indicators for the Goondir MSIP site in the following table.

Table 15. Evaluation domains: Goondir

Domains	Inputs	Outputs	Outcomes	Influence
Collaboration and formal partnerships	Collaboration between DDHHS and Goondir with QAIHC to MSIP project goal regarding referral pathways between Goondir and DDHHS.	• Proactive approach by both partners. • Appointment of Maternal and Child Health Nurse across Goondir and DDHHS. • Approval for funding within DDHHS for AHW/ ILO in future to support continuation MSIP. • Project meetings to identify gaps in system and maternal pathway for women birthing Aboriginal and Torres Strait Islander babies.	• Enhancement and increased efficiency of professional relationships between organisations—creating a 'team' approach to maternal care across the region. • Recognition of value of multidisciplinary team between Sectors.	Culturally safe pathway and maternal care for mothers and their babies in the Dalby, St George and Oakey region.

***Table 15. Evaluation domains: Goondir** (continued)*

Domains	Inputs	Outputs	Outcomes	Influence
Collaboration and formal partnerships *(continued)*	Collaboration between DDHHS and Goondir with QAIHC to MSIP project goal regarding referral pathways between Goondir and DDHHS.	• Development of formal agreement between partners (MOU/SLA). • Consistent communication and activities between services.	• Streamlining of referral pathways between Goondir and DDHHS for antenatal, birthing and postnatal care.	Culturally safe pathway and maternal care for mothers and their babies in the Dalby, St George and Oakey region.
Co-design	Commitment to MSIP goals by project partners.	Collaborative meetings to discuss: • gaps in system for antenatal, birthing and postnatal care • COVID-19 logistic impacts • inconsistencies and procedural mismatch across Sector • opportunities for care e.g. vitamin and medication access • possibilities for referral pathways at each stage of care.	• Development and established pathways of referral. • Increased attendance and engagement at DDHHS clinics for women birthing Aboriginal and Torres Strait Islander babies. • Resourcing of clients e.g. travel assistance. • Potential resourcing of clients in future e.g. vitamin and medication access.	
Information sharing	Collaboration between DDHHS and Goondir with QAIHC to MSIP project goal regarding referral pathways between Goondir and DDHHS.	• Knowledge of both HHS and ATSICCHO to identify and act on information flow needs. • Regular communication between DDHHS and Goondir throughout project. • Provision of technology to support MSIP e.g. laptop with remote access to shared software for data accuracy and flow. • Detailed record-keeping of project and communications.	• Streamlining of data collection, storage and sharing between Sectors. • Relationship building activities strengthened opportunity for data quality.	

Table 15. Evaluation domains: Goondir (continued)

Domains	Inputs	Outputs	Outcomes	Influence
Integration	Project partners committed to MSIP goals.	• Commitment and formal plans to address gaps in antenatal/maternal pathway. • Shared information technology access and software.	• Quality improvement in referral pathways AND data collection/flow for women birthing Aboriginal and Torres Strait Islander babies.	Culturally safe pathway and maternal care for mothers and their babies in the Dalby, St George and Oakey region.
Enablers and inhibitors	**Enablers**: • Key personnel appointment—Maternal and Child Health Nurse (MCHN) as a 'Sector Champion' to drive MSIP activities. • Appointed MCHN had experience with both Sectors—insights helped facilitate project goals. • Existing professional relationship between services. • Commitment of both services to collaborate on MSIP goals. • Resource support—information technology supplied to MCHN. • Flexibility and adaptation during COVID-19 challenges and other limitations. **Inhibitors**: • COVID-19 pandemic—project logistics. • Inconsistencies between DDHHS and Goondir. • Staff capacity—single driver of project.			

Site-specific challenges

- COVID-19 pandemic had less of an impact at this site than for others, but did impact logistics and aspects of support to clients e.g. transport for clients
- Inconsistencies in process were noted between DDHHS and Goondir
  - Reporting of Aboriginal and Torres Strait Islander data impacted by identification processes, e.g. Indigenous identity proof required by Goondir but not DDHHS, and identity only identifies mother as Aboriginal and/or Torres Strait Islander and not necessarily the child
  - Access to CTG scripts is restricted without identification as Indigenous within the HHS—this can be a significant health gap for Aboriginal and Torres Strait Islander People
- Concern expressed for staff capacity, with a single 'project champion' to drive the project and co-ordinate cross-sector meetings.

Site-specific data: Goondir

Site-specific data for Goondir documented the impacts of streamlining maternal health services and communications between DDHHS and Goondir. For example, a positive trend was observed in failure to attend (FTA) antenatal appointments across the span of the project (9.6 per cent May 2020—6.2 per cent September 2020 for DDHHS).

Table 16. Site-specific data: Goondir	March	April	May	June	July
Clients attending an early antenatal care visit *(percentage)*	95	55	53	47	48
Pregnant women attending five (5) antenatal visits *(percentage)*	57 (Feb)	*(Mar)	*(Apr)	51	39
Pregnant women with FTA antenatal appointment at DDHHS *(percentage (n=))*	9.6 (44) = Total DDHHS; 4.6 (4) = Western Downs	8.8 (32) = Total DDHHS; 12.5 (4) = Western Downs	7.2 (24) = Total DDHHS; 9.7 = Western Downs	7.4 (31) = Total DDHHS; 6.5 (14) = Western Downs	6.2 (26) = Total DDHHS; 3.1 (2) = Western Downs
Clients with birth weight recorded by Goondir *(percentage)*	95	100	100	97	100
Newborn health checks conducted *(percentage of 0–4 year Health Check)*	35	63	65	64	63
Newborns with a low birth weight recorded *(percentage)*	0 = Western Downs	9.8 = Goondir; 13 = Total DDHHS; 0 = Western Downs	15 = Goondir	16 = Goondir	13.3 = Goondir
Newborns birthed less than 37 weeks gestation *(percentage (number)*	0 = Western Downs	9.8(4) = Total DDHHS; 0 = Western Downs	26 (5) = Total DDHHS; 0 = Western Downs	12 (3) = Total DDHHS; 0 = Western Downs	*

*QIP Report using DDHHS data; *=unknown*

GIRUDALA DATA

Joint services prior to MSIP

- Minimal or no joint services relating to maternity care between Mackay Hospital and Girudala
- Professionally courteous relationship, but not utilising each other's' strengths
- Refer only for antenatal care as per protocol at 12 weeks

Evaluation domains: Girudala

The evaluation framework included five project domains that are documented with project indicators for the Girudala MSIP site in the following table.

Table 17. Evaluation domains: Girudala

Domains	Inputs	Outputs	Outcomes	Influence
Collaboration and formal partnerships	Enthusiasm and persistence on part of Girudala staff to collaborate on MSIP.	• Virtual and face-to-face meetings were held to discuss MSIP. • Site visits and increased understanding of MHHS by Girudala staff. • Regular email contact between Girudala staff and DON at MHHS. • Drafting of formal agreement between partners (MOU).	• Small but significant opportunities towards professional relationships e.g. recognition by Girudala staff of MHHS complexities. • Shared commitment to achieving MSIP goals. • MOU between MHHS and Girudala yet to be finalised.	Working towards culturally safe midwifery care led by Girudala for mothers and babies in Whitsunday region.
Co-design	Complexities and internal processes of MHHS limited MSIP capacity Leadership and advocacy of QAIHC to facilitate MSIP project	• Meetings were held throughout project timeline despite difficulties. • MOU. • Mapping of client journey through maternal care across MHHS and ATSICCHOs. • Site visit by Girudala to MHHS • Planning transport assistance for clients.	• Resourcing of clients e.g. travel support to HHS appointments. • Continued communication between services. • Navigation of organisational difficulties. • Co-design is a work in progress.	

***Table 17. Evaluation domains: Girudala** (continued)*

Domains	Inputs	Outputs	Outcomes	Influence
Information sharing	Key personnel sought information flow between MHHS and Girudala.	• Variety of communication avenues in response to COVID-19 impacts. • Upgrade and adoption of communication technology at Girudala. • Knowledge transfer of processes between services.	• Building blocks of enhanced information flow between services.	Working towards culturally safe midwifery care led by Girudala for mothers and babies in Whitsunday region.
Integration	Key personnel sought better integration between MHHS and Girudala	Collaborative work to plan for: • optimising culturally appropriate care • better transition for client from ATSICCHO to HHS • project officer to assist with transport • Girudala staff visits to MHHS.	• Building blocks for quality improvement in referral pathways AND data collection/ flow for women birthing Aboriginal and Torres Strait Islander babies. • Increased understanding and confidence for Girudala staff to integrate within mainstream services.	
Enablers and inhibitors	**Enablers**: • Shared passion for maternal health by staff from both services. • Persistence of Girudala staff to MSIP goals despite difficulties. • Engagement and contribution of DON to MSIP. • Resource support—upgrades to Information Technology for communication. • Flexibility and adaptation during COVID-19 challenges and other limitations. • QAIHC leadership and advocacy to navigate cross-sector difficulties. • Support and interest from community for culturally safe maternal health care.		**Inhibitors**: • Communication between MHHS and ATSICCHO was a significant barrier. • Apparent lack of MHHS internal communication caused confusion and delays. • Research ethics was a difficult process and stalled progress of MSIP. • Staff leave and restructure within MHHS reduced continuity and caused delays to the project. • COVID-19 pandemic—project logistics.	

Key site challenges

- Communication between MHHS and ATSICCHO was a significant barrier that caused confusion about the scope and ethics of the proposed project. Apparent lack of MHHS internal communication contributed to these difficulties.
- MHHS Human Research Ethics Committee were difficult to work with and did not support the context of the local MHHS project within a larger research context. This resulted in significant delays to the project and an overall change to the project objectives.
- Staff leave and restructuring within MHHS reduced project continuity and delayed progress.
- COVID-19 had less of a negative impact on this project, but did affect ability for services to meet in person.

Site-specific data: Girudala

Site-specific data for Girudala was intended to document the number of women engaging with the maternal health activities and birthing statistics. Key site challenges (described above) significantly impacted MSIP progress and limited data collection.

Table 18. Site-specific data: Girudala	March	April	May	June	July
Number of meetings with Bowen Hospital to design partnership agreement	Arranged for 12/6/2020	1	8	2	1
Number of pregnant women using the program	unknown	5	-	-	3
Number of women accessing five (5) antenatal appointments	unknown	-	-	-	-
Number of babies born with low birth weight	unknown	-	-	-	-
Number of women birthing after 37 weeks	unknown	-	-	-	-
Number of educational sessions delivered to pregnant women	unknown	-	-	-	-

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List of Terms and Abbreviations/Acronyms

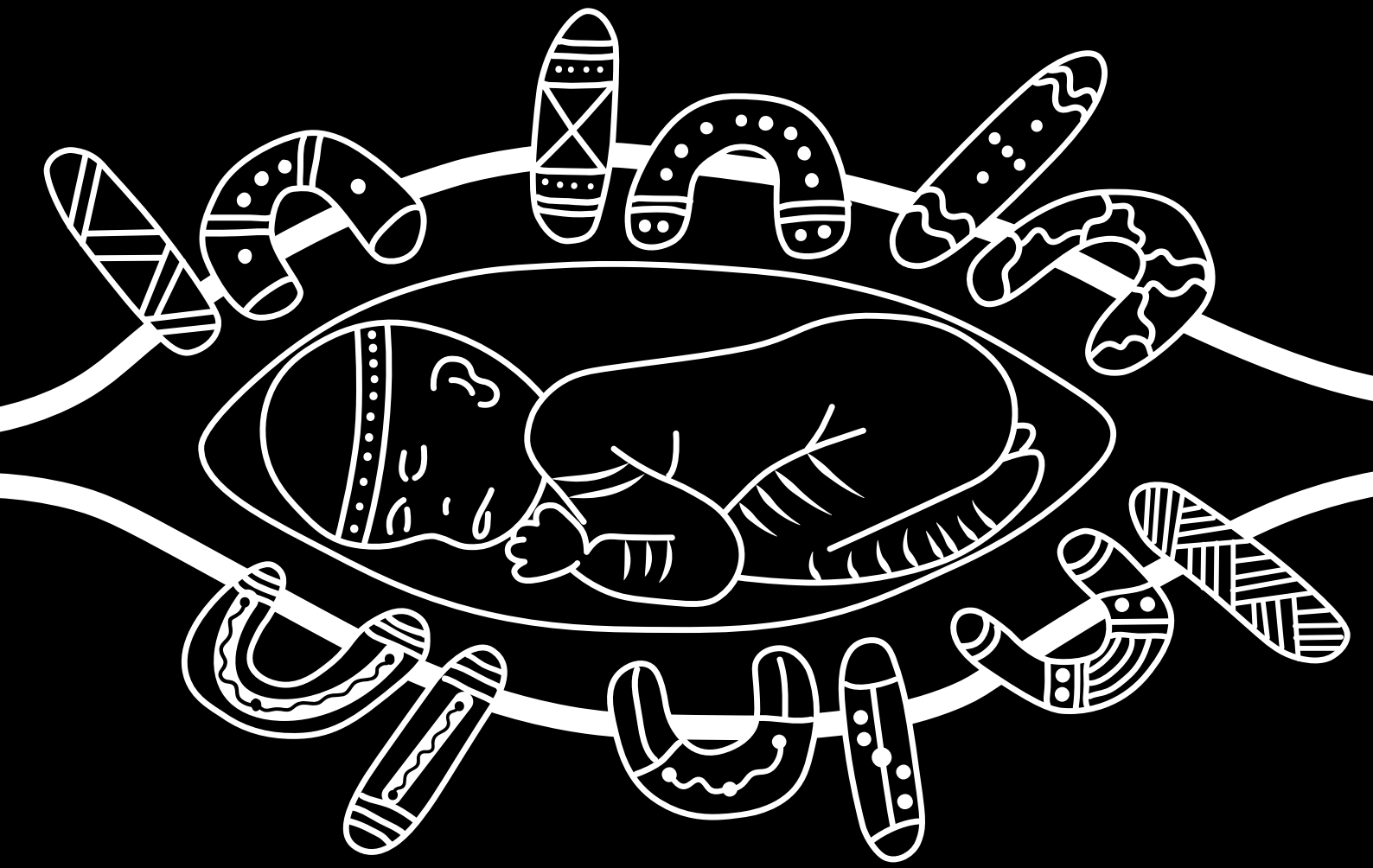
Abbreviation/ Acronym	Meaning
ATSICCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
ATSIHD	Aboriginal and Torres Strait Islander Health Division
ATSIHW/P	Aboriginal and Torres Strait Islander Health Worker / Practitioner
CATSINaM	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CTG	Closing the Gap
DON	Director of Nursing
FTA	Failure to attend
HHS	Hospital and Health Service
HREC	Human Research Ethics Committee
MGP	Midwife Group Practice
MMR	Maternal Mortality Ratio
MoC	Model of Care
MOU	Memorandum of Understanding
MSIP	Maternity Services Integration Project
National Agreement	National Agreement on Closing the Gap
NWHHS	North West Hospital and Health Service
PTSS	Patient Travel Subsidy Scheme
QAIHC	Queensland Aboriginal Islander Health Council
QHRC	Queensland Human Rights Council
QAIHC Members	
Apunipima	Apunipima Cape York Health Council

Abbreviation/ Acronym	Meaning
ATSICHS Brisbane	Aboriginal and Torres Strait Islander Community Health Services Brisbane
ATSICHS Mackay	Aboriginal and Torres Strait Islander Community Health Services Mackay
Bidgerdii	Bidgerdii Aboriginal and Torres Strait Islander Corporation Community Health Service
CACH	Cunnamulla Aboriginal Corporation for Health
Carbal	Carbal Medical Centre
CRAICCHS	Cherbourg Regional Aboriginal and Islander Corporation Community Controlled Health Service
CWAATSICH	Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health Limited
Galangoor	Galangoor Duwalami Primary Healthcare Service
Gidgee	Gidgee Healing
Gindaja	Gindaja Treatment and Healing Centre
Girudala	Girudala Community Co-Operative Society Limited
Goolburri	Goolburri Aboriginal Health Advancement Co Limited
Goondir	Goondir Health Services
Gurriny	Gurriny Yealamucka Health Services Aboriginal Corporation
Injilinji	Injilinji Aboriginal and Torres Strait Islander Corporation for Children and Youth Services
Kalwun	Kalwun Health Service

List of Terms and Abbreviations/Acronyms

Abbreviation/ Acronym	Meaning
Kambu	Kambu Aboriginal and Torres Strait Islander Corporation for Health
Mamu	Mamu Health Service Limited
Mookai Rosie	Mookai Rosie Bi-Bayan
Mudth-Niyleta	Mudth-Niyleta Aboriginal and Torres Strait Islander Corporation
Mulungu	Mulungu Aboriginal Corporation Primary Health Care Service
NCACCH	North Coast Aboriginal Corporation for Community Health
Nhulundu	Gladstone Region Aboriginal and Islander Community Controlled Health Service t/a. Nhulundu Health Service
NPA	NPA Family and Community Services Aboriginal and Torres Strait Islander Corporation
TAIHS	Townsville Aboriginal and Islander Health Services
Torres Health	Torres Health Indigenous Corporation
Wuchopperen	Wuchopperen Health Service Limited
Yulu-Burri-Ba	Yulu-Burri-Ba Aboriginal Corporation for Community Health
QAIHC Regional Members	
IUIH	Institute for Urban Indigenous Health
NATSIHA	Northern Aboriginal and Torres Strait Islander Health Alliance
QAIHC Affiliate Members	
PICC	Palm Island Community Company

Abbreviation/ Acronym	Meaning
Queensland Hospital and Health Services	
CHHHS	Cairns and Hinterland Hospital and Health Service
CQHHS	Central Queensland Hospital and Health Service
CWHHS	Central West Hospital and Health Service
CHHHS	Children's Health Queensland Hospital and Health Service
DDHHS	Darling Downs Hospital and Health Service
GCHHS	Gold Coast Hospital and Health Service
MHHS	Mackay Hospital and Health Service
MNHHS	Metro North Hospital and Health Service
MSHHS	Metro South Hospital and Health Service
NWHHS	North West Hospital and Health Service
SWHHS	South West Hospital and Health Service
SCHHS	Sunshine Coast Hospital and Health Service
TCHHS	Torres and Cape Hospital and Health Service
THHS	Townsville Hospital and Health Service
WMHHS	West Moreton Hospital and Health Service
WBHHS	Wide Bay Hospital and Health Service



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