Eligible midwives and collaborative arrangements
An implementation framework for Victorian public health services
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- Victorian Government Department of Health
- Australian College of Midwives (Vic Branch)
- Maternity managers of public health services
- Deans of Nursing and Midwifery Victoria
- Royal Australian College of Obstetricians and Gynaecologists (Vic)
- Maternity Coalition
- Victorian Managed Insurance Authority
- Metropolitan Directors of Medical Services
- Rural Directors of Medical Services
- General Practice Victoria and GP Liaison
- Australian Nursing Federation (Vic Branch)
- Midwives in Private Practice
- Childbirth Australia
- Regional Clinical Midwife Consultant in public sector
- Australian Health Insurers Association
- Rural General Practice obstetricians

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- South West Healthcare Warrnambool
- Bendigo Health
- Ballarat Health Services
- Northwest Health Wangaratta
- Latrobe Regional Hospital
- The Royal Women’s Hospital

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1. Introduction

Providing access to a range of birthing options for Australian women is a priority for Commonwealth, state and territory governments.

In 2010, the Australian Health Ministers’ Conference (AHMC) endorsed the National Maternity Services Plan (the Plan), which establishes a five-year vision for maternity care in Australia with a focus on the priority areas of access, service delivery, workforce and infrastructure.

As part of the maternity reform agenda, the Commonwealth Government has enacted legislative changes that expand the role of registered midwives by authorising them to access the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) when practising within a collaborative arrangement. Midwives entitled to access these schemes are called ‘eligible midwives’.

A key action (1.2.2) of the Plan is for states and territories to develop consistent approaches to the provision of clinical privileges in public maternity services, to enable admitting and practice rights for eligible midwives. In Victoria, this relates to the process of credentialling and defining the scope of clinical practice.

In Victoria, public health services are independent statutory entities governed by a Board of Directors or Board of Management that is accountable to the Minister for Health. Health services are responsible for ensuring that the care provided to all women (admitted publicly or privately) is safe, high quality and within the capability of the service. This includes responsibility for credentialling and defining the scope of health practitioners’ clinical practice in accordance with government policy.

Although Victorian public health services have experience and expertise in managing private practice arrangements for medical practitioners, the extension of this model to midwives is new. This document provides advice to health services on the establishment of collaborative arrangements, including credentialling for eligible midwives.

Collaborative arrangements will allow women to be admitted to a public hospital under the private care of a ‘known’ midwife. Collaborative arrangements between eligible midwives and obstetric medical practitioners allow for obstetric participation and intervention, where necessary, while supporting continuity of care for women engaging the private services of an eligible midwife. A collaborative arrangement must be in place for a woman to be able to claim Medicare rebates for private midwifery care provided by an eligible midwife.

Collaborative arrangements with eligible midwives provide an opportunity for health services to expand their service provision in line with the government’s commitment to providing a range of safe models of maternity care that recognise the important role of midwives. These arrangements may also help ease pressures on maternity services arising from demographic trends and workforce shortages. By providing care to low risk women, eligible midwives may free up general practitioner (GP) obstetricians and obstetricians to concentrate on more complex cases.
2. Purpose and scope

This implementation framework is intended to guide Victorian health services participating in collaborative arrangements with eligible midwives.

The implementation framework applies where women are planning to give birth in a public hospital as the private patient of an eligible midwife. It does not apply to women booking into a hospital as a public patient or where women planning a home birth require transfer to a public hospital.

The implementation framework outlines the policy and regulatory environment relating to collaborative arrangements with eligible midwives, followed by policy and guidance in each of six key areas:

1. Planning for collaborative arrangements
2. Credentialling and scope of practice for eligible midwives
3. Admission practices
4. Clinical governance and support
5. Role delineation, care planning and documentation
6. Review, ongoing monitoring and evaluation

The sections on each of the above areas include a guiding principle, guidelines for health services, implementation guidance and further information and resources.

The appendices

The appendices contain:

1. a template for credentialling and defining the scope of practice of eligible midwives
2. a sample collaborative arrangement between an eligible midwife and health service authorised obstetric medical practitioners
3. an example of an eligible midwife’s Notation on the Register of Midwives with the Australian Health Practitioners Regulation Agency (AHPRA)
4. indicative activities undertaken as part of a collaborative arrangement.

As this is new territory and there are complex issues associated with the implementation of eligible midwife collaborative arrangements, the department will review the framework document after at least 18 months from its initial publication. At that time, it is anticipated that health services will have identified a range of areas that could be amended or strengthened, and will be able to provide case studies to illustrate how collaborative arrangements are working in practice.

Note of caution

This document reflects the status of authorisations (including legislation) at the time of publication. As they may change, health services are advised to check the primary sources before progressing.
3. Policy context

Government policies that provide the context for this implementation framework are described below.

Victorian health priorities framework 2012-2022

The Victorian Government published the *Victorian Health Priorities Framework 2012–2022*\(^1\) in May 2011. This document outlines key directions for development of the Victorian health system from 2012 to 2022, and is the basis for the government’s *Metropolitan Health Plan (2011)* and the *Rural and Regional Health Plan (2011)*.

Future directions for Victoria’s maternity services

*Future directions for Victoria’s maternity services (2004)*\(^2\) sets directions for the provision of maternity care in Victoria. The policy reflects the belief that birthing is a normal process and, where possible, should occur close to the woman’s home. The principles underpinning the policy are:

- ensuring safety and quality
- providing women with informed choice and greater control of their birthing experience
- achieving the right balance between primary level care and access to higher levels of medical expertise when needed
- making the best use of the complementary skills of midwives, GPs and obstetricians
- enhancing a maternity team approach.

National maternity services plan

The *National maternity services plan (2010)*\(^3\) provides a national framework to guide policy and program development across Australia to 2015. Following an extensive national review of maternity services, the Plan focuses on the four priority areas of access, service delivery, workforce and infrastructure, with the aim of improving care for all Australian women and their families.

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4. Requirements for eligible midwives

4.1 Professional regulation

Prior to seeking private practice admitting rights at a public health service, a registered midwife must be recognised as an eligible midwife. The National Health (Eligible Midwives) Determination 2010 establishes the requirements that a midwife must meet in order to be an ‘eligible midwife’ under the National Health Act 1953.

The key requirements for recognition as an eligible midwife are:
- notation by the Nursing and Midwifery Board of Australia (NMBA) as an eligible midwife
- scheduled medicines endorsement by the NMBA
- authorisation to access the MBS and PBS
- professional indemnity insurance (PII) under the Commonwealth supported scheme.

These requirements are described below.

Eligible midwife notation

All eligible midwives will have a notation on their Australian Health Professions Registration Agency (AHPRA) midwifery registration. A sample is given in Appendix 3.

Access to the Medicare Benefits Schedule (MBS)

The Commonwealth Government has enacted legislative changes that authorise registered midwives to access the MBS and the PBS when practising within a collaborative arrangement.

Eligible midwives will require a Medicare provider number that allows them access to a specific range of MBS item numbers relevant to their scope of practice. As with other health practitioners, an eligible midwife is required to have a Medicare provider number for each health service at which they are authorised to practise.

Access to the Pharmaceutical Benefits Scheme (PBS)

Registered midwives must meet the NMBA standards for a scheduled medicines endorsement to be able to prescribe medicines. Eligible midwives will require a PBS provider number to prescribe medicines to private clients.

In April 2012, the Drugs, Poisons and Controlled Substances Act 1981 was amended to allow suitably qualified and authorised registered midwives (that is, registered midwives who have a scheduled medicines endorsement on their registration by the NMBA) to administer (use) and prescribe (supply) scheduled medicines in Victoria.

Under the Act, an appropriate list of medicines for prescribing by registered midwives in Victoria has been approved by the Victorian Minister for Health, following consultation with the sector (including midwifery and medical professional groups, consumers and health service providers). An endorsed registered midwife is able to prescribe the medicines limited to those on this list and appropriate for midwifery practice during pregnancy, labour, birth and the postnatal period.
Professional indemnity insurance for private practice

Professional Indemnity Insurance (PII) is a mandatory requirement for all health professionals registered by AHPRA.

Midwives and nurses employed by Victorian public health services receive indemnity protection via the Victorian Managed Insurance Authority (VMIA) when undertaking duties consistent with the terms of their employment.

Under section 129 of the Health Practitioner Regulation National Law 2009 (the National Law), registered midwives must have suitable PII when engaged in private practice. Under section 284, an exemption to this requirement is strictly limited to the provision of intra-partum home birth care. This exemption is current until 30 June 2015, pending legislative changes by the Commonwealth.

Under the Midwife Professional Indemnity Insurance Scheme, given effect by the Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010 and the Midwife Professional Indemnity (Run-off Cover Support Payment) Act 2010, registered midwives can apply for Commonwealth Government supported PII for private midwifery services only. This PII does not apply if the woman under the care of the midwife is admitted as, or transferred to, the status of a public hospital patient.

PII via the Midwife Professional Indemnity Insurance Scheme is exclusively provided by the Medical Insurance Group Australia (MIGA). Two levels of cover are available:

- private antenatal and postnatal care only
- private antenatal, intra-partum and postnatal care.

PII provided by MIGA for private intra-partum care is exclusively linked to women planning to birth in a hospital or birth centre setting and does not apply to planned home birth.

There may be instances where a registered midwife has a dual role at a health service, providing private midwifery care as an eligible midwife as well as being employed by the health service as a registered midwife or a registered nurse. The eligible midwife’s private practice admitting rights do not apply when s/he is acting in a capacity as a publicly employed midwife.

The following diagram provides a visual representation of the requirements for an eligible midwife practicings privately in a Victorian public health service or hospital.
Figure 1 Requirements for eligible midwives intending to admit women privately to a Victorian public health service

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognised by the NMBA</td>
<td>Must meet NMBA standards for:</td>
</tr>
<tr>
<td></td>
<td>• Professional Indemnity Insurance</td>
</tr>
<tr>
<td></td>
<td>• Continuing Professional Development</td>
</tr>
<tr>
<td></td>
<td>• Recency of Practice</td>
</tr>
<tr>
<td></td>
<td>• Scheduled Medicine endorsement standard (3yrs experience, Professional Practice Review approved course)</td>
</tr>
<tr>
<td>Registered Midwife</td>
<td>+</td>
</tr>
<tr>
<td>Scheduled Medicines (midwifery) endorsement</td>
<td>+</td>
</tr>
<tr>
<td>Eligible Midwife Notation</td>
<td>+</td>
</tr>
<tr>
<td>Recognised by Medicare (Provider Number)</td>
<td>Must meet requirements for collaborative arrangement</td>
</tr>
<tr>
<td></td>
<td>Rebate for midwifery items including births in hospitals and birthing centres.</td>
</tr>
<tr>
<td>Approved Victorian prescriber (Prescriber Number)</td>
<td>Drugs Poisons and Controlled Substances Act amended to allow midwifery prescribing and supply according to the midwifery list of scheduled medicines approved by the Minister for Health for use in certain circumstances.</td>
</tr>
<tr>
<td>Credentialed by public health service</td>
<td>Department of Health framework for public health services.</td>
</tr>
<tr>
<td>Eligible Midwife in public health service (private services)</td>
<td>=</td>
</tr>
</tbody>
</table>
Further information

Legislative instruments
The National Health (Eligible Midwives) Determination 2010 is part of the implementation of the Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010, which provides for new arrangements to enhance and expand the role of nurse practitioners and midwives. It can be found at <www.comlaw.gov.au/Details/F2010L01509>.

Eligible midwife notation
The registration requirements for eligibility notation can be found on the NMBA website at <www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx>. Health services can check the registration and notation of individual midwives by accessing the AHPRA register at <www.ahpra.gov.au>. A sample of the notation is provided in Appendix 3.

The MBS and PBS

Information from the the Department regarding drugs and poisons control in Victoria can be found at <www.health.vic.gov.au/dpcs/index.htm>. The Victorian Government has developed Frequently Asked Questions (FAQ) to help answer some of the questions about this Act and changes to the regulations. This can be found at <www.health.vic.gov.au/nursing/midwives-in-victoria>.

Professional indemnity insurance
Websites providing information about professional indemnity insurance for midwives are:
4.2 Collaborative arrangements

The requirements for collaborative arrangements are set out under the National Health (collaborative arrangements for midwives) Determination 2010 (the Determination). At the time of publication of this document, the Determination states that a midwife must be in a collaborative arrangement with a specified medical practitioner; being an obstetrician, a medical practitioner who provides obstetric services, or, a medical practitioner employed or engaged by a hospital authority and authorised by the hospital to participate in a collaborative arrangement. Health services are advised to extend the guidance within this document to future amendments to the Determination.

The Determination states that there are four kinds of collaborative arrangement:

- being employed or engaged by a medical practice that employs or engages at least one obstetrician or medical practitioner who provides obstetric services
- receiving patients on referral from a specified medical practitioner
- having a signed agreement with a specified medical practitioner
- maintaining written records of certain specified information relating to working collaboratively with a specified medical practitioner.

Advice in relation to the way in which Victorian public health services may consider participating in collaborative arrangements with eligible midwives is provided in Section 6.1.

Eligible midwives must record the following in their written records for women under their care:

- the name of at least one obstetric specified medical practitioner who is, or will be, collaborating with the eligible midwife in the woman’s care
- evidence that the eligible midwife has informed the woman that care will be provided in collaboration with one or more obstetric specified medical practitioners
- acknowledgement by an obstetric specified medical practitioner that the medical practitioner will be collaborating in the woman’s care
- plans for circumstances in which the midwife will consult, refer or transfer the woman’s care to an obstetric specified medical practitioner
- consultations, communication, referral and transfer of care between the eligible midwife and an obstetric specified medical practitioner, about the woman’s care
- acknowledgement that the obstetric specified medical practitioner has received a copy of the hospital booking letter (however described)
- acknowledgement of the obstetric specified medical practitioner’s receipt of the woman’s maternity care plan (however described)
- documentation that the eligible midwife has given results of diagnostic and pathology services to an obstetric specified medical practitioner
- documentation that the eligible midwife has given a discharge summary (however described) at the end of the midwife’s care for the woman to an obstetric specified medical practitioner and the woman’s usual general practitioner.

In relation to f) and g), it is recommended that the eligible midwife receive written acknowledgement from the collaborating obstetric specified medical practitioner(s).
Further information


The Australian Medical Association (AMA) Collaborative Arrangements - What you need to know can be found at <ama.com.au>.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists’ College Statement (C-Obs 33) Collaborative Maternity Care (2010) can be found at <www.ranzcog.edu.au>. 
Collaborative arrangements with eligible midwives should be based on mutual professional respect and reciprocity (cooperative exchange of favours or privileges) between the collaborating parties.

The guidelines for health services outlined in this implementation framework are based on the following principles:

**Principle 1**
Collaborative arrangements with eligible midwives are informed by a robust planning process, including an assessment of service capacity and capability, and stakeholder consultation.

**Principle 2**
Processes for credentialling and defining the scope of practice of all healthcare providers participating in collaborative arrangements are equitable and consistent with Victorian Government policy.

**Principle 3**
Women admitted under the care of an eligible midwife in a public health service remain private patients where possible.

**Principle 4**
Clinical governance and supports for credentialled eligible midwives are consistent with the health service’s existing policies and processes.

**Principle 5**
Roles and responsibilities of the collaborating parties, including responsibilities for care planning and provision, documentation and reporting of information, are clearly defined and communicated.

**Principle 6**
Models of collaboration with eligible midwives are regularly reviewed to ensure their responsiveness to the needs of all stakeholders, including the health service system and wider community.
6. Implementation framework for Victorian public health services

This section provides guidance for health services that are developing or implementing collaborative arrangements with eligible midwives. Guidance is organised around the six principles outlined in section 5.

6.1. Planning for collaborative arrangements with eligible midwives

**Principle 1**

Collaborative arrangements with eligible midwives are informed by a robust planning process, including an assessment of service capacity and capability, and stakeholder consultation.

Public health services, particularly the Board of Management or Board of Directors, are responsible for deciding if they will participate in collaborative arrangements and for ensuring these arrangements are consistent with relevant policies of the Victorian Department, the requirements of the Health Insurance Act 1973, the National Healthcare Agreement 2012, and other relevant Commonwealth and Victorian Government legislation and policies.

There is no single model for collaborative arrangements. At the time of publication of this document and according to the Determination, the two main ways collaboration may occur at Victorian public health services are:

- an arrangement between an eligible midwife and one or more obstetric specified medical practitioners who have private practice admitting rights to a Victorian public health service
- an arrangement between an eligible midwife and one or more obstetric specified medical practitioners employed by the health service and authorised by the health service to participate in a collaborative arrangement.

Following a decision by the Standing Council on Health in August 2012, the Commonwealth is considering further legislative changes to the Determination to allow:

- an arrangement between an eligible midwife and directly with the hospital or health service.

It is recommended that health services review the Determination independently for any amendments.

The following diagram provides examples for collaborative arrangements with eligible midwives.
**Figure 2** Example of collaborative arrangements at participating Victorian public health services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Issues for health service consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible midwife (EM) providing services to women admitted privately to a Victorian public hospital</strong></td>
<td><strong>Choice of midwife</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Continuity of midwifery care and health information</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Access to indemnified care and treatment</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Suitability of the service model in terms of organisational capacity, capability and consumer demand</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Compliance with the National Health Care Agreement (NHCA) and the Health Insurance Act 1973</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Midwifery back-up</strong></td>
</tr>
</tbody>
</table>

By combining A with B and/or C, various collaborative arrangements can be obtained.

**A** Arrangement with one or more GP obstetrician(s) or obstetrician(s) with private practice admitting rights to the health service or hospital

- Choice of collaborating obstetric medical practitioner
- Continuity of obstetric care and information, if required
- Minimises number of clinicians involved in care
- Women can remain private patients if escalation of obstetric care is required*
- Depending on remuneration model for medical officers, women may remain private patients if escalation of obstetric care is required*
- Availability of obstetric intervention if required
- Consistent coordination of care, health information and practice standards
- Medical/professional indemnity cover through VMIA (depending on remuneration model)

**B** Arrangement with a medical practitioner employed or engaged by a hospital authority and authorised to participate in a collaborative arrangement e.g. Director of Medical Services (DMS); clinical director of obstetric services

- Depending on remuneration model for medical officers, women may remain private patients if escalation of obstetric care is required*
- Availability of obstetric intervention if required
- Consistent coordination of care, health information and practice standards
- Medical/professional indemnity cover through VMIA (depending on remuneration model)
- Medical back-up / delegation of responsibility for obstetric treatment or management to other individual medical officers
- Remuneration model for participating hospital employed medical officers**
- Professional and medical indemnity insurance coverage for collaborating medical officer(s)
- Compliance with the NHCA and the Health Insurance Act 1973

**C** Individual medical practitioners employed or engaged by a hospital authority and authorised to participate in a collaborative arrangement and are acknowledged in provision of care e.g. obstetric consultant, specialist or registrar

- As with B
- Shared learning opportunities between private and public maternity care providers
- Collaborative arrangements may be built into roles and responsibilities of clinicians employed by the health service
- Availability of collaborating medical practitioner
- Potential for reduced continuity of obstetric care
- Requires documented acknowledgement of collaboration by each medical officer involved in each moment of care
- Remuneration model for participating hospital employed medical officers**
- Professional and medical indemnity insurance coverage for collaborating medical officer(s)
- Compliance with the NHCA and the Health Insurance Act 1973

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* Medicare rebates for midwifery care during labour and birth are payable regardless of who undertakes the delivery

** Under the NHCA medical officers employed by a public health service have a right to private practice
Health service guidelines

- Health services seek independent legal, financial and industrial advice, and undertake community consultation prior to participating in collaborative arrangements with eligible midwives.
- Health services assess service capacity and capability, in the context of clinical and financial risk, prior to participating in collaborative arrangements.
- When authorising medical practitioners to operate within a collaborative arrangement, health services determine the most appropriate type of arrangement for their organisation in the context of available resources, service capacity and capability.

Implementation guidance

Consultation with the local workforce and community stakeholders will assist individual health services to understand the benefits, enablers and barriers to establishing collaborative arrangements.

Health services are encouraged to consider a multidisciplinary steering committee to oversee the establishment, implementation and evaluation of the eligible midwife service model. This will strengthen health services’ governance of the model and their ability to provide safe, high quality maternity care to women admitted under the care of eligible midwives.

Further information


The Victorian health policy and funding guidelines 2012-13 can be found at <www.health.vic.gov.au/pfg>.

The Australian Medical Association provides guidance for medical practitioners who are considering engaging in a collaborative arrangement. Collaborative Arrangements - what you need to know is available at <ama.com.au>.


The Royal Australian and New Zealand College of Obstetricians and Gynaecologists’ (RANZCOG) College Statement C-Obs 33: Collaborative maternity care (2010) can be found at <www.ranzcog.edu.au>.

RANZCOG has developed a template: Collaborative maternity care agreement between the patient, specified medical practitioner(s) and an eligible midwife (2011). This template, intended for use by collaborating partners, is being considered by the Board of the Australian College of Midwives with the view to it being co-badged by the two colleges. The template can be found at <www.ranzcog.edu.au/members-services/fellows/resources-for-fellows.html>. 
6.2 Credentialling and scope of practice for eligible midwives

**Principle 2:**
Processes for credentialling and defining the scope of practice of all healthcare providers participating in collaborative arrangements are equitable and consistent with Victorian Government policy.

Victorian public health services require all privately practising clinicians to be credentialled at the organisation and to have their scope of clinical practice defined in accordance with their level of skill and experience and the capability of the health service.

Credentialling is a requirement under the Australian Commission on Safety and Quality in Health Care’s *National Safety and Quality Health Service Standards (2012)* for hospital accreditation. It is also a transparent way of clarifying the expectations, roles and responsibilities of health services and privately practising clinicians.

The Department’s *Credentialling and defining the scope of clinical practice of medical practitioners in Victorian health services – a policy handbook (2011)* (the Credentialling Policy) outlines the credentialling process for medical practitioners at Victorian public health services. As private midwifery services for women admitted to public hospitals are new, the Department has recently developed an addendum to the Credentialling Policy to guide health services on the minimum requirements for credentialling privately practising midwives and a template for use by health services to credential eligible midwives. A sample of the template is provided as Appendix 1.

As part of the credentialling cycle, senior medical practitioners appointed to Victorian public health services are required to participate in a performance review process. The Department has developed a document, *Partnering for performance - a performance development and support process for senior medical staff (2010)*, to assist this process. It provides tools and resources to support review of clinical practice and credentialling for senior medical staff. Health services should use an equivalent process to support credentialling of eligible midwives.

In the same way that a health service’s decision to facilitate admitting rights for eligible midwives is a matter for its Board of Management (see section 6.1), the scope of practice of an eligible midwife is at the discretion of the individual health service. For example, due to service capacity and capability constraints, some health services may limit the scope of practice for eligible midwives to antenatal and postnatal care. Other health services may be able to grant eligible midwives private practice admitting rights for more comprehensive services, including birthing.

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4 **Credentialling** is the formal process of verifying the qualifications, experience, professional standing and other relevant professional attributes of health practitioners for the purpose of forming a view about their competence and suitability to provide safe, high quality health care services within specific organisational environments. This is a process of verification of, rather than the assessment for, qualification, experience, professional standing or other professional attributes.

5 **Defining the scope of clinical practice**, also known as privileging, follows on from credentialling and involves delineating the scope of an individual health practitioner’s clinical practice within a particular organisation.
Health service guidelines

- The Department's Credentialling Policy (Credentialling and defining the scope of clinical practice of medical practitioners in Victorian health services – a policy handbook (2011)), and the template provided in Appendix 1 are used by public health services to credential eligible midwives seeking to provide private maternity services at their organisation.
- Health services’ policies and processes for credentialling midwives and defining their scope of practice are equitable and consistent with those used for other health practitioners.
- Health services have senior midwifery representation on their credentialling committee for eligible midwives, reflecting the status of credentialling as a peer-based process.
- In line with the Credentialling Policy's recommended verification processes, an eligible midwife’s registration and insurance is checked on an annual basis.
- Re-credentialling occurs 12 months after the initial credentialling unless indicated prior to this.
- Health services determine an appropriate process and timeframe for further re-credentialling, consistent with the guidance provided in the Credentialling Policy.
- Health services inform eligible midwives of their verification and re-credentialling policies and procedures at the time of initial credentialling.

Implementation guidance

The credentialling process is separate to the collaborative arrangement required under the Determination (see section 4.1). An eligible midwife may have multiple concurrent collaborative arrangements with a number of specified medical practitioners for a number of different women. Eligible midwives do not need to provide evidence of the collaborative arrangement with their credentialling application. Health services will, however, need to determine an appropriate process for checking the collaborative arrangements in place for each woman booked under the care of an eligible midwife.

Health services may incorporate existing professional standards when developing processes for re-credentialling. For example, the NMBA requires eligible midwives to undertake an additional 20 hours of continuing professional development per annum as well as triennial professional practice to maintain their eligibility notation. In addition, MIGA has an annual interactive risk management program and annual practice review.

Further information


6.3 Admission practices

Principle 3:
Women admitted under the care of an eligible midwife in a public health service remain private patients where possible.

Health services are required to admit patients in accordance with the Department’s Victorian Hospital Admission Policy 2012-13 (Admission Policy) and the Victorian health policy and funding guidelines 2012-13, which reflect the Victorian Government’s obligations under the National Health Reform Agreement (NHRA). The criteria for admission, as outlined in the Admission Policy, must be met before a health service is able to formally admit that patient.

Under the NHRA, a patient may elect to be treated as a public or private patient. Section G15 of the NHRA states that this election must be made on the basis of informed financial consent. Section G24 of the NHRA stipulates that a woman’s choice to be admitted as a private patient must be exercised in writing on, or as soon as practicable following, admission to a public health service.

The legislated authority of eligible midwives is dependent on them providing private services only. Eligible midwives should inform their clients early of the need to nominate to be a private patient when they are formally admitted if they wish to continue under the care of the eligible midwife.

If a woman is admitted as a public patient, an eligible midwife is no longer indemnified for practice and must hand over care to hospital employed staff. Maintaining private admission status supports continuity of care between a woman, her eligible midwife and the collaborating medical practitioner(s).

The NHRA requires that a patient's admission status can only be changed in the event of unforeseen circumstances. Specifically, the agreement (Section G24(g)) states that:

Examples of unforeseen circumstances include, but are not limited to, the following:

i. patients who are admitted for a particular procedure (i.e. birthing episode) but are found to have complications requiring additional procedures

ii. patients whose length of stay has been extended beyond those originally and reasonably planned by an appropriate health care professional

iii. patients whose social circumstances change while in hospital (e.g. loss of job).

Foreseeable obstetric complications that may occur in the course of labour and birth, for example assisted vaginal birth or emergency caesarean birth, are not considered additional procedures to the birthing episode requiring a change to admission status.
Health service guidelines

- Women choosing to birth under the care of an eligible midwife in a Victorian public health service are admitted as private patients.
- Where possible, women admitted under the care of an eligible midwife remain private patients, including in instances where obstetric consultation, escalation or transfer of care is required.
- Informed financial consent is obtained from women who elect to be admitted as a private patient in a Victorian public health service, as per sections G14 and G15 of the NHRA.
- A woman’s choice to be admitted as a private patient is exercised in writing on, or as soon as practicable following, admission to a public health service.
- Patient election forms comply with section G24(e) of the NHRA and state that a patient’s admission status can only be changed in the event of unforeseen circumstances.
- Women should be informed early of the types of circumstances that may require transfer to public admission status and that under such circumstances responsibility for her care will be transferred from the eligible midwife to hospital employed staff.
- Any change to a woman’s hospital admission status is documented in her medical record and on the health service’s admission form.
- Health services ensure the emergent care of all admitted patients (both public and private) is appropriately managed. This requires the expectations, roles and responsibilities of privately practising clinicians and hospital employed staff during obstetric and neonatal emergencies to be clearly defined and communicated.
- Implications for medical indemnity protection in these circumstances are known and communicated to all concerned.

Implementation guidance

Informed financial consent

While public health services are responsible for informing women of the costs incurred while admitted as a private patient, it is the role of the eligible midwife to inform her clients of the known and potential costs of care provided through a collaborative arrangement. These costs may relate to the woman’s inpatient hospital stay, use of operating theatre facilities, and consultation with private medical specialists (for example, obstetricians, anaesthetists or paediatricians).

Costs associated with the provision of services such as pathology, pharmacy, diagnostic imaging and allied health are billed according to the NHRA and health service policies related to the billing of private patients.

The MBS allows for obstetric escalation of care during labour and birth when a woman is admitted privately under the care of an eligible midwife. Medicare benefits relating to midwifery intra-partum care are payable whether or not the participating midwife undertakes the delivery.

Decisions to transfer a woman to public admission status are ultimately based on clinical judgement relating to the individual case.
Booking processes
In the interests of equity and consistency, health services should consider implementing a standard booking process for women admitted publicly and privately.

Eligible midwife care for public patients
While eligible midwives are not indemnified when providing care to women admitted as public patients, there may be circumstances where they are called to assist in an obstetric or neonatal emergency. In these cases the expertise and assistance of the eligible midwife could positively influence the health outcomes of the woman and/or her baby.

Eligible midwives should be advised to seek independent advice regarding professional indemnity insurance for the provision of emergency care to public patients.

Good Samaritan legislation\(^6\) may provide guidance to health services in developing policies and procedures regarding the expectations, roles and responsibilities of privately practising clinicians during obstetric and neonatal emergencies.

Further information

Information for health services regarding admission status and informed financial consent can be found in the National Health Reform Agreement at <www.coag.gov.au/node/96>.


The NMBA has provided a position statement on midwives in private practice. This is available at <www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Position-Statements.aspx>.


6.4 Clinical governance

**Principle 4**
Clinical governance and supports for credentialled eligible midwives are consistent with the health service’s existing policies and processes.

Clinical governance is the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the provision of high quality care, while continuously improving, minimising risks, and fostering an environment of excellence in care.

Health services are accountable under Occupational Health and Safety (OHS) legislation to provide a safe and healthy working environment. This extends to visitors, volunteers, contractors and privately practising professionals.

Equally, privately practising professionals have an obligation to work in a safe manner and to follow the policies and procedures of the health service.

An eligible midwife who has undergone credentialling and scope of practice processes may not have worked at the public health service before. To provide effective, high quality care, eligible midwives may need access to and information about, information technology systems, pathology, pharmacy, diagnostic imaging, allied health, medical review clinics and other necessary equipment.

Eligible midwives are responsible for maintaining their own professional standards and for meeting the requirements for notation on their AHPRA midwifery registration. Eligible midwives are required to report potential claims relating to adverse events to their professional indemnity insurer.

Health practitioners registered by AHPRA and their employers have responsibility under the National Law to report instances of notifiable conduct, that is, where registered health practitioners have:

- practised while intoxicated by alcohol or drugs
- engaged in sexual misconduct while practising their profession
- placed the public at risk of substantial harm due to their own impairment
- placed the public at risk of harm by practising in a way that constitutes a significant departure from accepted professional standards.

**Health service guidelines**

- Health services provide credentialled eligible midwives with appropriate induction, orientation and security clearances to the organisation, consistent with that provided to direct employees of the health service and visiting medical officers. This may include priority car parking access.
- Health services provide eligible midwives with access and orientation to the organisation’s clinical risk management policies and procedures, including, but not limited to, those relating to emergencies and evacuation, occupational violence, infection control, and incident reporting and review.
- Health services facilitate training of eligible midwives in clinical skills considered mandatory by the organisation (for example, adult and neonatal basic life support, fetal surveillance interpretation).
- Health services ensure that maternity care delivered by eligible midwives to privately admitted women is provided within the organisation’s safety and quality framework.
• Where appropriate, access to wider professional development activities, such as clinical review processes, should be extended to eligible midwives to promote effective collaborative relationships, consistent clinical practice standards and shared health service priorities. The health service should consider offering this to eligible midwives without charge or at cost.

• Where appropriate, health services offer clinical debriefing and support to eligible midwives involved in adverse events.

• Consistent with the Credentialling Policy, eligible midwives providing private midwifery care in a public hospital and other collaborative arrangement partners should formally report to the Director of Nursing/Midwifery or other appropriate health service lead from senior management within the organisation.

• Health services ensure there is a clear process for managing issues, complaints or conflicts relating to collaborative arrangements.

• Health services and medical practitioners acting on behalf of the health service seek independent advice from an appropriate source (for example, VMIA or another legal or industrial service) to ensure appropriate PII is in place while engaged in a collaborative arrangement with an eligible midwife.

• Health services report to their indemnity insurer any adverse events relating to an admitted patient (public or private) that may potentially impact on an eligible midwife’s PII.

**Implementation guidance**

Health services’ policies and procedures in respect of visiting medical officers may be used to guide clinical governance and support arrangements for credentialled eligible midwives.

An eligible midwife’s authorisation to access health service resources will need to be communicated to the relevant personnel of the health service.

In addition to the usual OHS requirements, the nature of the eligible midwife’s work with a woman during labour requires special consideration. Health services are encouraged to develop and implement a fatigue management policy that supports the provision of safe and high quality care for women under the care of privately practising professionals.

The MBS provides some guidance on OHS standards for eligible midwives providing private midwifery care. The schedule states that Medicare rebates are available for the attendance of an eligible midwife at a labour for up to 12 hours and for another eligible midwife to provide labour and birth care for an additional 12 hours. Similarly, current industrial frameworks for midwives working in a public hospital caseload model of care recommend the attendance of a midwife for up to 12 hours with entitlement to a 10-hour break between subsequent attendances.

**Further information**


**Work Safe Victoria’s Fatigue prevention in the workplace (2008)** provides a resource for fatigue management and can be found at <www.worksafe.vic.gov.au>.

6.5 Care planning and documentation

**Principle 5**

Roles and responsibilities of the collaborating parties, including responsibilities for care planning and provision, documentation and reporting of information, are clearly defined and communicated.

The National Health and Medical Research Council’s National guidance on collaborative maternity care (2010) defines collaborative maternity care as follows:

> In maternity care, collaboration is a dynamic process of facilitating communication, trust and pathways that enable health professionals to provide safe, woman-centered care. Collaborative maternity care enables women to be active participants in their care. Collaboration includes clearly defined roles and responsibilities for everyone involved in the woman’s care, especially for the person the woman sees as her maternity care coordinator.⁷

Collaborative maternity services require careful planning and coordination to ensure women remain central to the provision of safe, quality care.

> Care/case planning is a dynamic process that incorporates assessment coordination, care/case management, referral, information exchange, review, reassessment, monitoring and exiting. Care/case planning involves balancing relative and competing needs, and helping consumers make decisions appropriate to their needs, wishes, values and circumstances. Care/case planning may occur at an individual provider level and both within and across agencies.⁸

**Back-up arrangements**

Clinical back-up is an important factor in health services’ decision to participate in collaborative arrangements with eligible midwives and should be considered in the context of the service’s resources, capacity and capability.

Eligible midwives are responsible for ensuring that women under their care are fully informed of back-up arrangements for midwifery and obstetric care.

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⁷ NHMRC National Health and Medical Research Council (NHMRC) 2010, National guidance on collaborative maternity care, NHMRC, Canberra, p. 7.

⁸ Primary Care Partnerships, Victoria (PMPV) 2012, Victorian service coordination practice manual, PMPV, Melbourne.
Health service guidelines

- Health services clearly define and communicate their expected standards for consultation, referral and transfer of care to eligible midwives and obstetric specified medical practitioners operating within a collaborative arrangement.
- All collaborating partners retain a written copy of the collaborative arrangement agreement, which is executed in writing and signed by the eligible midwife and obstetric specified medical practitioner(s).
- Back-up plans for periods when collaborating partners are not available, including instances where more than one woman is labouring under the care of an eligible midwife, are negotiated, agreed and documented during the credentialling process and/or during the establishment of any collaborative arrangement undertaken with hospital-authorised medical practitioners.
- An eligible midwife who provides back-up midwifery care for the primary eligible midwife also has been assessed and has been granted private practice admitting rights at the health service where the care is being provided.
- Health services establish an agreed process for sharing ambulatory and inpatient health information pertaining to women under the private care of an eligible midwife. Consideration should be given to:
  - how evidence of informed consent by the woman to share her medical records with hospital employed staff will be managed
  - the medical record forms that will be used by the eligible midwife and collaborating partners
  - use of duplicate medical records for sharing of information
  - access to, and use of, hospital electronic medical records by the eligible midwife.
- Health services define and communicate the roles and accountabilities of eligible midwives for the collection, documentation and submission of reportable data. The reporting of data by eligible midwives includes (but is not limited to) the following:
  - Victorian Perinatal Data Collection
  - Victorian Registry of Births Deaths and Marriages
  - Victorian Birth Defects Register
  - Victorian Clinical Genetics Services
  - Consultative Council on Obstetric and Paediatric Mortality and Morbidity.

Implementation guidance

The expected standards defined by the health service for consultation, referral and transfer of care as part of the collaborative arrangement should be based on existing national guidance documents, including the Australian College of Midwives’ National midwifery guidelines for consultation and referral, 3rd Edition (2013) and/or the Australian and New Zealand College of Obstetricians and Gynaecologists College Statement: C-Obs 30 Maternal suitability for models of care, and indications for referral within and between models of care (2009, updated 2012) and the NHMRCs National guidance on collaborative maternity care (2010).
Documentation and sharing of information relating to the collaborative arrangement

An eligible midwife’s collaborative arrangement with an obstetric specified medical practitioner may cover more than one woman. However, eligible midwives are required to have at least one obstetric specified medical practitioner recorded for each woman.

Under the Determination, eligible midwives are required to inform women of the collaborative arrangement they have with an obstetric specified medical practitioner. Eligible midwives should also fully inform women of the benefits and potential issues of a collaborative arrangement so that women can make an informed choice about their maternity care.

While there is an expectation that eligible midwives will provide or arrange for the provision of labour and birth services to women under their care, health services may be required to provide postnatal midwifery care. This aligns with health service funding for the admission of private patients and should be clearly communicated to relevant hospital employed staff.

The intersection between the eligible midwife’s collaborative arrangement and the roles and responsibilities of hospital employed staff should be articulated in the collaborative arrangement documentation.

Care planning and documentation

MIGA requires eligible midwives to provide health services with a maternity care plan for women who are admitted privately under their care. Eligible midwives must also acknowledge that the health service has received the care plan.

The Department has developed the Victorian Maternity Record (VMR) to provide pregnant women with a uniform hand-held maternity record. The VMR contains information related to a woman’s care, investigations and preferences during pregnancy, as documented by her care provider(s) and, as such, is equivalent to a midwifery care plan. Although it is the preferred hand-held pregnancy record, individual services may have alternative documents aligned with the same principles as the VMR.

Further information


The Royal Australian and New Zealand College of Obstetricians and Gynaecologists’ College Statement (C-Obs 30) Maternal suitability for models of care, and indications for referral within and between models of care, (2012) is available at <www.ranzcog.edu.au>.

MIGA provides a midwifery care plan for consultation, referral and transfer of care that has been produced in consultation with the Australian College of Midwives and the Australian Private Midwives Association. This can be found at <www.miga.com.au>.


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6.6 Review, monitoring and evaluation

Principle 6
Models of collaboration with eligible midwives are regularly reviewed to ensure their responsiveness to the needs of all stakeholders, including the health service system and wider community.

Health services continually review and revise their service delivery models to ensure they are consumer-centred, evidence-based and organised for safety. New National safety and quality health service standards (mandatory from 1 January 2013) will help promote national consistency in the level of care consumers can expect from health services.

The Department provides information, guidance and tools to assist agencies in their program evaluation and research activities.

Health service guidelines
- Mechanisms for evaluation and ongoing monitoring and review of eligible midwife collaborative arrangements are in place from commencement of the initiative.
- Health services review the implementation of the initiative within 18 months of commencement.
- Health services monitor and review the initiative at appropriate internals over time.

Implementation guidance
The Department may ask health services to participate in a formal evaluation of eligible midwife collaborative arrangements after they have been established for long enough to allow meaningful review.

Further resources
The National Safety and Quality Health Service Standards can be found at <www.safetyandquality.gov.au/our-work/accreditation/nsqhss/>.


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Appendices
Appendix 1: Credentialling and scope of practice template sample

This template is available to download in Word format for use by health services at

Application/re-credentialling/change scope of practice
– eligible midwife

<Insert health service name>

Eligible midwife with independent responsibility for patient care
This form sets a minimum information standard. Information may be added, but not deleted.

Name of eligible midwife
Surname
First name    Middle name

This is a:
New application ☐  Re-credentialling ☐  Change scope of practice ☐

Please note: If you need to correct any error in your application, please initial the correction.

1. Application for appointment as an eligible midwife
The health service must verify midwifery registration and notation as an eligible midwife,
which can be accessed on the Nursing and Midwifery Board of Australia website at

Please attach the following to this form:

All applications/re-credentialling
• A copy of the current professional indemnity insurance certificate; initial applications need
to supply a certified copy
• Copies of relevant visa documents (if applicable)

New appointments only
• Current curriculum vitae
• Certified copies of qualifications, other than the primary midwifery degree,
  if these are not listed on AHPRA’s ‘Register of Practitioners’ at
• Proof of identification: 100-point test
• Working with children check (if applicable)
2. Applicant contact details

Surname

Given name(s)

Previous name(s)

Date of birth

Place of birth

Residency status

*(only applicable for re-credentialling if changed since last application at this health service)*

Australian citizen □  Permanent resident □  Temporary resident □

Professional address

Postcode

Postal address *(if different to professional address above)*

Postcode

Phone (BH)  Phone (AH)

Fax  Mobile/pager

Email address

Do you have a Medicare provider number for this location?  Yes □  No □

*If restrictions apply, please provide full details.*

If YES, is it subject to any restrictions?  Yes □  No □

*If restrictions apply, please provide full details.*

Site(s):

Provider number(s):

Do you have a prescriber number?  Yes □  No □

Prescriber number:
3. All qualifications including your primary midwifery degree

- **New appointments** – please list all your qualifications.
- **Re-credentialling** – please list any new qualifications obtained since your last appointment.

Please provide certified copies of new qualifications obtained.

<table>
<thead>
<tr>
<th>Qualifications</th>
<th>University/organisation</th>
<th>Year obtained</th>
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<tbody>
<tr>
<td>Primary midwifery degree</td>
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<td>Others</td>
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4. Eligible midwives – new applicants and change scope of practice

4a. What scope of clinical practice are you applying for?
I wish to apply to define my scope of clinical practice to undertake the following
(please select from the following groups):

<table>
<thead>
<tr>
<th>Midwifery care</th>
<th>Scope of practice as defined by the Australian College of Midwives’ National midwifery guidelines for consultation and referral and/or the Australian and New Zealand College of Obstetricians and Gynaecologists College Statement: C-Obs 30 Maternal suitability for models of care, and indications for referral within and between models of care.</th>
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<tr>
<th>Diagnostic imaging - please specify modality/modalities for which scope of clinical practice is sought</th>
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<tr>
<th>Other - please provide details for which scope of clinical practice is sought</th>
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</thead>
</table>
4b. Other training and clinical experience

With respect to your response to question 4a, please provide details of clinical experience and post-qualification training in the following areas.

Include the title of the specific course(s) undertaken or training undertaken or experience gained, the organisation offering the course, and the qualification obtained.

(If you received training in a specific area while working at a particular hospital or clinic, please list that hospital/clinic. If your training was received as part of rotations at a specific hospital, please list the relevant hospital.)

<table>
<thead>
<tr>
<th>Title of course/training/experience and qualification obtained</th>
<th>Organisation providing training</th>
<th>Date</th>
<th>Requested in scope of clinical practice?</th>
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Please provide further details/evidence to support your application for the proposed scope of clinical practice you are requesting from the health service. (If you require further space please attach a separate page.)
5. Clinical appointments*

Please provide details on all current and previous clinical appointments, including collaborative arrangements at other hospitals held within the past five years (including names of organisations and dates of appointment) or other places of practice (for example, private practice).

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Name and type of appointment</th>
<th>When did you work in that role?</th>
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* Appointment refers to granted private practice admitting rights.
7. Midwifery registration and other matters

Please refer to <www.nursingmidwiferyboard.gov.au> for definitions.

What is your AHPRA registration number?

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Have you ever been formally disciplined (by an employer or other organisation) in the course of your work as a midwife?</td>
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<tr>
<td>Have you ever been the subject of prior disciplinary decision(s) or ruling(s) imposed by any registration board either in Australia or elsewhere?</td>
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<tr>
<td>Do you currently have any conditions, restrictions, undertakings, reprimands or notations placed on your registration or your clinical practice either in Australia or any other country?</td>
<td></td>
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<tr>
<td>Have you ever had any conditions, restrictions, undertakings, reprimands or notations placed on your registration either in Australia or elsewhere?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your right to practise ever been withdrawn, suspended, terminated or reduced by an organisation, employer or professional body?</td>
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<tr>
<td>Have you ever been convicted or found guilty of any criminal offence, including a drug- or alcohol-related offence?</td>
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<tr>
<td>Are you the subject of current or pending criminal charges?</td>
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</table>

If you answered yes to any of the above, please provide full details. Or, if you prefer, provide the information in a sealed envelope marked ‘Confidential for Director of Nursing/Midwifery’ appended to this application, and indicate here that additional information is provided separately in this manner.

Are you registered as a midwife in any other country? | Yes | No |

If yes, please specify.

Have you ever been registered as a midwife in any other country? | Yes | No | N/A |

Do you have a current working with children check? | Card number:  
See website*  
Please attach a photocopy of your current card.  

Expiry date:

7. Professional indemnity insurance information

Current private medical indemnity insurance cover (if applicable),
Please attach a copy of your current policy renewal certificate. New appointments need to attach a certified copy.

Name of insurer:
Policy number:
Expiry date:

Is your proposed scope of private clinical practice reflected in or covered by your current professional indemnity insurance?
Yes ☐ No ☐ N/A ☐

Have there ever been, or are there currently pending, professional indemnity claims, settlements or judgments against you?
Yes ☐ No ☐

Has your current or any previous professional indemnity insurer ever excluded or reduced any specific area of practice, or terminated or denied coverage?
Yes ☐ No ☐

If the answer to either of the above two questions is YES, please provide a detailed explanation and specify the name of the relevant insurer.

If you require further space to answer any questions, please attach separate pages, identified with the relevant section number.
8. Continuing professional development

Have you met the continuing professional development requirements for the most recent registration period of the Nursing and Midwifery Board of Australia?  
Yes ☐ No ☐


Provide a copy of your current college certificate or evidence of relevant continuing professional development (such as a CPD logbook).

9. Quality activities (new appointments only)

Have you participated in regular clinical reviews, audits and/or peer-review activities in any clinical setting?  
Yes ☐ No ☐

If YES, please provide details of these activities (provide attachments if necessary).
10. Health status

Do you have a disability or health issue that:

- may impact on your ability to perform any of the cognitive and physical functions that would fall within the scope of practice that you are seeking in this application?
- may require special equipment, facilities or work practices to enable you to perform any aspect of the scope of practice you are seeking in this application?
- may be relevant to determining your scope of practice?

Yes ☐ No ☐

If you answered YES, please provide details of the disability or health issue and its likely, or possible, impact on your ability to carry out the sought scope of practice. Details of any special equipment facilities or work practices required should be included.

This information can be provided on this form or, alternately, you can provide the information in a sealed envelope marked ‘Confidential for Director of Nursing/Midwifery only’ appended to this application. Indicate here if additional information is being appended.

This information is sought to enable an assessment to be made as to whether you can safely perform the inherent and reasonable requirements of the work that you seek to perform at the health service or whether any reasonable adjustments might be required to ensure you can work at the health service in a way that ensures patient safety.
11. Referees:  
new appointments and change scope of practice only

Please provide details of at least two professional referees who have been in a position to judge your experience and performance during the previous three years and who have no conflict of interest in providing a reference.

<table>
<thead>
<tr>
<th>Referee 1</th>
<th>Referee 2</th>
<th>Referee 3</th>
</tr>
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<tbody>
<tr>
<td>Name</td>
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<td>Email address</td>
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14. Agreement/undertakings

I understand that in assessing my application for appointment as eligible midwife the health service will make additional enquiries as to my suitability for the position.

**New applications only**

| I understand the health service will conduct a routine police check. | Yes ☐ No ☐ |

**New appointments and expanding scope of practice only**

| I authorise the health service to seek information from my referees as to my past experience, performance and current fitness to practise. | Yes ☐ No ☐ |
| I agree to familiarise myself with relevant hospital by-laws, policies and procedures for clinical practice and Occupational Health and Safety and to abide by them. | Yes ☐ No ☐ |

**All applications**

| I accept that the health service will obtain information relevant to my application from the Nursing and Midwifery Board of Australia and any other authority that regulates health practitioners. | Yes ☐ No ☐ |
| I authorise the health service to obtain information relevant to my application from my current and any previous professional indemnity insurer. | Yes ☐ No ☐ |
| I authorise the health service to seek information from other persons as the health service considers appropriate, including any relevant health service, college or other professional organisation. | Yes ☐ No ☐ |
| I agree to abide by the organisation’s and state and national confidentiality and privacy laws and policies and understand that breaches may result in the cessation of my appointment. | Yes ☐ No ☐ |
| I agree to notify the Director of Nursing/Midwifery of any event/situation that may impact on my ability to exercise my scope of clinical practice, whether it be due to registration matters or otherwise. This includes matters about which I consider that the Director of Nursing/Midwifery would wish to be informed and, as a minimum, includes the kinds of information covered in this application (such as any criminal charges or convictions or reductions in registration or insurance). | Yes ☐ No ☐ |
| I agree to participate in this health service’s performance development and support process (Partnering for performance or equivalent). | Yes ☐ No ☐ |
| I agree to practise in accordance with the Australian College of Midwives’ guidelines for consultation and referral and/or the Australian and New Zealand College of Obstetricians and Gynaecologists College Statement C-Obs 30, and health service policies, procedures and guidelines. | Yes ☐ No ☐ |
I will ensure that all documentation complies with the requirements as described in the National Health (Collaborative arrangements for midwives) Determination 2010

I acknowledge the hospital’s commitment to teaching and learning and will support the learning needs of students and staff within the maternity service

I will ensure that documentation is contemporaneously documented on hospital medical record forms and/or entered onto the hospital database.

When on leave or ill I will ensure that appropriate arrangements are made for continuing care with an equivalently credentialed eligible midwife.

I will ensure that reportable data is submitted to relevant agencies (e.g. Victorian Perinatal Data Collection Service and Newborn Screening Program within the Victorian Clinical Genetics Service) and, where relevant, copies are sent to the hospital.

I authorise the hospital to exchange details of my midwifery affiliation including contact details with other relevant clinical agencies or individuals.

I authorise the hospital to advertise my practice details, area of interest and languages spoken.

I agree to promptly notify the Director of Midwifery/Nursing of any adverse clinical incident I am involved in, or become aware of.

I agree to work within my defined scope of clinical practice and to make a further application should I seek to extend the scope of clinical practice granted to me.

Should any question as to my scope of clinical practice arise, I agree that the health service may make such enquiries as it considers necessary to assess whether that scope of clinical practice is appropriate.

15. Declaration

I hereby declare that the information contained in this application is true and correct.

Signature of applicant  Date

If, for any reason, you are unable to sign the declaration above, please explain the circumstances.

Please note: the information collected on this form will be used by the <insert health service name> Credentialling and Scope of Clinical Practice Committee(s) to assist in the Determination of your application. Information provided on this form will not be used, or disclosed, for any other purpose.

<Insert health service name> operates in accordance with federal and state privacy legislation, including adherence to the national privacy principles. Copies of <insert health service name> privacy and confidentiality policies are available upon request.
Health service use only

 Applicant name

<table>
<thead>
<tr>
<th>Item</th>
<th>Checked/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Proof of identification</td>
<td></td>
</tr>
<tr>
<td>2. Working with children certificate (if applicable)</td>
<td>Sighted / Not sighted</td>
</tr>
<tr>
<td>3. Contact details provided</td>
<td></td>
</tr>
<tr>
<td>4. Provider number</td>
<td></td>
</tr>
<tr>
<td>5. Prescriber number</td>
<td></td>
</tr>
<tr>
<td>6. Qualifications</td>
<td></td>
</tr>
<tr>
<td>7. Training and experience (if required)**</td>
<td></td>
</tr>
<tr>
<td>8. Clinical appointments (if required)**</td>
<td></td>
</tr>
<tr>
<td>9. Midwifery registration</td>
<td></td>
</tr>
<tr>
<td>10. Medical indemnity cover currency</td>
<td></td>
</tr>
<tr>
<td>11. Academic appointments / teaching experience</td>
<td></td>
</tr>
<tr>
<td>12. Continuing professional development</td>
<td></td>
</tr>
<tr>
<td>13. Grand rounds (if applicable)</td>
<td></td>
</tr>
<tr>
<td>14. Health status</td>
<td></td>
</tr>
<tr>
<td>15. Referees (if required)**</td>
<td></td>
</tr>
<tr>
<td>16. Existing contract/employment arrangements checked and relevant documentation available (if required)**</td>
<td></td>
</tr>
<tr>
<td>17. Declaration signed</td>
<td></td>
</tr>
</tbody>
</table>

Other comments:

Application details checked by <insert name>

Signature                  Date

Letter to applicant advising outcome of application Yes Copy attached

** Not required for reappointment at same health service with no change in scope of practice.
### 100 points – verification details

<table>
<thead>
<tr>
<th>Type of check</th>
<th>Available points</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passport (current or expired by less than two years, not cancelled)</td>
<td>70</td>
<td>Must contain name and a photo.</td>
</tr>
<tr>
<td>Citizenship certificate (Australian only)</td>
<td></td>
<td>Select one only.</td>
</tr>
<tr>
<td>Birth certificate (original or extract)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth card issued by the Victorian Registry of Births, Deaths and Marriages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Written reference</td>
<td>40</td>
<td>Select one only.</td>
</tr>
<tr>
<td>Written reference from an acceptable referee from a financial institution</td>
<td></td>
<td>Referee to have known the signatory for at least 12 months.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Both signatory and referee must sign the reference.</td>
</tr>
<tr>
<td>Driver's licence. Renewed, interim, provisional, truck or learner's</td>
<td>40</td>
<td>Must contain name, expiry date, a photo or signature.</td>
</tr>
<tr>
<td>Other acceptable government-issued licences include boat, gun or pilot</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Public Service Employee Identification Card</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Pension or government Health Care Card (reference number required)</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Identification card issued by a tertiary education institute</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Letter from a current employer (current or must have been employed by the employer within the past two years)</td>
<td>35</td>
<td>Must be on letterhead or company seal.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Both employer and employee's signature must be on the letter, along with the name and address of the employee.</td>
</tr>
<tr>
<td>Medicare card</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Overseas or international driver's licence or Proof of Age card</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Financial institution's credit card, cash card or passbook</td>
<td>25</td>
<td>Only one current card/passbook can be accepted from each financial institution. You may supply details from several different institutions but cannot solely rely on this form of identification.</td>
</tr>
<tr>
<td>Type of check</td>
<td>Available points</td>
<td>Notes</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>Rating authorities</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Rate notice (current). Provide the deposited plan (DP) number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public utility (water rate notice, electricity, gas or telephone account – no mobile accounts). Take a current notice with you.</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Statement from landlord, managing agent or owner of customer premises</td>
<td>25</td>
<td>Take letter, rental contract or rent receipt with you.</td>
</tr>
</tbody>
</table>
Appendix 2: Collaborative arrangement
template sample

Adapted from Queensland Health’s template for use by health services: Collaborative arrangement between an eligible midwife and specified medical practitioner(s) (2011).

This template is available to download in Word format for use by Victorian health services at <www.health.vic.gov.au/maternitycare>.
<Insert health service>

COLLABORATIVE ARRANGEMENT

BETWEEN

(NAME - eligible midwife)

AND

<Insert name (s) of the specified Medical Practitioner(s)>

Adapted from Queensland Health’s template for use by health services: Collaborative arrangement between an eligible midwife and specified medical practitioner(s) (2011). This template is available to download in Word format for use by Victorian health services at <www.health.vic.gov.au/maternitycare>
This Collaborative Arrangement (the Arrangement) is made on the day of <insert date> 

BETWEEN
<insert name of eligible midwife>

AND
<insert name of health service specified medical practitioner(s)>

PREAMBLE
The National Maternity Services Review (2009) highlighted the need for eligible midwives in private practice to access clinical privileges in public maternity services, to enable women to receive continuity of care by their known midwife in a hospital setting.

PURPOSE
The purpose of this Arrangement is to meet the requirements of the National Health (collaboration arrangements for Midwives) Determination (2010). This Arrangement will provide for collaboration between the Eligible Midwife (EM) and <insert health service> Specified Medical Practitioner/s (SMP).

RECITALS
A. The EM and SMP acknowledge that each party has respective roles and professional obligations with regard to the transfer of pregnant and birthing women to <insert health service>.
B. The EM and SMP wish to work in cooperation to enable the effective and efficient delivery of health services to pregnant and birthing women, by ensuring the EM can continue to provide care when the EM seeks admission for their client to <insert health service>.
C. The EM and SMP agree that this Arrangement does not create any legal relationship between them.
D. Nothing in the Arrangement is intended to affect the obligations that each individual has to maintain the recognised standards as set down by the parties’ respective professional bodies; the Australian Health Practitioner Regulation Agency (AHPRA), the Australian Medical Association (AMA), the Australian College of Midwives (ACM) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

THE PARTIES TO THIS ARRANGEMENT AGREE AS follows:

1. DEFINITIONS
1.1 In this Arrangement the following definitions apply:
“Arrangement” means this Collaborative Arrangement.
“Associated staff” means Registrars and principal house officers in obstetrics and gynaecology.
“Australian College of Midwives’ (ACM) National midwifery guidelines for consultation and referral” and the “Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) College Statement: C-Obs 30 Maternal suitability for models of care, and indications for referral within and between models of care” means the current publications of the ACM National Guidelines for Consultation and Referral and/or the RANZCOG Maternity suitability and indications for referral statement C-Obs 30 are to be used by maternity health practitioners to guide consultation, referral and transfer of an EM client to an obstetric SMP.

Adapted from Queensland Health’s template for use by health services: Collaborative arrangement between an eligible midwife and specified medical practitioner(s) (2011). This template is available to download in Word format for use by Victorian health services at <www.health.vic.gov.au/maternitycare>
“Client” means the pregnant woman and/or neonate.

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

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

“Eligible Midwife (EM)” means a self-employed registered midwife who has fulfilled the requirements for eligibility and has been provided with a scope of practice and private practice admitting rights at <insert health service> to deliver private midwifery services.

National Health (collaboration arrangements for Midwives) Determination (2010) means the determination outlining the collaborative arrangements required for midwives.

Director Medical/Obstetric Services <insert health service> means the person with operational responsibility for medical services at <insert health service>.

“Parties” mean the signatories to this Arrangement.

“Pregnancy Health Record” means the current Victorian Department of Health Victorian Maternity Record (VMR) or health service equivalent.

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

“Specified Medical Practitioner (SMP)” means a specified medical practitioner, authorised by <insert health service> to participate in collaborative arrangements.

“Transfer” means when primary care is transferred, permanently or temporarily, from an EM to a specified medical practitioner. The Specified medical practitioner assumes full responsibility during the period the SMP is the lead carer.

2. COMMENCEMENT AND DURATION
2.1 This Arrangement will commence on the date to be agreed.

3. GUIDING PRINCIPLES
3.1 The parties agree that this Arrangement is based on mutual respect, cooperation and shared principles to ensure that clients of the EM are provided with safe maternity care, with the expectation of a birth within the <insert health service>.

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

a) care is woman centred
b) care is provided within a cooperative, collaborative and efficient framework
c) all communications between individuals is courteous, respectful, culturally sensitive and professional

Adapted from Queensland Health’s template for use by health services: Collaborative arrangement between an eligible midwife and specified medical practitioner(s) (2011). This template is available to download in Word format for use by Victorian health services at <www.health.vic.gov.au/maternitycare>
d) there is transparency across all care provided to the clients of the EM.

3.3 The parties acknowledge that the SMP does not endorse the practise of home births and nothing in this agreement endorses the practise of home births.

4. COOPERATIVE ARRANGEMENTS

4.1 In a spirit of cooperation between the EM and SMP(s), the parties agree to do the following:

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

b) document maternity care on the Victorian Maternity Record (or health service equivalent).

5. RESPONSIBILITIES OF THE PARTIES

5.1 The responsibilities of the EM are to:

a) ensure all legislative or other professional requirements which the EM is required to be meet are met. This includes maintaining national registration, adequate private indemnity insurance and having a Medicare provider number at all times

b) practise at all times in accordance with the Australian College of Midwives’ (ACM) National midwifery guidelines for consultation and referral and/or the RANZCOG Maternity suitability and indications for referral statement C-Obs 30, and/or local health service policy

c) ensure that the care provided to the pregnant client during pregnancy, labour, birth and the postpartum period accords to the agreed standards of the midwifery profession and/or local health service policy

d) liaise with the SMP using the principles outlined in the National Health and Medical Research Council (NHMRC) Collaborative guidelines (2010) and/or local health service policy

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

f) acknowledge and understand that this carer collaborative agreement will not apply when the SMP provides the advice to the EM as specified in 5.2(g)

g) ensure that any alternative midwife who is providing back-up to the EM has signed a Collaborative Agreement with SMP(s) from <insert health service>

h) abide by relevant <insert health service> policies, procedures and Code of Conduct while in attendance at <insert health service>

i) ensure that when the care required is a variance from normal care that consultation occurs in accordance with the ACM National midwifery guidelines for consultation and referral and/or local health service policy in a timely manner

j) ensure that when the care required is a variance from normal care that the appropriate referral of a client to an SMP occurs in accordance with the ACM National midwifery guidelines for consultation and referral and/or local health service policy in a timely manner

k) ensure that when the care required is a variance from normal care that the transfer of a client’s care to an SMP directly or via associated staff occurs in accordance with the ACM National

Adapted from Queensland Health’s template for use by health services: Collaborative arrangement between an eligible midwife and specified medical practitioner(s) (2011). This template is available to download in Word format for use by Victorian health services at <www.health.vic.gov.au/maternitycare>
midwifery guidelines for consultation and referral and/or local health service policy

l) work in partnership with SMP(s) and associated staff when recommendation is to temporarily or permanently transfer a patient's care to an SMP consistent with ACM National midwifery guidelines for consultation and referral and/or local health service policy

m) understand that when the care is transferred from primary to secondary care responsibility for care will transfer to the SMP and ongoing midwifery care may be provided by the EM, provided the woman remains admitted as a private patient

n) understand that in the event of the woman requiring a change of admission status from private to public the EM will not be able to provide further midwifery care

o) provide supportive education for health professionals and students working in <insert health service> if and when requested by the <insert health service>

p) collaborate with <insert health service> staff when dealing with complaints about client care or the operation of this Agreement.

5.2 The responsibilities of the SMP(s) are to:

a) acknowledge the accepted standards of midwifery care as defined by the ACM National Guidelines for Consultation and Referral and/or the RANZCOG Maternity suitability and indications for referral statement C-Obs 30

b) engage in a timely manner with the EM when consulted to provide medical advice

c) engage in a timely manner with the EM when asked to accept a referral

d) facilitate the transfer of a client’s care when the care required is a variance from normal care

e) consider the continuation of midwifery care being provided by the EM if the client’s care is temporarily or permanently transferred

f) attend case conferencing with the EM as agreed and scheduled or arrange a proxy of another SMP.

g) promptly advise the EM and Director of Medical/Obstetric Services in a case where the SMP disagrees with any client being cared for under this agreement

h) ensure any alternative SMP providing back-up to the SMP has signed a collaborative agreement with the EM.

6. EXCHANGE OF INFORMATION

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

6.2 The parties agree to:

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

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

Adapted from Queensland Health’s template for use by health services: Collaborative arrangement between an eligible midwife and specified medical practitioner(s) (2011). This template is available to download in Word format for use by Victorian health services at <www.health.vic.gov.au/maternitycare>
c) recognise and observe the confidentiality of information and agree that the collection, release and use of information will comply, so far as they apply to the relevant party, with all applicable <insert health service> policy and legislative requirements

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

7. VARIATION AND REVIEW

7.1 This Arrangement may be varied by agreement between the parties in writing. Any proposed alterations shall be raised and addressed through the EM and the Executive Director of the <insert health service>.

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

8. TERMINATION

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

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

9. DISPUTE RESOLUTION

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

a) will attempt to resolve the matter at the workplace level between the EM and the Executive Director of the <insert health service>.

b) agree that, if the matter is not resolved at the workplace level, the matter will be referred to CEO <insert health service> for resolution

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

10. NOTICES

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

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

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

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

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

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

Adapted from Queensland Health’s template for use by health services: Collaborative arrangement between an eligible midwife and specified medical practitioner(s) (2011). This template is available to download in Word format for use by Victorian health services at <www.health.vic.gov.au/maternitycare>
10.3 Unless otherwise advised in writing, addresses for each party being:

Party A: ___________________________________________
Address: __________________________________________
Party B: __________________________________________
Address: __________________________________________

SIGNED:

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

Name: ________________________________ Signature:
Date: ________________________________

Signature of Witness Name and Date

For and on behalf of Specified Medical Practitioner in the presence of:

Specified Medical Practitioners:

Name: ________________________________ Signature:
Date: ________________________________

Name: ________________________________ Signature:
Date: ________________________________

Name: ________________________________ Signature:
Date: ________________________________

Name: ________________________________ Signature:
Date: ________________________________

Name: ________________________________ Signature:
Date: ________________________________

Signature of Witness Name and Date

Adapted from Queensland Health’s template for use by health services: Collaborative arrangement between an eligible midwife and specified medical practitioner(s) [2011]. This template is available to download in Word format for use by Victorian health services at <www.health.vic.gov.au/maternitycare>
Appendix 3: Notation on register of midwives sample

A sample of an eligible midwife’s notation on the Australian Health Practitioners Regulation Agency’s (AHPRA) register of midwives is provided below.

<table>
<thead>
<tr>
<th>Health Practitioner:</th>
<th>&lt;Midwife name will appear here&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Details</td>
<td></td>
</tr>
<tr>
<td>Sex:</td>
<td>Female</td>
</tr>
<tr>
<td>Spoken languages (in addition to English):</td>
<td></td>
</tr>
<tr>
<td>Qualifications:</td>
<td>• REGISTERED MIDWIFE</td>
</tr>
<tr>
<td></td>
<td>• REGISTERED GENERAL NURSE</td>
</tr>
<tr>
<td>Principal Place of Practice</td>
<td></td>
</tr>
<tr>
<td>Suburb:</td>
<td></td>
</tr>
<tr>
<td>State:</td>
<td></td>
</tr>
<tr>
<td>Postcode:</td>
<td></td>
</tr>
<tr>
<td>Country:</td>
<td></td>
</tr>
<tr>
<td>Registration Details</td>
<td></td>
</tr>
<tr>
<td>Profession:</td>
<td>Midwife</td>
</tr>
<tr>
<td>Registration number:</td>
<td>NMW</td>
</tr>
<tr>
<td>Data of first Registration:</td>
<td>View definition of 'Date of first Registration'</td>
</tr>
<tr>
<td>Registration status:</td>
<td>Registered</td>
</tr>
<tr>
<td>Registration expiry date:</td>
<td>Under the National Law, registrants are able to practise while their renewal application is being processed. Practitioners also remain registered for one month after their registration expiry date. If the practitioner’s name appears on the Register, they are registered and can practice (excepting practitioners with a Registration Type of ‘non-practising’ or those with a condition which stops them from practising, or where their registration is suspended).</td>
</tr>
<tr>
<td>Conditions:</td>
<td>• None</td>
</tr>
<tr>
<td>Undertakings:</td>
<td>• None</td>
</tr>
<tr>
<td>Reprimands:</td>
<td>• None</td>
</tr>
<tr>
<td>Registration Type:</td>
<td>General</td>
</tr>
<tr>
<td>Endorsements:</td>
<td>• Endorsed as qualified to prescribe schedule 2, 3, 4 and 5 medicines required for midwifery practice across pregnancy, labour, birth and postnatal care, in accordance with relevant State and Territory legislation.</td>
</tr>
<tr>
<td>Notations - General:</td>
<td>• Eligible midwife competent to provide pregnancy, labour, birth and postnatal care and qualified to provide the associated services and order diagnostic investigations required for midwifery practice, in accordance with relevant State and Territory legislation.</td>
</tr>
<tr>
<td>Notations - Registration Requirements:</td>
<td>• None</td>
</tr>
</tbody>
</table>

[View definition of 'Condition']
[View definition of 'Undertaking']
[View definition of 'Reprimand']
[View definition of 'Endorsement']
[View definition of 'Notation']
Appendix 4: Indicative activities undertaken in a collaborative arrangement

The following diagram represents how a collaborative partnership between an eligible midwife and a health service or hospital may work. The activities shown are not exhaustive but demonstrate the key areas where a clear process is recommended.
**Figure 3: The collaborative partnership process**

<table>
<thead>
<tr>
<th>Eligible Midwife (EM)</th>
<th>Victoria public health service or hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Establishment phase</strong></td>
<td><strong>Application for CSoP is successful, granting private practice admitting rights</strong></td>
</tr>
<tr>
<td>Establishes collaborative arrangement with one or more:</td>
<td><strong>Undertake local community and workforce consultation to assess capacity, capability and consumer demand for service model</strong></td>
</tr>
<tr>
<td>OSMP(s) with private practice admitting rights, or</td>
<td><strong>Establish policy and system for participation in collaborative arrangements with EM(s) and OSMP(s), including remuneration model(s) consistent with the NHCA</strong></td>
</tr>
<tr>
<td>OSMP(s) employed by the hospital and authorised to participate in collaborative arrangements</td>
<td><strong>Develop CSoP application and review process, consistent with DH policy; Establish midwifery credentialing committee</strong></td>
</tr>
<tr>
<td>Participates in the planning and implementation of new service model related to collaborative arrangements</td>
<td><strong>Develop policy and procedures for workforce utilisation including back up arrangements, consistent with relevant legislation and policies</strong></td>
</tr>
<tr>
<td>Liaises with the lead contact as nominated by the health service</td>
<td><strong>Provide orientation and ongoing access to secure systems, e.g.: Facility access - IT, Pathology, Pharmacy, Investigations - Priority parking</strong></td>
</tr>
<tr>
<td>Familiar with health service policies related to private patients, including the criteria for change of admission status</td>
<td><strong>Develop agreed policy and process for workforce utilisation including back up arrangements, consistent with OH&amp;S standards</strong></td>
</tr>
<tr>
<td>Provides informed financial consent to women booked under their care, consistent with the NHCA</td>
<td><strong>Communicate expectations regarding care planning, health information management, communication, referral, reporting of clinical data, consistent with policies of the DH</strong></td>
</tr>
<tr>
<td>Participates in the planning and implementation of new service model related to collaborative arrangements</td>
<td><strong>Develop policy and processes for ongoing CSoP review, consistent with policies of the DH</strong></td>
</tr>
<tr>
<td>Participates in the planning and implementation of new service model related to collaborative arrangements</td>
<td><strong>Include EM(s) and collaborating OSMP(s) in organisational safety and quality activities</strong></td>
</tr>
<tr>
<td>Liaises with the lead contact as nominated by the health service</td>
<td><strong>Involve EM(s) and collaborating OSMP(s) in relevant core business, e.g. maternity unit meetings, communication and professional development opportunities</strong></td>
</tr>
<tr>
<td>Familiar with systems and processes related to: IT, Pathology, Pharmacy, Investigations</td>
<td><strong>Establish robust process for periodic service model review and participate in evaluations undertaken by the DH</strong></td>
</tr>
</tbody>
</table>

**RECOMMENDED PROCESSES FOR COLLABORATIVE PARTNERSHIPS BETWEEN HEALTH SERVICES AND ELIGIBLE MIDWIVES**

<table>
<thead>
<tr>
<th>Prior to admission as a private patient</th>
<th>Subsequent in-patient episodes</th>
<th>Ongoing review</th>
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</thead>
<tbody>
<tr>
<td>Completes hospital orientation; Satisfies organisational requirements for mandatory training and education</td>
<td>Care planning, health information management, communication, referral and reporting of clinical data complies with the Determination, local hospital policy and policies of the DH</td>
<td>Completes with initial 12 month and ongoing review of CSoP, consistent with DH policy</td>
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<tr>
<td>Participates in the planning and implementation of new service model related to collaborative arrangements</td>
<td>Negotiates backup arrangements and complies with OH&amp;S standards</td>
<td>Participates in health service safety and quality activities, e.g. perinatal mortality and morbidity reviews, incident reporting and consumer feedback</td>
</tr>
<tr>
<td>Familiar with health service policies related to private patients, including the criteria for change of admission status</td>
<td>Completes initial 12 month and ongoing review of CSoP, consistent with DH policy</td>
<td>Participates in relevant core business e.g. maternity unit meetings and ongoing professional development opportunities</td>
</tr>
<tr>
<td>Provides informed financial consent to women booked under their care, consistent with the NHCA</td>
<td>Completes initial 12 month and ongoing review of CSoP, consistent with DH policy</td>
<td>Participates in health service safety and quality activities, e.g. perinatal mortality and morbidity reviews, incident reporting and consumer feedback</td>
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<tr>
<td>Participates in the planning and implementation of new service model related to collaborative arrangements</td>
<td>Complies with initial 12 month and ongoing review of CSoP, consistent with DH policy</td>
<td>Participates in health service safety and quality activities, e.g. perinatal mortality and morbidity reviews, incident reporting and consumer feedback</td>
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<tr>
<td>Glossary Item</td>
<td>Definition</td>
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<td>Collaborating partners</td>
<td>Collaborating partners are maternity care professionals who are actively collaborating (i.e. not in an employee–employer relationship). Collaborating partners refer women to each other as the need arises.</td>
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<tr>
<td>Collaborative agreement/arrangement</td>
<td>A collaborative agreement or arrangement is an informal and/or formal recognition of the terms of a collaboration.</td>
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<tr>
<td>Credentialling</td>
<td>Credentialling refers to the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality healthcare services within specific organisational environments.</td>
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<tr>
<td>Defining the scope of clinical practice</td>
<td>Follows on from credentialling and involves delineating the extent of an individual practitioner’s clinical practice within a particular organisation, based on the individual's credentials, competence, performance and professional suitability, and the needs and capacity of the organisation to support the practitioners scope of clinical practice.</td>
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<tr>
<td>Eligible midwife</td>
<td>A registered midwife recognised by the Nursing and Midwifery Board of Australia as an eligible midwife with a notation on their registration (under section 38(2) of the National Health Practitioners Law (the National Law)). Having a notation on the Register of Midwives as an eligible midwife indicates the applicant is qualified to provide pregnancy, labour, birth and postnatal care to women and their infants; including the capacity to provide associated services and order diagnostic investigations appropriate to the eligible midwife’s scope of practice. An eligible midwife may also prescribe scheduled medicines in accordance with relevant state and territory legislation once an endorsement for scheduled medicines under section 94 has been obtained.</td>
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<tr>
<td>Endorsement (registration process)</td>
<td>Under the National Law, each board sets registration standards, approved by Ministerial Council that every registered health practitioner must meet. These standards are designed to ensure patient safety. Endorsement of registration identifies practitioners with additional qualifications and specific expertise. The endorsements for nursing and midwifery include “Scheduled medicines for eligible midwives”.</td>
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<tr>
<td>Health Service (public)</td>
<td>A public hospital, metropolitan health service or multipurpose service identified in schedules 1, 2, 3, 4 and 5 of the Health Services Act 1988.</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<td>Informed choice</td>
<td>Occurs when a woman has the autonomy and control to make decisions about her care after a process of information exchange that involves providing her with sufficient, evidence-based information about all options for her care, in the absence of coercion by any party and without withholding information about any options.</td>
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<tr>
<td>Informed consent</td>
<td>Is when a woman consents to a recommendation about her care after a process of information exchange that involves providing her with sufficient, evidence-based information about all the options for her care so that she can make a decision, in the absence of coercion by any party, that reflects self-determination, autonomy and control.</td>
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<tr>
<td>Medical Benefits Scheme</td>
<td>Public health care for Australian residents and citizens managed by the Department of Health and Ageing and administered by Medicare. Health professionals need to be authorised by Medicare to access the rebate scheme.</td>
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<tr>
<td>Medicare Benefits Schedule (MBS)</td>
<td>A listing of the Medicare services subsidised by the Australian Government.</td>
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<tr>
<td>Medical Indemnity Insurance</td>
<td>Medical Indemnity Insurance (MI) (also known as Medical Malpractice insurance) is a form of Professional Indemnity Insurance that provides protection for persons who provide medical services against claims for compensation that arise out of the provision of such services. In Australia, AHPRA now requires specific health specialties/practitioners to provide evidence of valid MI insurance in order to retain professional registration. Most insurance organisations offer MI and PII as two distinctly separate policies.</td>
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<tr>
<td>Medical Insurance Group Australia (MIGA)</td>
<td>Comprises Medical Defence Association of South Australia Limited (MDASA) and Medical Insurance Australia Pty Ltd.</td>
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<tr>
<td>Pharmaceutical Benefits Scheme (PBS)</td>
<td>The PBS is part of the Australian Government’s broader National Medicines Policy and ensures that the community has timely, reliable and affordable access to necessary medicines. The government subsidises the cost of medicine for most medical conditions. Most of the listed medicines are dispensed by pharmacists and used by patients at home. Health professionals need to be authorised by Medicare to access the rebate scheme.</td>
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<tr>
<td>Private maternity care</td>
<td>Private patients of a midwife, obstetrician or GP obstetrician attending private rooms for antenatal care, or receiving care in the home, and are attended by the same maternity professional for labour and postnatal care.</td>
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</tr>
<tr>
<td>Private patient</td>
<td>Private patient, in relation to a hospital, means a patient of the hospital who is not a public patient.</td>
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<tr>
<td><strong>Private practice admitting rights</strong></td>
<td>The right, granted to private health practitioners, to admit private patients to a health service following successful application for Credentialling at that health service.</td>
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<tr>
<td><strong>Public patient</strong></td>
<td>Public patient, in relation to a hospital, means a patient in respect of whom the hospital provides comprehensive care, including all necessary medical, nursing and diagnostic services and, if they are available at the hospital, dental and paramedical services, by means of its own staff or by other agreed arrangements.</td>
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<tr>
<td><strong>Professional Indemnity Insurance</strong></td>
<td>Professional Indemnity Insurance (PII), also called Professional Liability Insurance (PLI), is a form of liability insurance that helps protect professional advice- and service-providing individuals and companies from bearing the full cost of defending against a negligence claim made by a client, and damages awarded in such a civil lawsuit. The coverage focuses on alleged failure to perform on the part of, financial loss caused by, and error or omission in the service or product sold by the policyholder. These are potential causes for legal action that would not be covered by a more general liability insurance policy which addresses more direct forms of harm. Professional liability coverage sometimes also provides for the defence costs, including when legal action turns out to be groundless. Professional Indemnity Insurance generally excludes coverage for claims for Bodily Injury which is more aptly provided under a Medical Indemnity or Medical Malpractice policy.</td>
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