WHA Breakthrough Collaborative
Improving outcomes for women through reducing avoidable 3rd & 4th degree tears

Project Overview
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Introduction

This document provides an overview of an exciting new opportunity being offered by Women’s Healthcare Australasia (WHA), in partnership with the NSW Clinical Excellence Commission (CEC), to collaborate with other maternity services across Australia on an agreed priority for improvement: reducing harm from third and fourth degree perineal tears.

As a not-for-profit organisation, whose member hospitals support more than 60% of public births in Australia each year, WHA is well placed to support members to collaborate on quality improvement priorities. WHA is pleased to partner with the leading agency for patient safety and quality in NSW, the CEC.

This partnership provides participating hospitals with access to significant expertise in collaborative improvement methodologies, informed by the globally renowned Institute for Healthcare Improvement (IHI). Further, by working in partnership, WHA and the CEC strengthen the prospect that participating teams will be successful in achieving measurable reductions in rates of third and fourth degree perineal tears, and in sustaining improved rates beyond the life of the Collaborative.

This document provides an overview of WHA’s plan for hosting the Breakthrough Collaborative during 2017/18 with a view to reducing the rate of third and fourth degree perineal tears. It provides summary information on:

- the current picture in terms of harm to women from a 3rd or 4th degree tear
- the aim of this Collaborative
- the methodology to be used in this Collaborative
- what WHA and CEC will provide for participating teams
- what your hospital will need to provide for your participating team
- the enrolment fee and what it includes
- the estimated return on investment
- how to apply to enrol
- next steps following enrolment

WHA welcome applications from both member and non-member hospitals interested in collaborating to improve perineal outcomes for women. Priority will be given to WHA member hospitals, with an upper limit of 30 hospitals.

For further information or to express interest in this project, please don’t hesitate to contact WHA using the details provided below:

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T: 02 6175 1900
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About the Collaborative Hosts

Women’s Healthcare Australasia

WHA is the peak not-for-profit body for health services providing maternity and women’s healthcare in Australia. Our vision is to enhance the health and wellbeing of women and babies through supporting hospitals and health services to achieve excellence in clinical care.

Formed in the early 1990’s, WHA supports information exchange, benchmarking and peer networking among executives and staff in both specialist and general hospitals offering maternity and women’s healthcare services. WHA is a highly regarded, multidisciplinary organisation in which the unifying interest of members and staff alike is to enhance the health and wellbeing of women and their babies.

WHA’s membership includes more than 100 maternity hospitals supports over 136,000 births a year (more than 60% of public births). That makes us the largest maternity advocacy, networking and benchmarking organisation in Australia. Our members include the majority of tertiary maternity hospitals, as well as a wide range of medium and small maternity units in both urban and regional/rural areas.

WHA’s focus on excellence, and its network of expertise across the sector, means we are ideally placed to facilitate a formal collaborative improvement project amongst interested hospitals.

Clinical Excellence Commission

The CEC is a pillar agency of NSW Health. Emerging amid system-wide patient and safety concerns, the primary focus of the CEC has been to promote and support improved clinical care, safety and quality across the NSW public health system.

The CEC is a board-governed statutory health corporation established under the Health Services Act 1997. Since its development, the CEC has gained local, national and international recognition by developing and driving programs and initiatives in collaboration with clinicians, managers, consumers and health service partners.

The range of areas addressed includes clinical incident review, deteriorating patients, end of life care, falls prevention, human factors, infection control, leadership, medication safety, mortality review, open disclosure, paediatric quality and safety, partnering with patients, pressure injury prevention, safety and quality education, sepsis, teamwork, transfusion medicine and venous thromboembolism prevention. Monitoring processes and performance, to provide assurance of clinical quality and safety improvement at a system-wide level, has been a central and distinct role of the CEC within the NSW health system.

The CEC has significant expertise in internationally renowned methodologies for safety and quality improvement in healthcare.
What is a Breakthrough Collaborative?

The IHI Breakthrough Collaborative is an improvement method pioneered by the US Institute for Healthcare Improvement (http://www.ihi.org) that relies on spreading and adapting existing knowledge of best practice care to multiple settings for a common aim.

The goal of a Collaborative is to achieve results, and to close the gap between evidence based medicine and evidence based delivery. Collaboratives are designed to achieve sustained reliable improvement for patients and to decrease harm. Participating teams report feeling buoyed by regular peer and expert coaching to strive for, and achieve, improved outcomes for patients over the short and long term.

Collaboratives operate on adult learning principles; require focused work by each team to adapt effective changes to their setting; use methods for accelerating improvement; and capitalise on shared learning and collaboration.

There is significant evidence that this methodology delivers results in terms of patient outcomes on a wide range of healthcare problems across many countries. The method involves the following key elements:

- **Formation of an Expert Panel**
  The role of the Expert Panel is to identify and agree on the evidence based interventions known to improve processes and outcomes and minimise harm; and establish the measurement framework that will be used during the collaborative by all participating clinical units. These data measures provide the organisation with the effectiveness of the clinical learning system at the micro, meso, and macro level to monitor and evaluate the reliability and sustainability of the system improvement from ‘Ward to Board’ on a continuous improvement basis.

- **Three face to face learning sessions**
  These two (2) day meetings support participating teams to develop their understanding and capacity of improvement science, and help them to share with one another rapid cycle testing of change strategies and consolidate reliable system design. The meetings, facilitate cross fertilisation of ideas; establish a robust and critical communication network; and significantly build staff morale and experience.

- **Monthly reviews of progress during ‘Action Periods’**
  This is done through web conferences with peer teams. The Action Periods are where the work of improvement takes place in individual hospitals, supported by regular sharing of data and learnings with other teams. Measurement data is collected and recorded throughout this period by the participating team members.

- **Regular coaching and advice**
  This is provided by experts in improvement science, as well as regular access to peers in other teams to resolve common challenges and share learnings. This capacity and capability building in improvement science within hospitals, has additional long term benefits for topics beyond the focus of the collaborative and the life of it.
To gain the most from the Learning Sessions and Action Periods it is essential that there is robust preparation in advance. WHA and CEC will support enrolled teams to:

- Identify their local perineal tears improvement team
- Map their hospital’s baseline performance
- Prepare for and gain maximum benefit from the Learning Sessions,
- Determine local tests of change to implement the evidence based bundle
- Utilise measurement tools by which to assess their progress during the life of the collaborative
- Share results from their rapid change tests with peers and learn from successes and challenges

The project will also assist participating teams to spread their achievements across their own hospital or health service.
Why focus on preventing third and fourth degree tears?

Approximately 75% (n=172,700) of all women who give birth in Australia each year sustain some form of perineal tear (AIHW, 2016a). More than 3.6% (n=6,365) (AIHW, 2016a) of these women will sustain third and fourth degree tears which have the potential for long term, or even lifelong, impact on their wellbeing. The consequences of such injuries include both physical and psychological morbidities (Beckmann & Stock, 2013; Farrar, Tuffnell, & Ramage, 2014), as illustrated in the next section by the stories shared with WHA by women with experience of this harm.

Evidence suggests that the incidence of third and fourth degree tears is increasing in developed countries (Dahlen, Priddis, & Thornton, 2015). Australian data also shows a year on year increase in the number of women who sustain these tears (AIHW, 2016b).

This rising rate of harm from tears is occurring despite a declining vaginal birth rate. Data from the National Hospital Cost Data Set indicates that women who have an instrumental vaginal birth are particularly vulnerable to perineal harm. 68% of women who had a complex instrumental birth and 86% of women who had an instrumental birth with minor complexity reportedly suffered third or fourth degree tears in 2014/15 (unpublished advice from IHPA provided to WHA in March 2017).

There is also considerable variation in rates of third and fourth degree tears among WHA member hospitals. This variation is not specific to different service capabilities, as illustrated in the 2015/16 Benchmarking Maternity Care report below.

According to data submitted to WHA for 2015/16, hospitals supporting more than 500 births p.a reported rates of 3rd and 4th degree tear ranging between 1.3% and 5.6%, with an average of 3.43% (WHA, 2016). For hospitals supporting less than 500 births per annum the
rates varied from 0% to 10%, with an average of 2.46%. Rates of third and fourth degree tears also vary by level of maternity care. WHA utilises the Guide to Role Delineation of Clinical Services (NSW Ministry of Health, 2016) to assess service level. Level 1-5 hospitals report an average rate of 3.1%, and level 6 hospitals report an average of 4% (WHA, 2016).

An additional consideration for hospitals moving forwards is that the Australian Health Ministers Advisory Council (AHMAC) has determined that all Australian hospitals will soon be penalised for Hospital Acquired Complications (HAC). WHA advocated that 3rd and 4th degree tears be excluded from this list, for fear that a penalty may contribute to under-reporting and under-treatment. However, the decision has been taken to retain them on the HAC list. This means that from July 2018 services will have funding reduced for each episode of care where a woman sustains a third or fourth degree tear (to an amount yet to be determined) (see IHPA, Pricing Framework 2017-2018).

A further reason WHA members agreed to focus this collaborative on 3rd and 4th degree tears is that this harm is not limited to any particular level of maternity service. Our benchmarking data suggests this harm is occurring in services large and small, in both urban and rural areas. There is also strong clinical interest across the maternity care sector in reducing this harm to improve women’s lives and that of their families.
Women's Experience of third and fourth degree perineal tears

Third and fourth degree tears have the potential for long term, or even lifelong, impact on women’s wellbeing, including both physical and psychological morbidities (Beckmann & Stock, 2013; Farrar, Tuffnell, & Ramage, 2014). Women's stories provide a powerful insight into why it is essential that we strive to minimise this harm in the future:

“…part of me thought ‘[my best friend] will judge me if I tell her that I’m poohing my pants’. Not that I think she would’ve thought any less of me, I’m sure there would have been sympathy, but I thought it was disgusting so I didn’t want anybody else to judge me for that…”

“Three months after my daughters’ birth I had a dentist appointment. I remember parking the car, going up the escalator into the shopping centre where the dental rooms were. I was walking along when I felt something run down my legs. I quickly ran to the toilet, thinking perhaps I had gotten my first period. But I was horrified to see that I had become incontinent for faeces. I remember sitting in the toilet, crying, wondering what on earth to do. I threw my underpants out, and I tried to clean myself, luckily I had nappy wipes in my handbag and I used those to clean myself the best I could. Once I composed myself I went into a chemist and used one of their sample perfumes to spray myself, I was completely paranoid that I smelt of faeces. I still had to go to the dentist appointment but the whole time I lay there praying that I didn’t smell and that no more would run out. I have never forgotten that day, or the absolute disgust that I felt with myself that I had no bowel control.”

“It’s almost like trying to do it for the first time…and I’m almost in tears because I’m so scared. He’s so patient but he does go, maybe tonight we can try and I’m like sure. I was so anxious about it—I made myself really sick. I get migraines and I gave myself a massive migraine—the worst and I was vomiting. How classy is that? I’m like all this because I’m thinking I want to have sex.”

All participating teams will also be encouraged to involve consumers throughout their improvement project. They frequently are engaged with during the action periods to help facilitate reliable design. WHA will provide training and support to these consumers to foster their constructive engagement in the Collaborative.

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Collaborative Aim

WHA has convened an Expert Panel including obstetricians, urogynaecologists, midwives and consumers to assist with the design and delivery of this Collaborative (see Appendix A). In particular, the Expert Panel will determine:

- the measurable aim for this collaborative,
- the evidence based bundle of care that will drive improvement, and
- the measures to be used by participating teams to determine the efficacy of the changes they make locally to reduce the rate of tears.

As of April 2017, the Expert Panel has identified the draft aim for the Collaborative as being to reduce the incidence of 3rd and 4th degree tears by 20% in participating hospitals by 1 December 2018. This aim may be refined further following the May Expert Panel meeting.

Care Bundles

The care bundle describes a collection of interventions to improve the process of care and outcomes (Institute for Healthcare Improvement (IHI), 2017). Using IHI methodology, care bundles should be concise, comprising three to five evidence based practices that, when performed together, reliably improve patient outcomes (IHI, 2017).

At its first meeting in March 2017, WHA’s Expert Panel reviewed contemporary research literature and identified the following areas as being important for reducing 3rd and 4th degree tears.

1. Antenatal education for women on perineal care, and how to minimise the risk of tears
2. Supporting a slow and gentle birth of the baby’s head and shoulders during second stage
3. Selective use of mediolateral episiotomy for non-instrumental delivery, performed at least a 60 degree angle when required.
4. Preference for vacuum assisted births if the clinical option exists over forceps.
5. Episiotomy is strongly recommended with the use of forceps and should be considered with vacuum assisted births
6. Vigilance in recognition and consistent classification of type of tear at the time of delivery
7. Appropriate evidence based management including rectovaginal examination for all women
8. Appropriate and timely follow up of all women who are harmed

These areas will be discussed and refined at a meeting planned for May 2017, into a specific, evidence based bundle with associated measures to be used by all participants to drive measurable sustained improvement across the entire collaborative.

Measurement strategies

Establishing a measurement and evaluation framework prior to the commencement of the collaborative is a critical factor to the success the whole project. Drawing on the expertise of our Expert Panel, WHA is committed to developing a framework of measures that will
include:

- **Outcome measures** – Monthly rate of 3rd/4th degree tears for women giving birth with/without instruments, Outcome of specific harm as measured by urinary and faecal incontinence; dyspareunia, etc.

- **Process measures** – % compliance with all component parts of the bundle per clinical unit

- **Balancing measures** – Increased rate of Caesarean Section; Increase in reporting of 3rd and 4th degree tears.

What WHA and CEC will provide for participating teams

WHA proposes to use the IHI Breakthrough Series methodology for this Collaborative.

The collaborative will focus on achieving measured reductions in rates of 3rd and 4th degree tears for all participating hospitals over their July 2017 rate by the end of 2018. One of the key tangible benefits to hospitals enrolling in this process will be building capacity within their team in the science and methodology of achieving improved outcomes for patients. These skills can then be deployed on other priority topics subsequent to the completion of this collaborative improvement project.

The following table outlines the contribution that the WHA and CEC in partnership propose to provide to participating teams and the value of investing in this collaborative,

<table>
<thead>
<tr>
<th>Nature of Contribution</th>
<th>Estimated Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preparation for the collaborative</strong></td>
<td></td>
</tr>
<tr>
<td>Support with forming a suitable local team and engaging in Pre-work to establish a clear baseline in terms of current ascertainment and reporting of 3rd and 4th degree perineal tears against which efforts to improve will be assessed</td>
<td>Access to web conferences, email and telephone coaching from the Medical Collaborative Director and Improvement Advisors</td>
</tr>
<tr>
<td>Quality Improvement Capacity and Capability assessment of all participating units to establish appropriate educational needs of all team members prior to commencing</td>
<td></td>
</tr>
<tr>
<td><strong>Learning Session 1</strong> (late August/September 2017)</td>
<td></td>
</tr>
<tr>
<td>Participants will learn about improvement science including basic data collection principles, the evidence bundle to be adopted, the measurement framework,</td>
<td>2 day complimentary meeting for up to 5 staff with improvement and subject matter experts and with up to 150 peers (valued at $2,500 per team).</td>
</tr>
<tr>
<td><strong>Action Period 1</strong></td>
<td>Access to web conferences, email and telephone coaching from our Collaborative Director and Improvement Advisors</td>
</tr>
<tr>
<td>- Phone and web conference coaching and developing local tests of change within the collaborative framework</td>
<td></td>
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<tr>
<td>- Opportunity to share results with peer teams via a secure online portal</td>
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<tr>
<td>- Monthly web conferences with QI experts and Collaborative peers to share findings and lessons learnt</td>
<td></td>
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<tr>
<td><strong>Learning Session 2</strong> (late October/November 2017)</td>
<td></td>
</tr>
<tr>
<td>- Deepening of education about improvement science and methodology and its use locally to include reliable system design; human factors.</td>
<td>2 day complimentary meeting for up to 5 staff with improvement and subject matter experts and with up to 150 peers (valued at $2,500 per team).</td>
</tr>
<tr>
<td>- Improvement science statistics will be applied by the teams to individual collected clinical unit data sets imported onto the data measurement platform.</td>
<td></td>
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<tr>
<td>- Support and coaching with local interventions and troubleshooting</td>
<td></td>
</tr>
<tr>
<td><strong>Action Period 2</strong></td>
<td>Access to web conferences, email and telephone coaching from our Collaborative Director and Improvement Advisors</td>
</tr>
<tr>
<td>- Phone and web conference coaching with accelerating and scaling up local tests of change within the collaborative framework</td>
<td>Opportunity to host complimentary site visit by Director and QI Advisor for face to face education, advice and support</td>
</tr>
</tbody>
</table>
- Monthly web conferences with QI experts and Collaborative peers to coach; share findings and lessons learnt

<table>
<thead>
<tr>
<th>Learning Session 3 (March/April 2018)</th>
<th>2 day complimentary meeting for up to 5 staff with improvement and subject matter experts and with up to 150 peers (valued at $2,500 per team).</th>
</tr>
</thead>
</table>
| - Deepening of education about improvement science and methodology to spread and scale up of the changes driving improvement; leadership at all levels; safety learning culture and staff engagement  
- Support and coaching with local interventions and troubleshooting | |

| Action Period 3 | - Ongoing coaching from improvement experts and peers to achieve results  
- Opportunity to showcase achievements to peers |
|-----------------|-------------------------------------------------------------------------------------------------------------|
| - Ongoing coaching and support to December 2018 - securing improvement through implementation and spread of proven change strategies  
- Showcase of successful endeavours at WHA Safety and Quality Forum in December 2018 | |

<table>
<thead>
<tr>
<th>Improvement Data Platform Sharing of data throughout collaborative</th>
<th>valued at $40,000 for IT build</th>
</tr>
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</table>
| - Access to a secure dedicated online data portal and collaborative measurement platform - to post data across the collaborative learning system.  
- Access to discussion forum re collaborative | |
What hospitals will need to provide for their participating team

The IHI breakthrough model is a resource intensive improvement methodology. Countless hospitals in Australia and abroad have participated in projects using this methodology over the past 15 years because of its proven success in supporting them to achieve measurable and sustained improvement in outcomes for patients. Such results are only achieved by hospitals that actively engage in the collaborative improvement process. Enrolling in the collaborative in and of itself will not guarantee improvement.

IHI advises hospitals that choose to invest in a Breakthrough Collaborative that they need to understand the importance of establishing and supporting their participating team. The individuals who form this team will ideally remain consistent throughout the life of the collaborative project and represent both management and frontline staff in all relevant areas affected by the collaborative topic.

The key stakeholders are:
- CEO
- Executive Sponsor
- Senior Medical Leader (e.g. Obstetrician/Urogynaecologist)
- Senior Nursing/Midwifery leader (e.g. Maternity Unit Manager or Midwife/Educator)
- One or more junior medical and midwifery staff with a passion for clinical practice improvement
- A consumer representative

The project team participants should include individuals who:
- Have a working knowledge of 3rd and 4th degree perineal tears and the factors contributing to them
- Can work together as a functioning team and at an accelerated pace and strive to create a healthy safety culture
- Have dedicated time allocated by the senior leadership of the organisations to work on the improvement project. It is critical that time is allocated to all members of the team particularly the senior medical and midwifery lead from the outset. Their participation in the Learning sessions will be critical*
- Are motivated and driven to improve the system and are willing to engage in the consistent delivery of the evidence based bundle (unless by clinical exception) using improvement science techniques of rapid testing and small data collection sets.

A dedicated home team of 4 or 5 people should be selected to become the “travel team”. Participation by the identified senior medical and midwifery lead in the Learning Sessions will be critical*. International evidence would suggest that without their active engagement at all stages in the collaborative the ability to sustain reliable system improvement and decrease potentially avoidable harm is very difficult to achieve even in the short term.

The IHI advises that as a rule of thumb, to consider a requirement of 1 FTE of time spread across the entire team to deliver the sustained reliable system improvement. This does not mean that a new position should be created and filled. Rather it is a guide to the kind of hours that is likely to be necessary to achieve the goal of reducing rates of perineal trauma by 20%.
There will be no registration fee for delegates to the Learning Session meetings. However, hospitals will need to budget for any airfares, accommodation and related travel costs that may be required for 4-5 staff to attend each Learning Session.

We will identify through the application process the capability and capacity within the collaborative learning system prior to commencement of the project. This will allow the Medical Director of the collaborative to establish the appropriate level of education and approaches that may be required both prior to commencement of, and including, the first Learning session.

All data is typically collected at the clinical unit level by team participants. A dedicated data person is not essential although prior knowledge of excel at an introductory level would be ideal.

**Business Case for Hospitals to Invest in Improvement on Perineal Tears**

According to WHA benchmarking data, the average cost reported by tertiary hospitals for women experiencing 3rd and 4th degree tears in 2015/16 was $8,830 per woman (WHA, 2017a). This was for inpatient costs associated with the episode in which the tear occurred. Additional inpatient costs associated with third and fourth degree tears varied depending on the DRG to which the birth was coded.

For women having a complicated instrumental birth (O02A), reported costs in 2015-16 were approximately $800 higher than the National Efficient Price. For women who had an otherwise uncomplicated vaginal birth (O60C) but experienced a 3rd or 4th degree tear, the cost of care was reported at approximately $3,000 above the National Efficient Price.

WHA has also identified that many of these women were admitted more than once during the period in which they birthed. The average cost of these additional admissions was $1,389. WHA was not able to ascertain the additional cost of re-admissions associated with the primary tear throughout further years. The majority of these women would also have had outpatient visits following their birth related to treatment of their tear, however WHA lacks sufficient data to estimate this cost.

The average tertiary hospital with 3,000 or more births has a rate of 3.6-4% of women incurring a 3rd or 4th degree tear, or between 160-200 women. A 20% reduction in 3rd and 4th degree tears equates to approximately 30-40 fewer women a year at each tertiary hospital. Should the collaborative help these hospitals to achieve this target reduction, each service stands to make a conservatively estimated cost saving of approximately $25,000-$50,000 in the 2017-18 financial year.

Costs of litigation arising from 3rd and 4th degree tears is also a consideration. While Australian data is scarce, in the United Kingdom it has been reported that between 2000 to 2010 there were 441 successful claims alleging negligence after women sustained perineal trauma (NHS Litigation Authority, 2012). The total value of these claims was estimated to be £31.2 million, and is reported to relate primarily to third and fourth degree perineal tears. In Australia, WHA members have anecdotaly advised that successful claims are typically between $80,000 and $300,000 each.

From 1 July 2018, maternity services will have some funding withheld as a result of a woman sustaining a third or fourth degree tear (IHCP Pricing Framework 2017-18), following the
inclusion of this harm on the national Hospital Acquired Complications list (ACSQHC https://www.safetyandquality.gov.au/our-work/information-strategy/indicators/hospital-acquired-complications/). The extent of this financial penalty is yet to be announced by the Independent Hospital Pricing Authority.

Notwithstanding these financial considerations, investing in reducing rates of preventable harm cannot help but be beneficial for a maternity service in terms of reputation, staff morale, and most importantly, the immeasurable benefits to individual women and their families.
Enrolment Fees

In order to provide participating teams with education, advice and support throughout the life of the Collaborative from suitably qualified experts in improvement science, WHA needs to levy an enrolment fee. Since 3rd and 4th degree tears occur in all member hospitals, the WHA Board has resolved to price fees on a sliding scale to maximise equity of access to the project from maternity hospitals of different size and capacity.

When reviewing the fees please note:

- The resources required to ensure the Collaborative is successful for participating teams have been identified following extensive consultation with existing experts in hosting collaborative improvement projects in the United States and the United Kingdom. WHA is confident that the human and other resources proposed for this project will enable participating teams to succeed in achieving measured reductions in rates of 3rd and 4th degree perineal tears.

- WHA is partnering with the CEC to leverage significantly greater expertise and resources for this project than would otherwise be possible at no additional cost to member hospitals.

- WHA will provide complimentary registrations for the face to face Learning Sessions for up to 5 members of your Collaborative team. The ‘travel team’ from all participating hospitals will only be required to pay registration fees to attend Learning Sessions for the 6th or more delegate sent.

- The Collaborative enrolment fee includes monthly web conferences about progress and access to a secure on line portal to share data with and learn from peers.

- All participating teams will also have access to expert advice on the day to day mechanics of change management, testing and improvement. This includes the opportunity to host a face to face meeting with the Collaborative Director and Improvement Advisor at your hospital if required.

- All elements of the Project Budget are at cost price. There is no ‘profit taking’ for WHA planned into this project Budget. Rather WHA will be contributing approximately $100,000 of in kind resources to the delivery of this project, in addition to the revenue raised by enrolment fees. The CEC is also making a significant in-kind contribution.

- The Collaborative fee covers all of the above for an 18 month period from July 2017 to December 2018. Participating hospitals have the option to pay their fee up front in a single payment (with a 5% discount) or to make payment in 3 instalments as shown in the table below.
### Enrolment fees for WHA Collaborative 2017-2018: per hospital site

<table>
<thead>
<tr>
<th>Total number of births p.a.</th>
<th>WHA Member Hospitals</th>
<th>NON MEMBER HOSPITALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Option A - payment in full</strong></td>
<td><strong>Option B - payment by instalments</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong> (pay by 30/6/2017)</td>
<td><strong>Deposit</strong> (pay by 30/6/2017)</td>
</tr>
<tr>
<td>&lt;1,000</td>
<td>$9,900</td>
<td>$995</td>
</tr>
<tr>
<td>1,001 - 2,000</td>
<td>$14,850</td>
<td>$1,500</td>
</tr>
<tr>
<td>2,001 - 3,000</td>
<td>$20,790</td>
<td>$2,100</td>
</tr>
<tr>
<td>3,001 - 4,000</td>
<td>$29,700</td>
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<td>4,001 - 5,000</td>
<td>$34,650</td>
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</tr>
<tr>
<td>6,001 - 7,000</td>
<td>$44,550</td>
<td>$4,500</td>
</tr>
<tr>
<td>7,001 - 8,000</td>
<td>$49,500</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

Please note: In recognition of the significant in-kind contribution being provided by the NSW Clinical Excellence Commission to the Project, WHA member hospitals in NSW will receive a discount of 10% on their relevant enrolment fee.

### How to Enrol

WHA plans to limit enrolment to 30 hospitals on a first come, first served basis. This will ensure all participating teams receive appropriate levels of advice and support throughout the life of the collaborative with available resources.

To confirm your hospital’s place in the Collaborative, simply fill in the enrolment form at Appendix B and return it to WHA by **7 June 2017**

By email: collaborativewcha.asn.au

By post: PO Box 50
Deakin West 2600

If you would like further information about any aspect of the Collaborative, please contact our CEO, Dr Barbara Vernon on ceowcha.asn.au or 02 6175 1900.

**Applications close: 7 June 2017**
Next Steps following enrolment

Once WHA receives your hospital’s completed Application to Enrol, we will:

- Send you a brief letter confirming your application to enrol has been received
- Issue an invoice in accordance with your preference (full or partial payment). Timely payment of which will secure your hospital’s place in the Collaborative
- Provide you with a handbook on preparing for the Improving Perineal Outcomes Collaborative including advice on:
  - Identifying and forming your collaborative team
  - Measuring your hospital’s current performance on 3rd and 4th degree tears and identifying areas for improvement
  - Preparing for the first Learning Session
- Contact your hospital's nominated Executive Sponsor to discuss your planning and provide advice/support
- Undertake a capability and capacity exercise prior to commencement of the collaborative to establish prior knowledge of Improvement Science. This will allow appropriate structuring and timely delivery of the quality improvement science educational curriculum required throughout the Collaborative.
- Invite your nominated team to join a Pre-Learning Session briefing via web conference
- Confirm plans for the first Learning Session to be held, to be held in late August or early September 2017.

This promises to be an exciting project. We look forward to working closely with you and your team to achieve measurable reductions in rate of harm to women from third and fourth degree tears.

For further information or to express interest in this project, please don’t hesitate to contact WHA using the details provided below:

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E: ceo@wcha.asn.au
T: 02 6175 1900
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Appendix A: Collaborative Expert Panel

WHA and CEC appreciate the expertise and advice of the following individuals who form the Expert Advisory Panel for this Collaborative:

Medical

- **A/Prof Anne Sneddon**, Obstetrician and Gynaecologist at Gold Coast University Hospital, QLD and WHA Vice President
- **A/Prof Boon Lim**, Clinical Director, Obstetrics & Gynaecology at Centenary Hospital for Women and Children, ACT
- **A/Prof Andrew Bisits**, Medical Clinical Co-Director, Maternity Services Division at the Royal Hospital for Women, NSW
- **Dr Jenny King**, Head of Department of Urogynaecology at Westmead Hospital, NSW
- **Dr Oliver Daly**, Staff specialist Urogynaecologist and Obstetrician at Western Health, VIC
- **Dr Michael Beckmann**, Director Mothers, Babies and Women’s Health Services at Mater Health, QLD
- **Prof Jeremy Oats**, Chair of the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity and member of National Perinatal and Maternal Mortality Advisory, VIC

Midwifery

- **Prof Deborah Davis**, Professor and Clinical Chair, Midwifery at the University of Canberra and Centenary Hospital for Women and Children, ACT
- **Prof Hannah Dahlen**, Professor of Midwifery at the University of Western Sydney, NSW
- **Vanessa Watkins**, Deputy Director of Nursing and Midwifery at Sunshine Hospital, VIC
- **Rukhsana Aziz**, Clinical Midwifery Consultant at Ipswich Hospital, QLD
- **Dr Holly Priddis**, Lecturer of Midwifery at University of Western Sydney, NSW

Consumers

- **Leah Hardiman**, President of Maternity Choices Australia, QLD
- **Leslie Arnott**, Consumer advocate and WHA Board member 2012-16, VIC
- **Wendy Langshaw**, Consumer, Physiotherapist, SA
Reference List


