Australian College of
Midwives

Continuity of Care Handbook

Recommended citation:

Australian College of Midwives (2017). Delivering midwifery continuity of care to Australian women: A handbook for hospitals and health services (3rd Edition). Australian College of Midwives: Canberra.

ISBN 978-1-925358-05-6

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ACKNOWLEDGEMENTS

This handbook was initially adapted with permission from the Queensland Health guide "Delivering continuity of midwifery care to Queensland women" (2009). Australian College of Midwives would like to thank everyone who has contributed to this publication. In particular, our thanks to:

Dr Jyai Allen and Professor Caroline Homer who updated and adapted the 3rd Edition

Liz Wilkes, Bruce Teakle and Dr Jocelyn Toohill as the lead authors of the 2nd edition produced by Queensland Health

Anne Moore who produced the 1st edition of the guideline for Queensland Health

Other colleagues who have provided advice, support and assistance through the development of the initial guide including Professor Jenny Gamble, Lorraine Mathison, Amanda Ostrenski, Katie Jefford, Helen Timms, Sandra Eales, Sharon Dalton, Kerry-anne Maddox, Kay Wilson, Dr Karen Yates, Rebecca Jenkinson, Queensland Nurses Union, the Midwifery Advisory Committee and the Maternity Unit of Queensland Health.

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Overview of this Handbook

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This handbook has been developed and adapted to support services who wish to deliver continuity of midwifery care to women and families... In essence, this is a guide to making the changes needed to build these models, so that they work for staf f and for women.

Midwifery continuity of care and carer (referred to in this Handbook as 'continuity models') are common internationally and supported by the highest level evidence [1] and recommendations from the World Health Organization [2].

Midwifery continuity of care models provide each woman with care from a known midwife or a small number of midwives who are known to the woman. These models provide continuity of carer through pregnancy, during labour and birth and usually to six weeks postpartum. To meet the needs of women and be sustainable for midwives, continuity models are innovative and flexible in relation to place of care and midwives' working arrangements. Women with any level of complexity of care benefit from continuity of midwifery care. Midwives consult with and refer to doctors and other caregivers according to guidelines and clinical need.

These models are popular with women, improve birth satisfaction, deliver better perinatal outcomes and are cost-effective. Continuity models also have advantages in the development and retention of a skilled workforce which is responsive to day-to-day demand.

Midwifery education models in Australia have been reshaped in the past decade to reflect the demand for continuity of care for women and also to reflect the unique role of the midwife in contemporary maternity services. Newly graduating midwives expect to work in continuity of care models and have received training which enables them to be autonomous health professionals who look to form partnerships with women and their family for the best health outcomes. For maternity service managers, this means that development of midwifery models, especially providing continuity of care across the full scope of practice, will be required to attract and retain their midwifery workforce. Whole-of-service changes, significant professional development for midwives and adaptation to new ways of working will be required for many staff.

Midwifery continuity of care has been implemented in many health services across Australia, however they are not universal. One study has estimated that less than 10% of Australian women have access to this model of care [3]. Given the high level of evidence supporting midwifery continuity of care it is now imperative that considerable efforts are made to implement continuity models across the country so that all women have access to this evidence-based service [4].

The Australian College of Midwives is committed to supporting access to continuity of midwifery care for women using public maternity services. Many services are now facing the challenge of developing new midwifery skills and capacity as they establish new models or expand existing models.

This handbook has been developed and adapted to support services who wish to deliver continuity of midwifery care to women and families. These models are significantly different from the models most maternity care staff are familiar with, presenting significant challenges for those establishing them. In essence, this is a guide to making the changes needed to build these models, so that they work for staff and for women.

This handbook was originally developed by the Nursing and Midwifery Office of Queensland (NMOQ). The NMOQ kindly gave the Australian College of Midwives permission to use the core content which we have adapted for use nationally. We thank Queensland Health, and also acknowledge the great number of people who have assisted with the initial development and subsequent updating of the handbook.

This Handbook provides an overview of the evidence for midwifery continuity of care and provides a framework for the implementation of these in Australian health systems. This will include an overview of the key components for successful implementation. The handbook is presented in a number of sections which build upon each other, each providing a different focus.

We hope you find the handbook useful in your endeavours to ensure all childbearing women in Australia have access to midwifery continuity of care.

Australian College of Midwives
September 2017

01 Why provide continuity of midwifery care?

Midwifery continuity models are consistently popular with women and there is high quality evidence of improved outcomes. Experience also shows that these models work for midwives and for maternity services, when well-established, well-supported, and when all staff understand how they work.

Historically women in Australia have had limited access to continuity of midwifery care. While many states and territories are moving towards community and primary health models to provide maternity services, including primary midwifery care, Australian maternity services are still based largely in secondary care hospital facilities and in the primary medical care arena.

Midwifery care in Australia is provided through either the public health system or by privately practising midwives; the majority of midwifery care takes place in the public system. Australia has seen steady progress toward increasing women's access to midwifery continuity models over the last 20 years. Birth centres and Midwifery Group Practices (MGPs) are in place in all states and territories and numbers have been increasing. Demand for these models is also increasing. Some states and territories have continuity models that include publicly funded homebirth - New South Wales, Victoria, South Australia, Western Australia and the Northern Territory [5].

While this guide often uses examples of publicly funded maternity services, the Australian College of Midwives recognises the work of privately practising midwives and the growth in this sector. Case studies of the work of such midwives will also be described.

The first survey to explore the national implementation of caseload asked midwifery managers how many of their hospitals had provided publically-funded caseload models of midwifery care. Of the 235 eligible respondents, only 31% reported that their hospital offered caseload midwifery, and most of the women who accessed the programs were considered to be "low obstetric risk". Funding to establish caseload programs was considered to be a key factor by respondents, along with consumer demand, organisational support and staff who were available to work in the program [3].

A summary of the evidence from the Cochrane Library

The safety and quality of midwifery continuity of care is well established [4]. The Cochrane Review of midwife-led continuity of care was updated in 2016 by Jane Sandall and her team. The Review includes 15 randomised controlled trials involving 17,674 mothers and babies [1]. These have direct relevance for the Australian context – of the 15 trials, seven were undertaken in Australia – in New South Wales [6-9], Victoria [10, 11] and Queensland [7, 12]. All 15 trials provided care from professional midwives in collaboration with doctors where necessary. The women in most trials were predominately at low risk of obstetric complications although one of the more recent trials conducted in Sydney, New South Wales and Brisbane, Queensland [7], women were of a mixed obstetric and medical risk status and were not transferred out of the model if they developed further risk factors. Trials that included homebirth were not included.

In the studies that examined satisfaction, women rated midwife-led continuity models highly.

The Cochrane Review shows a number of benefits to women, babies and health systems with no adverse effects compared with other models. Importantly, women who received midwife-led continuity of care were more likely to have a midwife they knew with them during labour and birth, more likely to have a spontaneous vaginal birth and less likely to have epidural analgesia, episiotomies or instrumental births. Women were less likely to experience a preterm birth and they were also at a lower risk of their babies dying (includes all deaths before and after 24 weeks gestation plus neonatal death).

Cost effectiveness was also examined although there was some inconsistency in the way cost outcomes were reported. In general though, there was a trend towards a cost-saving effect for the midwife-led models compared to other care models [1].

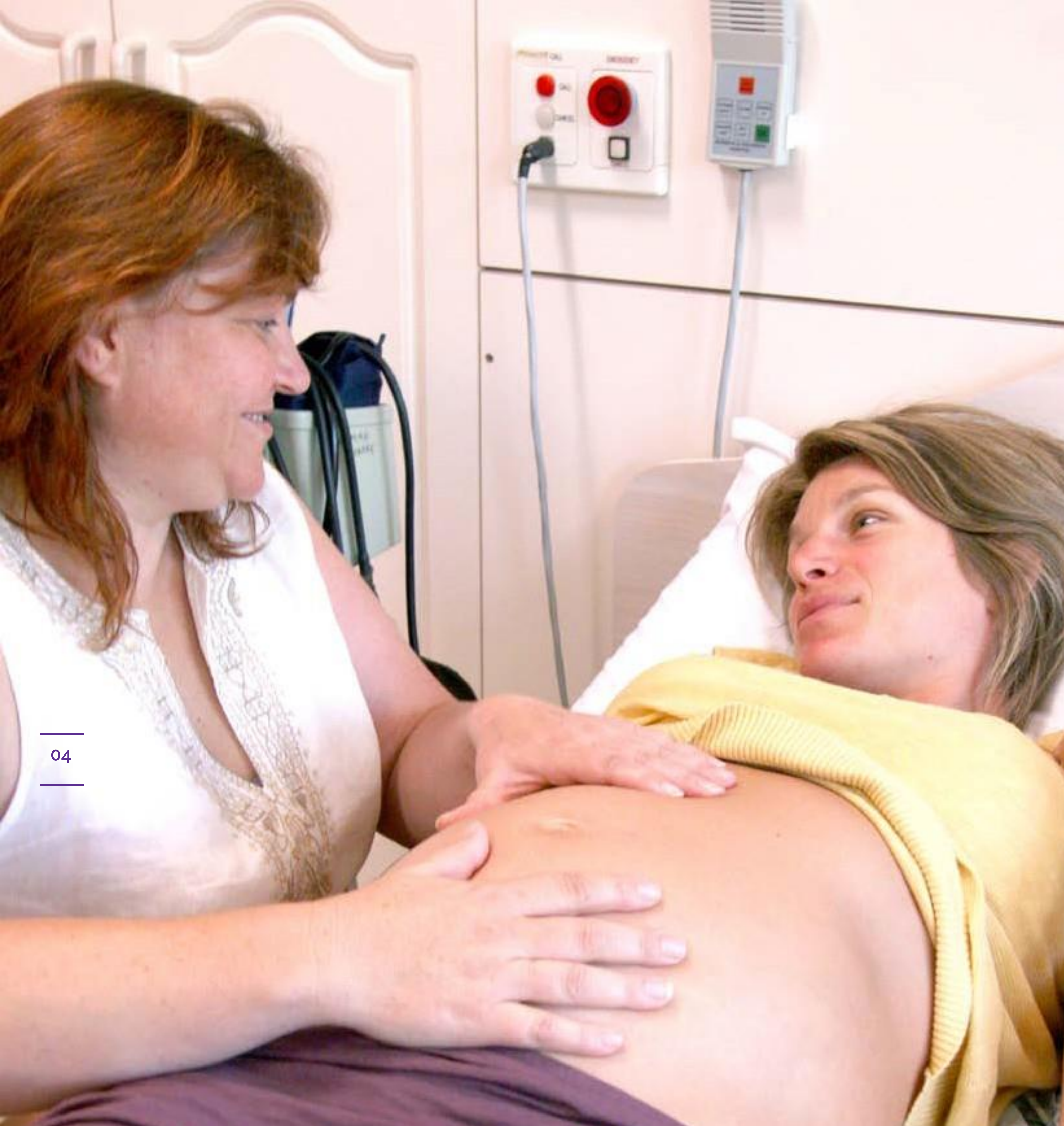
The Cochrane Review concluded that 'most women should be offered midwife-led continuity of care' (p. 3). While some of the trials did include women of mixed risk who were cared for in collaboration with doctors, more research is needed to determine the most effective models of care for women with existing serious pregnancy or health complications.

Recommended by the World Health Organization

In light of the evidence supporting midwifery continuity of care, in 2016 the World Health Organization's guidelines on antenatal care for a positive pregnancy experience [2] recommended that:

RECOMMENDATION E.2: Midwife-led continuity-of-care models, in which a known midwife or small group of known midwives supports a woman throughout the antenatal, intrapartum and postnatal continuum, are recommended for pregnant women in settings with well-functioning midwifery programmes (Context-specific recommendation).

The remarks that followed this recommendation are reproduced in the Box overleaf (page 5).



Midwifery led models of care (MLCC) are models of care in which a known and trusted midwife (caseload midwifery), or small group of known midwives, supports a woman throughout the antenatal, intrapartum and postnatal period, to facilitate a healthy pregnancy and childbirth, and healthy parenting practices.

Midwifery led models of care (MLCC) are models of care in which a known and trusted midwife (caseload midwifery), or small group of known midwives, supports a woman throughout the antenatal, intrapartum and postnatal period, to facilitate a healthy pregnancy and childbirth, and healthy parenting practices.

MLCC models are complex interventions and it is unclear whether the pathway of influence producing these positive effects is the continuity of care, the midwifery philosophy of care or both. The midwifery philosophy inherent in MLCC models may or may not be enacted in standard midwife practice in other models of care.

Policy-makers in settings without well-functioning midwife programmes should consider implementing this model only after successfully scaling up of the number and quality of practising midwives. In addition, stakeholders may wish to consider ways of providing continuous care through other care providers, because women value continuity of care.

The panel noted that with this model of care it is important to monitor resource use, and provider burnout and workload, to determine whether caseload or team care models are more sustainable in individual settings.

MLCC requires that well trained midwives are available in sufficient numbers for each woman to see one or only a small group of midwives throughout pregnancy and during childbirth. This model may therefore require a shift in resources to ensure that the health system has access to a sufficient number of midwives with reasonable caseloads.

The introduction of MLCC may lead to a shift in the roles and responsibilities of midwives as well as other health-care professionals who have previously been responsible for antenatal and postnatal care. Where this is the case, implementation is likely to be more effective if all relevant stakeholders are consulted and human resources departments are involved. In some settings, government-level consultation with professional organizations could also aid implementation processes.

The need for additional one-off or continuing training and education should be assessed, and should be provided where necessary.

The evidence from other relevant studies

Other studies have also shown benefits associated with midwifery continuity of care. For example, a clinical audit including over 300 women who received care from a Medicare-eligible private midwifery group practice reported better outcomes than the national average on selected indicators. Women electing this type of care were less likely to have an induction of labour, pharmacological pain relief, caesarean section and more likely to have a normal vaginal birth [13].

Cost effectiveness has also been examined in another Queensland study [14]. The cost of care for women receiving Midwifery Group Practice (MGP) care at Gold Coast Hospital's Birth Centre was compared with cost of providing standard care to women with the same risk profile. From a hospital cost perspective, the MGP model saved $825 per birth, at $4,696 per birth compared to $5,521 per birth in standard care. Because MGP postnatal care is inclusive of home visits to six weeks compared to home visits to one week in standard care, postnatal costs were higher in MGP care. However, intrapartum and newborn care costs were low enough to realise overall savings [14]. Further savings may be realised in Australia through the evidence of reduction in sick leave, retention of workforce and midwives' improved satisfaction levels from working in MGP models [15] and lower rates of burnout [16, 17].

Women's satisfaction has been reported to be high where midwifery continuity of carer has been available [18, 19]. Many women consider it important to know the person providing their care, especially in labour. Women also want to be able to make choices about their care, which are more easily negotiated with a known individual carer than with an organisation or within team models where it has been reported women can be exposed to up to 30 different carers across the continuum [20].

Midwifery continuity in rural settings in Australia

Australia has a large number of small rural maternity services where birth numbers are low. In some communities, maternity services are provided during the antenatal and postnatal period, but women must travel away from home to give birth. Retaining rural maternity

Throughout the childbirth continuum, the midwife seeks to build and maintain a partnership between herself and the woman, whereby both parties are respected for the valuable contributions they bring to the relationship.

services is important to women and their communities. Midwifery continuity models have significant potential to improve the quality and sustainability of services for women in Australian rural and remote areas.

Current workforce shortages in rural maternity services threaten the sustainability of rural services. Some rural services have identified that providing nursing care for sick non-maternity patients in a shift work model, and providing occasional birth care, undermines midwives' job satisfaction and skill levels. Additionally, this model requires rostering midwives on all shifts and is highly dependent on local GPs to provide shared care, sometimes in areas where GPs are overloaded. In these ways traditional rural models of midwifery practice may contribute to workforce problems [21].

In contrast, continuity models mean that midwives are available for women when they need maternity care. Midwives increase their skills and experience and are able to take higher levels of responsibility for care. Birthing numbers may increase as women, who may previously have travelled to regional centres for birth, choose to stay and use the continuity model [22].

Midwives increase their skills and experience and are able to take higher levels of responsibility for care.

Continuity models may be particularly important for rural Indigenous communities, providing an option for women to give 'birth on country' [23]. Giving birth on country has great cultural significance, in that it gives the baby a spiritual, physical and social connection to the land. Apart from the cultural significance to the individual, there can also be benefits to Indigenous health as a whole, which could help to 'close the gap' between Indigenous and non-Indigenous health outcomes. The benefits occur because the opportunity to give birth in a culturally appropriate way is closely linked to the willingness of Indigenous women to engage in midwifery services, which will impact significantly upon the perinatal health of the baby and mother [23, 24].

International examples

While midwifery continuity models are only available to a small proportion of Australian women, they are well-established in several other countries and are standard care.

For example, New Zealand women can choose a Lead Maternity Carer (LMC), who can be a midwife, GP or obstetrician [25]. Midwife LMCs provide continuity of care to a caseload of women from community-based private practices, often called "group practices", in which several midwives work together. Midwife LMCs provide antenatal and postnatal care mostly in the community and birth care in urban hospitals, rural primary birthing units or at home, sometimes in remote locations. "Core" midwives based in hospitals, working shifts, support the primary midwives when women are admitted. Introduction of this model started in 1990 after reform of NZ's health legislation allowed midwives access to maternity funding. As well as delivering greater continuity of carer to NZ women, these reforms have delivered cost savings through reducing interventions and resources and cost shifting more expensive secondary services to primary and community services.

In 2012, the majority of women giving birth in New Zealand were registered with a midwife lead maternity carer (LMC) (92.0% of women who were registered with an LMC) [25]

In the United Kingdom (UK), The National Health Service (NHS), covering health services provides community-based midwifery continuity of care to a high proportion of women. There has been a long history of support for midwifery continuity pf care over the past two decades. Most recently, the Better Births [26] policy from the UK Department of Health has stated that:

Every woman should have a midwife, who is part of a small team of 4 to 6 midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally (page 9)

Ensuring cultural safety through midwifery continuity of care

A benefit of continuity of midwifery care is that cultural safety can be facilitated by the model. Culture includes, but is not limited to, age or generation; gender; sexual orientation; occupation and socio-economic status; ethnic origin or migrant experience; religious or spiritual belief; and disability' [31]. Cultural safety means the midwife evaluates privately held belief patterns and is able to understand, and mitigate, the impact this has on their provision of maternity care.

The benefit of cultural safety is the improved health status of those who access healthcare services. This is particularly important for Aboriginal and Torres Strait Islander mothers and infants who have poorer perinatal outcomes compared to non-Indigenous mothers and babies. Culturally safe care for Aboriginal and Torres Strait Islander birthing women need to address social, emotional, cultural health needs, and be as close to home as possible [23, 32, 33]. Midwifery continuity of care can meet these needs.

Throughout the childbirth continuum, the midwife seeks to build and maintain a partnership between herself and the woman, whereby both parties are respected for the valuable contributions they bring to the relationship. Women from socially and ethnically diverse backgrounds value caseload midwifery compared to standard care [34]. Specifically they appreciate the ability to form a close relationship with their midwife and feel more able to openly discuss their concerns with their midwife [34].

Conclusion

The evidence showing the benefit of midwifery continuity of care for women, providers and organisations is now clear. A re-organisation of the way maternity services are provided across Australia is now required [4]. This Handbook will provide a blueprint to enable this to occur.

02 Midwifery continuity models - what do they look like?

This section provides an introduction to midwifery continuity models. The ways midwives actually provide care, including on-call and off-call arrangements and day-to-day clinical care, are outlined in Section 10. Detailed case studies from across Australia have been provided (see Appendices 1-3).

One way to determine whether the service provides midwifery continuity of care is ask the woman "who is your midwife and what is her contact number?" If the woman is able to tell you, then the service is offering continuity of care. In situations where the woman does not know, or isn't sure, the service obviously is not providing continuity of care.

Definitions

Models of maternity care is a phrase widely used but it is often unclear what this actually means [12]. In Australia, models of maternity care are provided in a number of ways – including in the public and private sectors; for normal-risk, high-risk and all risk women; from midwives, general practitioner (GP) obstetricians, specialist obstetricians and trainee obstetricians; and in hospitals and in the community. A national project has undertaken to classify all the possible models of maternity care [35, 36]. This is known as the Maternity Care Classification System, or MaCCS [37]. There are more than 10 major model categories including midwifery models of care that provide continuity of care (see Table 1). Midwife-led continuity of care models includes midwifery group practice caseload care, team midwifery care and private midwifery care.

A national project has undertaken to classify all the possible models of maternity care [35, 36]. This is known as the Maternity Care Classification System, or MaCCS [37].

Table 1: Identified major models of maternity care in Australia [35]

Major model category	Brief description
Private obstetric (specialist) care	Antenatal care provided by a private specialist obstetrician. Intrapartum care provided in a private or public hospital by the private specialist obstetrician and hospital midwives. Postnatal care provided in hospital and or later at home or in a hotel.
Private midwifery care	Antenatal, intrapartum and postnatal care provided by a private midwife or group of midwives in collaboration with doctors if needed*. Intrapartum and postnatal care provided in a range of locations including at home.
General practitioner obstetrician care	GP obstetrician provides antenatal care. Intrapartum care in a private or public hospital by the GP obstetrician and hospital midwives. Postnatal care provided in the hospital by the GP obstetrician and hospital midwives and may continue in the home or community
Shared care	Antenatal care provided by a community provider (doctor and/or midwife) in collaboration with hospital staff under an established agreement. Intrapartum and early postnatal care usually takes place in the hospital with hospital midwives and doctors, often in conjunction with the community provider (particularly in rural settings).
Combined care	Antenatal care provided by a private maternity service provider (doctor and/or midwife) in the community. Intrapartum and early postnatal care provided in the public hospital by hospital midwives and doctors. Postnatal care may continue in the home or community by hospital midwives.
Public hospital maternity care	Antenatal care provided in hospital outpatient clinics (onsite or outreach) by midwives and/or doctors. Intrapartum and postnatal care is provided in the hospital by midwives and doctors. Postnatal care may continue in the home or community by hospital midwives.
Public hospital high risk maternity care	Antenatal care is provided to women with medical high risk/complex pregnancies by maternity care providers (specialist obstetricians and/or maternal-fetal medicine subspecialists with midwives) with an interest in high risk maternity care in a public hospital. Intrapartum and postnatal care is provided by hospital doctors and midwives. Postnatal care may continue in the home or community by hospital midwives.
Team midwifery care	Antenatal, intrapartum and postnatal care provided by a small team of rostered midwives in collaboration with doctors where needed. Intrapartum care is usually provided in a hospital or birth centre. Postnatal care may continue in the home or community by the team midwives.
Midwifery group practice (public) caseload care	Antenatal, intrapartum and postnatal care provided by a known primary midwife with secondary backup midwife/midwives providing cover and assistance with doctors where needed. Antenatal and postnatal care is provided in the hospital, community or home with intrapartum care in a hospital, birth centre or home.
Remote area maternity care	Antenatal and postnatal care provided in remote communities by a remote area midwife (or a remote area nurse) or group of midwives sometimes in collaboration with a remote area nurse and/or doctor, with telehealth or fly-in-fly-out clinicians. Intrapartum and postnatal care provided in a regional or metropolitan hospital (involving temporary relocation prior to labour) by hospital midwives and doctors.
Private obstetrician and privately practising midwife joint care	Antenatal, intrapartum and postnatal care is provided by a privately practising obstetrician and midwife from the same private practice. Intrapartum care is provided in either a private or public hospital by the private specialist obstetrician, privately practising midwife and/or with hospital midwifery staff. Postnatal care provided in the hospital and may continue on in the home, hotel or hostel by the private midwife.

* Collaboration with doctors 'where needed' means 'in the event of identified risk factors'.

The definitions below are more specific to the different terms used in midwifery continuity of care. These are commonly used terms in Australian health systems [38].

Major model category	Brief description
Caseload midwifery	In caseload midwifery, each woman has a primary midwife providing the majority of her pregnancy, birth and post birth care. This model is also referred to as a "continuity of carer model" or "one to one" midwifery care. Caseload midwives provide care to a defined number of women per year (their annual caseload), organise their time flexibly around their women's care needs in an on-call capacity [38] and don't work rostered shifts. Private practice midwives typically provide care in a caseload model.
Midwifery Group Practice (MGP)	A MGP is the organisational or management unit in which caseload midwives usually work [38]. The purpose of the MGP is to support the practice of the caseload midwives within it and to facilitate communication within the MGP and with management. Within Australia most caseload midwives work in a MGP. There may be more than one MGP within a facility.
Maternity Care Co-ordinator	This person is nominated by the woman to coordinate her maternity care . This is usually a primary maternity care provider such as a midwife or GP. In the private hospital sector, this may be the woman's private obstetrician. In an MGP the woman's primary midwife would also be her maternity care coordinator. An important part of the role is to coordinate the woman's access to services and care from other clinicians according to her needs.
Primary midwife	Each woman receiving caseload midwifery care will have a "primary midwife" who provides the majority of her midwifery care and is her maternity care coordinator. 'Known midwife' and 'named midwife' have the same meaning as 'primary midwife'. The woman will probably describe her primary midwife as 'my midwife'.
Team midwifery	A model of maternity care in which a woman receives all of her midwifery care from a team of midwives (six to eight midwives, sometimes more, sometimes less), but does not have a primary midwife. Meeting a number of the team midwives antenatally may provide some relational continuity for intrapartum care. Team midwives usually work in shifts across the 24 hour day, and rotate across the antenatal, intrapartum and postnatal stages of care for their group of women [38]. In effect, the whole team carries a case load collectively. In general, team midwives do not work on-call and are not paid an annualised salary. There may be more than one team operating within the same facility.

In midwifery continuity of care, a woman has a 'named' or 'primary' midwife, typically working with one or more backup midwives, providing care from early in pregnancy, throughout pregnancy, labour and birth, to six weeks following birth.

Characteristics of a midwifery continuity of care model

The key characteristics that define an Australian continuity model that they [38]:

- aim to provide the woman with access to a known midwife at all times during pregnancy, labour and birth and the postnatal period
- provide antenatal in a range of venues: community centres, hospital and home
- have midwives who facilitate information sharing and antenatal support
- include planning, involving the whole family, around birth and postnatal care
- enable the woman to know her midwife who cares for her during labour and birth
- provide care during labour and birth in whichever setting is appropriate for the individual needs and wishes of the woman and depends on what is available locally.
- provide postnatal and newborn care in the community with much of it taking place in the woman's home.
- facilitate consultation and referral using the ACM National Midwifery Guidelines for Consultation and Referral [39]

What is a midwifery continuity model?

In midwifery continuity of care, a woman has a 'named' or 'primary' midwife, typically working with one or more backup midwives, providing care from early in pregnancy, throughout pregnancy, labour and birth, to six weeks following birth. The primary midwife is the woman's coordinator of care, facilitating her access to more complex care and other carers (often obstetricians) according to her needs.

It is important to consider continuity models from a woman's perspective. Women want:

- to know who is responsible for their care
- to have most of their primary care provided by the same caregiver
- to have access to that caregiver when they consider it important.

Having intrapartum care from their known and trusted midwife is particularly highly valued.

Midwifery Group Practice (MGP) is the most commonly used term to describe midwifery continuity of care in Australia. The MGP is organised to maximise continuity of carer for individual women, while supporting and sustaining midwives in their work. The key to effective delivery of care by an MGP is to ensure partnership and backup arrangements within the MGP to provide care to each woman from only two or three midwives.

There are a range of ways to organise midwives' work in an MGP, which are described in Section 9.

A key function of an MGP is to provide backup for each caseload midwife and ensure she has adequate rest and time off-call. This is commonly achieved by midwives working in partnership pairs (or occasionally groups of three). The 'pair' may be consistent or may only work together on a case by case basis. Partnership pairs or threes negotiate backup arrangements for each other's women.

Each midwife will be the named midwife for a number of women. They will also have another group of women for whom they are the back-up midwife. In small MGPs the woman's access to a known care provider for intrapartum care is relatively straightforward, as the pool of possible caregivers is small. In larger MGPs (≥4 midwives), women's access to continuity of carer, particularly for intrapartum care, must be tightly monitored. Broadly distributed backup arrangements (e.g. whole group providing back up) in large MGP's will tend to provide only a small proportion of women with care from their named midwife in labour and birth.

Team midwifery care is another way of providing midwifery continuity of care although in this approach there is usually less continuity of carer provided to women. Team midwifery is provided by a group of midwives who work shifts, but also rotate across antenatal, intrapartum and postnatal stages of care. This builds midwives' skills and may deliver increased continuity of care, but generally delivers a low level of continuity of carer to women and may also contribute to fragmentation of care [40].

An Australian trial of caseload midwifery found that women with known midwives were admitted to hospital later in labour and were less likely to have their labours augmented with accompanying interventions [44].

Where to locate care?

As women progress through pregnancy, the midwife meets their continuity needs by working in various environments, particularly the woman's own home. This brings benefits to the woman as well as to the midwife and the institution. Ideally, care should be local or feel local for women [41].

For urban units the challenge is to reorient care provision from predominantly hospital-based services to community-based services. The change in the way urban units provide care is explained throughout this handbook with considerations such as transport, equipment and staffing.

Rural maternity services face a significant change to the entire way hospitals are staffed and care is provided. The move to midwifery continuity of care models within rural units is essential to sustainable service provision and is in alignment with consumer preference. The challenge for rural units is understood and this guide provides these units with step by step processes to reorient their entire service.

Antenatal care – including home, hospital clinics, community centres

Antenatal care can be provided in a range of settings. The most common settings for midwifery continuity models are the woman's home or the hospital where the midwife is based. However, midwives are increasingly moving out into the community to provide care in a range of other settings including shopping centres, community health facilities, other practitioners' clinical space (including medical practitioners), private clinic locations and agencies such as young women's services.

Home-visiting can provide the midwife with an insight into the woman's home environment, her social support network and the other external factors that may be impacting her pregnancy.

Labour and birth care

Labour and birth care may be provided in a hospital birth suite, a birth centre or potentially in the woman's home. For well women, evidence supports the use of specific, low-risk-focussed birth environments [42].

It is important, however, not to confuse place of birth care with model of care.

Midwifery continuity of care has the potential to address early presentation to hospital. Presentation to hospital in early labour is associated with an increase in unnecessary admissions increasing bed occupancy and costs. It is also associated with increased intrapartum intervention rates [43].

In midwifery continuity of care, intrapartum care usually starts with phone contact between the woman and her midwife (or back-up midwife). The midwife's familiarity with the woman usually helps her to make decisions about early labour care and when to travel to the place of birth, if not birthing at home. Early labour care may be provided in the woman's home in some instances. This may avoid early admission to hospital as an essential aspect to improving outcomes.

An Australian trial of caseload midwifery found that women with known midwives were admitted to hospital later in labour and were less likely to have their labours augmented with accompanying interventions [44]. Remaining at home in early labour (before 5 cm cervical dilation) may be one of the mechanisms by which caseload care was effective in reducing caesarean section.

- **Early labour care at home**

  Some MGPs provide for women to be visited in their home for early labour assessment by their primary midwife. If the midwife's clients are within a limited geographical area, the midwife can schedule antenatal and postnatal home visits for other women around early labour care of the woman. This provides for effective and supportive care, minimises unnecessary hospital attendances for the woman and enables efficient use of the midwife's time.

- **Complex care in labour and birth**

  In situations of increasing complexity, the woman's named midwife—her maternity care coordinator—continues to provide primary care and continuity. Women who start labour at home or in a birth centre may be transferred to secondary care providers such as obstetricians, or tertiary care facilities. When practical it is highly desirable that the midwife continue to provide midwifery care to the woman. This maintains continuity of care, supports the woman's plans and choices, is very reassuring to the woman. Continuity in these situations also maintains midwives' skills in complex care (e.g. induction of labour).

- **Midwifery continuity during and after transfer**

  In some cases, when women need to transfer from rural continuity of care models to a tertiary setting they will be accompanied by their MGP midwife, who may then provide ongoing primary midwifery intrapartum care during obstetric-led care. In other rural settings women will have the midwife organise their transfer but, dependent on workloads at the primary hospital, they may not provide ongoing care at the transfer site. Midwives in most birth centres continue to provide care to women following transfer to hospital birth suites. Midwives in MGPs without designated birth centres also continue to provide care by the primary midwife should the woman's care be transferred to obstetric care in birth suite.

Postnatal care

In many midwifery continuity of care models, especially those for healthy women of normal risk status, initial postnatal care is provided for a period of a few hours (usually four to six) in hospital with women offered early discharge from birth suite or early discharge within 24 hours from the postnatal ward. There is the potential for longer hospital stays if clinically required by mother or baby. After this time most postnatal care is provided in the woman's home. Some women may attend hospital, community facilities or clinics for particular needs.

Postnatal care in the home enables a midwife to assist the woman with the transition to mothering in her own environment, importantly this avoids the stress of travel early in the postnatal period allowing vital family rest and stability. By working with the woman in her own environment, the midwife can assess and support the woman's adaptation to parenting within the woman's context, environment and family.

Breastfeeding support is a key part of postnatal care and is greatly enhanced by continuity of midwifery care. Women benefit from receiving advice from one midwife (instead of contradictory advice from multiple caregivers) who can work through challenges with them. Ongoing access to midwifery care by phone and home visiting enables early intervention in breastfeeding crises when women are at risk of losing confidence and giving up.

As with antenatal care, postnatal care in the woman's home helps the midwife to understand the woman's social circumstances.

Postnatal care is most effective if it continues for six weeks. There may be times late in the postnatal period where the woman may prefer to come to the midwife. The midwife may also provide postnatal care at a community base or clinic, possibly in conjunction with group education. Both of these situations may provide an opportunity for the woman to start to develop or extend social networks with women in the community. The primary or back-up MGP midwife continues to be available on-call 24 hours a day to respond to any urgent postnatal concerns.

Transition to child health care

Prior to the midwife concluding her care with the woman, at around six weeks postpartum, the woman is linked to community and child and family health services (also known as maternal and child health services in some parts of Australia). This ensures a seamless transition of care.

In circumstances where the woman and her baby would benefit from earlier integration to child health services, child health practitioners may be involved in care with the midwife during the antenatal period and/or immediate post-birth period to ensure continuity of care is extended beyond six weeks. Continuity of care midwives are very well placed to work with child and family health services as the partnership between the woman and the midwife can provide the basis for a longer term relationship with child health services.

Balancing on-call in midwifery continuity of care

In many caseload models, midwives are on call only for their own women. In these cases, callouts will be infrequent; however midwives do need time off-call. The aim for midwives is to work out a method which allows adequate time off-call, while ensuring most women receive care from their primary midwife. There are a number of approaches to on-call in these models which are presented below.

1. Time off in short periods (e.g. a night off-call to provide for adequate sleep and sustainability).

In this approach, time off is organised to fit around births. You remain on-call for your own clients for birth, having periods off-call for all other aspects of care. This way the midwife may have 'days off' set down unless a birth occurs. The midwives in a partnership need to be vigilant; to ensure required time off is taken.

It is important that women meet midwives who are named as the backup midwives for their birth so that they are familiar with possible alternative caregivers. In models where the majority of care is in the home, one or two appointments may be scheduled in a community or hospital setting during the pregnancy where all midwives in the MGP attend.

It is important to recognise that midwives' hours will fluctuate very significantly and that at times midwives will work much more than a 38 hour week. This needs to be offset by weeks where the midwife works much less than a 38 hour week. Industrial conditions will regulate within what timeframe hours need to average out.

2. Caseload—rostered off-call

Midwives working within group practice models often work in this way. Off-call time, usually two days per week, is rostered in accordance with the industrial Award. From within the MGP back-up midwife/ midwives provide care when their colleagues are rostered off-call. Depending on these arrangements and the woman's ability to meet the backup midwife/ midwives, continuity of carer is high.

Midwives working this way may have a consistent partner. Essentially the midwife is the named midwife for their own caseload and the named backup for their partner's caseload. They get to know both groups of women well.

Time off can be organised regularly with set times each week where your partner midwife is on-call for your women. For example midwives working in pairs may alternate weekends off and have the same day off each week. This enables long-term planning and allows for days 'work free'. It also allows for a flexible day off in the fortnight to avoid fatigue.

An alternative way of providing rostered off-call is to provide care for your own caseload and have one or more colleagues within the MGP who are named as backup on a client by client basis. This requires slightly more complex off-call rostering to ensure that off-call time does not clash and that at least one of the known midwives is available for every woman.

3. Caseload—rostered on-call

Rostered off-call means midwives have their own caseload for whom they are the named or primary midwife, however they limit the time they are on-call. Typically, the on-call component is one or two nights per week. It also may vary depending on whether the midwives are full or part-time and how many midwives are within the MGP.

This way of working limits women's access to their primary midwife for intrapartum care to one to two nights per week. The level of continuity of carer will be reduced. However this model has evolved to reduce midwives' on-call time, minimising disruption to their lives.

It is important to consider other stressors in this model:

- Midwives are on-call for large numbers of women (i.e. the whole of the MGP). The size of the MGP will determine how many women the midwife is on-call for.
- Midwives are caring for women for whom they are not the named midwife. This minimises the benefits of the midwifery partnership to the woman and the midwife.
- The additional stress for midwives being on-call for the whole MGP means that recovery time after an evening/night on-call is more significant.

Appendices 1-3 have a number of examples about the implementation of continuity of midwifery models around Australia.

Other ways of providing midwifery continuity of care

Group antenatal or postnatal care is another way that continuity of care may be provided. Group antenatal or pregnancy care was initially developed in the USA in a model known as CenteringPregnancy. Care is provided by a midwife or an obstetrician to groups of eight to 12 women of similar gestational age. Groups meet eight to 10 times during pregnancy at the usual scheduled visits, with sessions running for 90 to 120 minutes. All pregnancy care is provided in this group setting by integrating the usual pregnancy health assessment with information, education and peer support [45]. Group antenatal care has now been implemented in Australia –including in New South Wales [46-48] and Queensland [49].

Group antenatal care is generally provided from a community-based centre. Midwives may have any or all of their clients attend these sessions so they are able to meet their partner midwives' clients. Sessions generally occur once a week. This method of provision of care is best suited to the middle to late weeks of pregnancy where visits are frequent and women have formed a relationship with their care provider. It is also possible for midwives to provide this type of care postnatally, after the initial postnatal period when feeding is being established.

The following list identifies some of the essential elements of group antenatal care [47, 50]:

- health care and pregnancy assessment is provided in the group space
- women are involved in self-care activities such as opportunity for massage
- the group is not "conducted" by an expert, rather facilitated
- the group is not rigid, but is relatively stable
- the leadership is also relatively stable.
- discussions are triggered by scenarios or returning group members

The benefit of this model is that it maximises effective use of education time as the midwife provides educational sessions once, rather than spending time discussing the same elements with each woman individually. The other significant benefit in using a group model for antenatal care is the relationships that are built within the group. This relationship also tends to decrease reliance on health practitioners.

However, there has been very little research on the combination of group antenatal care into a caseload midwifery model. Replacing one-to-one appointments with group antenatal care could influence the development of the midwife-woman relationship in a caseload midwifery model [49].

03 Key elements to implementing midwifery continuity of care

This section explores a number of elements which have been found to determine the success of midwifery continuity models:

- woman-centred philosophy of care
- vision
- leadership
- communication pathways
- Clear expectations
- engagement of stakeholders

The text, Midwifery Continuity of Care: A Practical Guide [38] is referred to several times and is recommended reading.

A woman-centred philosophy

Most maternity care providers are familiar with the term woman-centred care. Patient-centred care is recognised as a dimension of high quality health care providing strong evidence of quality health improvements through increasing safety, cost effectiveness and client and family satisfaction [51]. For maternity services, the concept of patient-centred care translates to woman-centred care.

Midwifery is a woman-centred primary health care discipline founded on the relationship between the woman and her midwife. These principles are mandated in regulatory documents [52]. The Primary Maternity Services document [53] and the National Maternity Plan [54] both identify woman-centred care provision as the foundation of service development.

A woman-centred model of care is designed to allow the woman to make informed choices. A woman's individual needs and context are the basis from which decisions for care are considered

Woman-centred care:

- is focused on the woman's individual, unique needs, expectations and aspirations rather than the needs of institutions or professions involved;
- recognises the woman's right to self-determination in terms of choice, control and continuity of care from a known caregiver or caregivers;
- encompasses the needs of the baby, the woman's family, her significant others and community, as identified and negotiated by the woman herself;
- follows the woman across the interface between institutions and the community, through all phases of pregnancy, birth and the postnatal period, involving collaboration with other health professionals when necessary;
- is holistic in terms of addressing the woman's social, emotional, physical, psychological, spiritual and cultural needs and expectations;
- recognises the woman's expertise in decision making [52]

Vision

Having a clear vision for your service is vital. Staff involved in the transition of services must have belief and conviction in the model. Some years ago the following preconditions to successful organisational change were articulated [55]. We have included and adapted them here as they still stand as important aspects of having a clear vision. In order to be successful, the organisation and the individuals must have a:

- genuine will to succeed
- clearly articulated vision for the model that is mutually developed by providers and women
- understanding of the central values of the model
- willingness to share from grass roots to executive

The vision needs to address key aspects including the:

- size of the model in terms of women and midwives
- arrangements or organisation of provision of care (model of care)
- places/settings care is to be provided
- who the service relates to (e.g. specific needs groups, all risk, low risk)
- how the model interrelates to existing staff or co-exists with conventional models and other services.

Having values and vision that is shared within the entire maternity unit will be very useful and worth the time to develop. A short, clear mission statement ensures a consistent message is provided for communication both within the unit and to external stakeholders.

Leadership

The most critical aspect in implementation of midwifery models of care is leadership. Without leaders who understand and embrace the key elements of midwifery continuity of care, midwifery models will not succeed. Leadership also requires effective succession planning to ensure that all levels of a service maintain and develop the vision of the model.

Historically, services have operated within what may have been regarded as a multidisciplinary team approach, but this has been largely within a hierarchal arrangement which often fails to use the skills of the midwives effectively. Generally senior nurses and medical practitioners have been responsible for decision making in a top-down approach.

Undertaking a leadership role in developing a new midwifery continuity service is different from leading a traditional maternity service. Facilitating and leading change requires an ability to be innovative and to negotiate the existing system, networks and philosophical barriers. The leader's role includes communicating the vision for the model, protecting the philosophy of woman-centred care and supporting and making understood the autonomous role of the midwife. Leaders require the energy to change both the direction of a service and the placement of midwives within nursing structures and medical models.

Key issues for leaders in midwifery continuity models

Leaders need to understand woman-centred care and informed choice. They must understand the philosophy for the model is the rudder that keeps it on course. A key requirement for leaders in midwifery continuity of care models is that they not only understand the value of midwifery continuity of care but also embrace the model. The commitment and drive required to transform traditional models to midwifery continuity of care requires leaders to research and understand the importance of continuity of care for women.

Leadership from the health services is required to:

- support and articulate to others that midwifery continuity of care is gold standard maternity care and needs to be widely implemented in all services in Australia
- facilitate women to be a key partner in the development, planning and implementation of midwifery continuity of care
- ensure that midwives can be self-managing and receive support and access to ongoing professional growth and development opportunities.
- inspire and ensure development of policy and processes that support the development of midwifery continuity of care.
- clarify and model respectful communication and collaborative interdisciplinary relationships as is expected in the provision of contemporary woman-centred care.
- guide and monitor development of, and agreement to, robust maternity clinical governance providing for safety and sustainability.

Leaders need to understand woman-centred care and informed choice.

There is a need for patience and persistence to develop interdisciplinary relationships which have a basis of respect and collegiality. This leads to trust in the midwives as primary caregivers. Organisations that trust midwives as primary caregivers are most likely to succeed in implementing midwifery continuity of care models.

Communication

Establishing effective communication within services can be challenging. A communication plan ensuring all stakeholders within the service are, and remain, aware and updated on the development of the new model is one element of successful implementation of the model.

Successful communication involves:

- identifying key multidisciplinary leaders who can influence change within the service
- open dialogue within the service is required to identify the level of support for midwifery continuity of care models
- a positive commitment to inclusion, shared decision making and problem solving and identifying barriers.

Securing a senior level sponsor for the development of the model is important and provides a shared responsibility for success. It is strategically effective to have communication and discussion within the organisation led by a person in a position of influence who can provide guidance in relation to strategies and available resources and who can keep the model on the agenda at state-wide and local government meetings.

Effective communication ensures everyone has:

- been identified for inclusion in the steering committee for the model (see Engaging Stakeholders below)
- access to information i.e. proposal shared, minutes of meetings are available and displayed, information sessions provided, newsletters distributed
- opportunities to contribute i.e. genuine representation within planning or management groups
- processes for clarification i.e. consultation has occurred at a number of levels and

The entire team needs to be involved in planning communication processes. In one MGP model, obstetricians were unable to attend regular collaborative clinical meetings with the midwives because the administration team had changed the obstetric rosters. Despite seeking rectification of this, senior administrators seemed not to comprehend the importance of these meetings to the sustainability of the model. This resulted in internal conflict and major difficulties for the service. Significant discussion and an entirely new way of approaching collaborative meetings (new time, new people involved, quicker processes) was required to resolve the situation.

Clear expectations

Staff working in midwifery continuity of care models will need to have a clear picture of what they can expect. Communication of the expectations leaves staff with clarity about their roles. It is important to document role delineation so that if situations arise where staff members act outside of the parameters expected of them, there are opportunities for early resolution of difficulties.

Expectations to address include:

- What is the arrangement for midwife-midwife handover of care, by what means and with whom?
- When and where are clinical outcomes recorded and audited?
- Who and how can collaborating staff be contacted regarding variations in a woman's health?
- How will staff respond when women choose to take a different path to that which is recommended?

A range of communication strategies are outlined in Section 10 and Section 11.

> Communication of the expectations leaves staf f with clarity about their roles.

Engagement of stakeholders

Engaging stakeholders with diverse expertise and motivation for the model informs direction, identifies opportunities and threats and allows open dialogue for planning, developing, implementing and sustaining models. Stakeholders may include midwives and medical officers, child and family health nurses, service administrators, business managers, industrial representatives and partners with whom the service networks.

Consumers

A woman-centred model of care requires consumer engagement in development and ongoing management. Consumer input raises issues possibly not considered by the service providers. Consumer representation also facilitates focus on consumer needs by clinicians and management at the table as consumers are ultimately the reason for the existence of the service.

Managers and service leaders

Early engagement of senior administrative and management staff is required for development of new models. See a brief outline in Section 4 about steps in this process:

The Executive Director of Nursing and Midwifery, the Chief Executive Officer of the service, the Director of Nursing and Midwifery and the Director of Obstetrics for the service should be involved from the very early planning stages as staff who have overall responsibility for the service.

The business manager should participate actively to advise on expenditure for equipment, facilities and redirection of funds from mainstream maternity services. The business manager will be involved in developing the project plan and business case and should participate in the steering committee.

Senior staff providing support at an external site where transfers may be received or sent would be invited to participate at a steering committee level, working group or community forum level depending on their discipline and involvement.

In situations where the service is working with the nearest tertiary hospital for birth care or other services, the tertiary service must be fully engaged as a stakeholder in the development of communication processes and pathways.

Midwifery Unit Managers providing the day-to-day services will either manage the project or be closely involved with the project officer. Unit size and context of practice will determine which unit managers are involved (this may include areas external to maternity such as the accident and emergency department in rural areas).

Obstetric and neonatal services

Meaningful engagement of medical staff is essential [56]. New models that have developed successfully have found that one or more consultants attached to a group of continuity midwives provide for improved interdisciplinary relationships and assist with continuity of care.

Please see Section 11 which discusses initial engagement, communication and collaboration with medical staff.

In larger units, neonatal or paediatric staff should be involved from initial planning and development through implementation, ongoing collaboration and evaluation. Opportunities for meaningful contribution from other medical staff may need to be actively pursued.

Engagement and collaboration with GPs is covered in Section 11. The timing and involvement of GPs depends on the local context and the role of GPs within the model. In rural areas, where the model is dependent on GP engagement, Section 11 should be studied in detail.

Midwives: core and potential caseload

Midwives working in a service where a new model is to be introduced will be affected whether they are employed in the model or not. Ensure that midwives across the service are aware how the model inter-relates with existing services, or how any services will be realigned. Communication strategies have been outlined throughout this document.

Steering committees must include representation of midwives planning to work in the continuity model as well as core midwifery staff. All staff must have an opportunity to be a vital member of the team and be equally valued in relation to their input.

Industrial organisations

The various Nursing and Midwifery and/or Nursing unions around Australia play an advocacy and expert role in advising on the industrial processes and legal working arrangements for staff in the midwifery continuity of care model and also remaining maternity and nursing staff.

Industrial representation should be sourced via a written request to the State Secretary of the union in question so that appropriate representation can be provided and supported.

Facilitated meetings are required between managers within the service, the union and MGP midwives to discuss model proposal, workforce, and population demographics, to ensure safe working arrangements and for annualised salary.

Unions have a key role in supporting midwives and midwifery models. They are more likely to support models that increase workforce satisfaction and facilitate differentiated career paths.

Professional organisations

Professional organisations such as the Australian College of Midwives are also important stakeholders. For example, members of the ACM around the country have expertise and experience with midwifery continuity of care and could play a significant support and advisory role. ACM can also provide access to mentors, ongoing continuity professional development and networking with others models across the country.

Professional representation should be sourced via a written request to the Chief Executive Officer in question so that appropriate representation can be provided and supported.

Other key partnerships

A range of partnerships with interconnected services are integral to midwifery continuity of care. Some partnerships are consolidated through service agreements or collaborative arrangements to secure continuity of care beyond the facility. Other partnerships complement the local model, such as emergency transport services, community services or higher level maternity support services.

Communicating with stakeholders

Once initial links are made, a range of communication strategies may be used to keep the community informed about changes that may directly or indirectly affect them. Examples include community flyers, local newspaper articles and public forums. One essential component of ongoing community participation is consumer representation on the committee/s associated with your project.

The media represents an extremely useful tool in developing and implementing a new model. Media releases may help when networking and communication is required to identify external stakeholders. Once the model is being implemented the media will be very interested to report on progress (especially the first birth), as mothers and babies are usually a popular subject. Opportunities to promote your service should be acted upon. The communication support unit of your hospital or district can be of great help in this area.

A range of partnerships with interconnected services are integral to midwifery continuity of care. Some partnerships are consolidated through service agreements or collaborative arrangements to secure continuity of care beyond the facility.

04 Implementing a new model

This section outlines the steps in planning, preparing and implementing a new midwifery continuity model. Brief explanations are provided, with signposting to other sections of this handbook which provide more detail.

Dependent upon existing resources and community links, planning and preparing for implementation may take 8 to 12 months. Carefully approaching the planning process will avoid significant difficulties later on in the implementation phase.

Implementation tasks have been listed below under five headings:

- **Phase 1—Preparation:** Steps taken by senior management to allow the establishment of a new model of care.
- **Phase 2—Commencement of the project:** Detailed consultation and decision-making about what the model will look like.
- **Phase 3—Pre-implementation:** Detailed planning and preparations for implementation.
- **Phase 4—Implementation:** Assisting midwifery staff to deliver care and function effectively in the service.
- **Phase 5—Evaluation:** this must be factored into implementation.

Not all services will need to follow each step below in the specified order. Steps may need to be re-ordered due to local needs and some steps may have already been achieved.

Phase 1 - Preparation

A senior executive sponsor or sponsors for implementation (in most cases the Director of Nursing and Midwifery (DONM) or the Executive Director of Nursing and Midwifery (EDNM) needs to be identified. A group to lead the development of the model of care is required – this would usually be a Midwifery Unit Manager or senior clinical midwife.

The executive sponsor ensures the leadership team have the change management skills to enable the model to be successfully commenced.

This phase may also include the need for funding for a project officer but this is not always required.

Staff in the service need to be informed about the model of care that will be implemented and the timeline. Opportunities to announce plans in the media can be considered by the executive sponsor (e.g. community forums or media events).

Phase 2 - Commencing the implementation process

An implementation plan needs to be developed. This will identify a timeline and a process for the establishment of a steering committee to guide the implementation. This should also identify internal and external stakeholders for inclusion on the steering committee or for engagement through other communication strategies.

Terms of reference for the steering committee need to be developed and meetings for the next 6-12 months planned. The steering committee to guide implementation and ongoing monitoring for the new model. This may include the following internal and external stakeholders depending on the context and the type of model:

- Executive sponsor
- Maternity consumer representatives
- District management
- Senior midwifery and medical staff
- Midwives interested in new model
- The industrial organisation
- Australian College of Midwives
- Aboriginal health worker / clinician / consumer (all if possible)
- Allied health staff
- Child and family health service
- Finance officer
- General Practitioner/s
- University midwifery academic

The role of the steering committee:

- agreeing to the philosophy and vision of the model
- setting the strategic direction for the service
- reviewing work on the process—business case, model of care, mapping pathways
- overseeing ongoing development of the model over time
- overseeing clinical guideline development
- involvement of consumers in a meaningful way throughout
- nomination of key members to formulate and develop a local agreement relating to the terms and conditions of the midwives (if different from current arrangements)
- setting, reviewing and monitoring clinical key performance indicators with reference to statewide requirements
- monitoring of activity, finance, human resources issues and outcomes
- monitoring quality and safety including clinical risk review, complaints, consumer feedback, workplace health and safety and audit.

Mapping the demographic needs

The demographic factors within the geographic/ catchment area can be mapped to assess past trends and future demand for maternity services. Identify where the current primary, secondary and tertiary services are provided. Assess current key outcomes which may align with the outcomes you would expect within midwifery model of care (e.g. normal birth rates and breastfeeding rates).

Community forum

A community forum or consumer working group will assist to assess the specific maternity care needs and preferences of local women and families. This forum does not need to address whether consumers want a midwifery model. Focus on women who currently use local maternity services the least (e.g. travel elsewhere for care, attend fewest appointments).

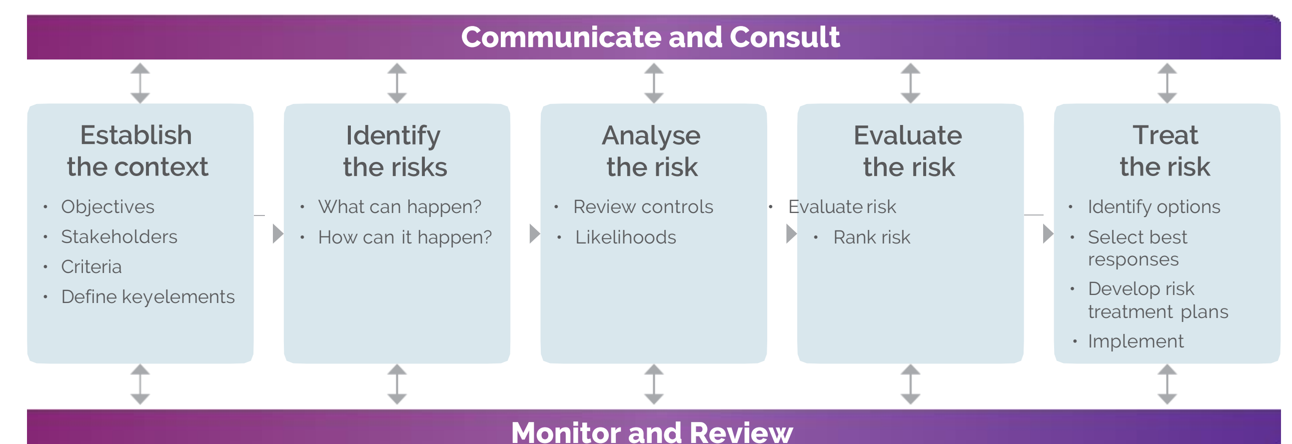
This process may also assist to develop the philosophy for the model.

Developing a business case

A business plan for implementation of the model needs to be developed. This should consider ongoing office space, administrative support and data collection.

Undertaking a risk assessment

Develop a risk register based on AS/NZS Risk Management Standards 4360:2004 and the companion guide (Standards Australia and Standards New Zealand, 2004). The figure below provides a framework that might assist a risk assessment process.



Phase 3 – Pre-implementation

After development and approval of the business case, a staged implementation plan needs to be developed. This will include:

- service agreements with non-government providers of maternity or child health services to facilitate models of care appropriate to the community
- access and transfer arrangements such as emergency transport services
- Involvement of the industrial organisation to develop the local industrial agreement to include case load numbers per FTE midwife
- Develop the midwifery role and position descriptions
  - *ensure clarity about the minimum skill required. In some areas (particularly rural) existing midwives may be recruited and may require support to upskill to required level for continuity practice.*
  - *plan the partnership arrangements among the caseload midwives. Support midwives to determine their practice partners, considering factors such as personality, geographical location, like strategies and practice philosophies*
  - *develop a recruitment plan for midwives*
  - *develop an orientation and ongoing professional development plan for the midwives*
- In rural services, accommodation may be required for midwives in the town where intrapartum care is provided.

Multidisciplinary workplace guidelines

The implementation team will review (or develop if necessary) multidisciplinary workplace guidelines including:

- criteria to determine who receives continuity of midwifery care
- consultation and referral pathways to be used with ACM Consultation and Referral Guidelines [39]
- processes that provide for informed consent and refusal (including where women make decisions outside of agreed pathways)
- ensure case review pathway is developed and agreed
- internal and external communication tools and pathways including regular case conferencing with obstetric staff (internal or external to service)
- pathways to order and access pathology and diagnostic imaging.

Communication pathways

Communication pathways need to be developed with:

- medical staff
- allied health staff including hospital and community-based social workers, physiotherapists, dieticians
- tertiary services in case referral is needed

Communication for consumers is also important. This should include a webpage on the hospital website that provides women with information about the models of care available at the health service.

Identifying the resources needed

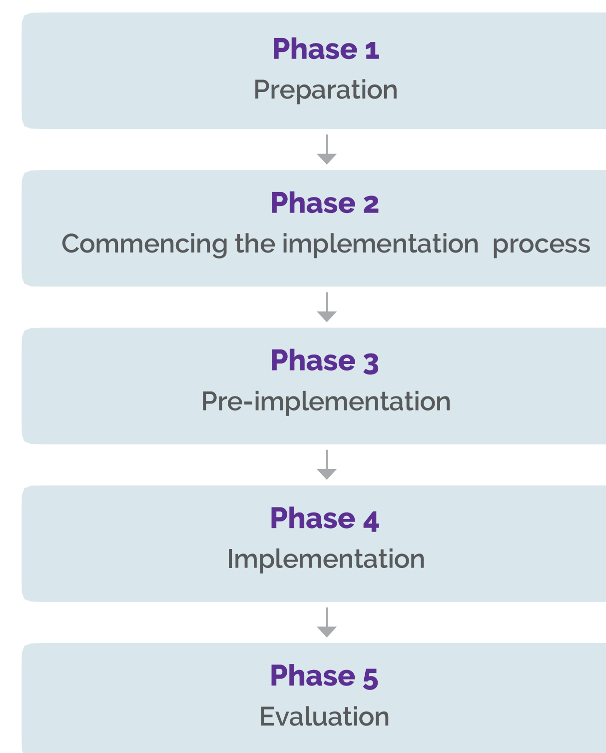
The infrastructure for the model including pagers, telephones, arrangements and agreement for car usage (hospital or personal vehicles) needs to be decided and funding made available.

Administration officer (AO) may also be required to manage ongoing administration, information technology (IT), develop letter templates for referral, wait list process, phone enquiries.

Developing the clinical governance systems

The clinical governance processes include:

- the quality and safety processes including service mortality and morbidity review meetings
- the means for reporting clinical incidents, near misses or advise events (these should be in line with usual health service processes)
- the midwifery portfolios for maintaining the model (e.g. data recording, maintaining CPD requirements, developing safe working hour arrangements and on-call/off-call arrangements, managing sick leave)
- the frequency and time of team meetings and case management meetings with medical staff



Phase
Phase 1 Preparation
Phase 2 Commencing the implementation process
Phase 3 Pre-implementation
Phase 4 Implementation
Phase 5 Evaluation

- the means to audit and report of industrial, clinical and consumer satisfaction outcomes
- the ongoing education and professional development activities

Section 5 provides a detailed description of the processes to be undertaken.

Phase 4 - Implementation

In this phase, the reorganisation of the midwives into group practices is required. For medium to large hospitals establishing a small midwifery continuity model, a minimum of four FTE midwives is recommended to sustain the model and cover leave. In small models, especially covering whole of service, it is beneficial to employ part-time midwives and maintain a higher number of midwives. Four midwives of proportionate FTE to the number of births is a suitable compromise. More information about the size of caseload can be found in Section 10. Models where there are less than four midwives will be more difficult to sustain.

Three months lead-in is essential for midwives to build their caseload and to assist with transition to a new way of working. The lead-in should include:

- The development of clerical processes
- The dates of midwifery group meetings and case reviews with medical staff are determined and booked for at a minimum of three months in advance (multidisciplinary case review is a requirement of clinical governance).
- Official launch, invite stakeholders and media.

Phase 5 - Evaluation

Evaluation of a new model of midwifery care should be an ongoing process. Ideally the first evaluation occurs after 12 months.

There are a number of ways to evaluate a new midwifery model of care. Two common ways are to measure and compare clinical outcomes, and to elicit consumer feedback.

Clinical outcomes should be linked to KPIs, and identified in advance. Some MGPs may choose to incorporate indicators of 'normal birth' into their evaluation. There are a number of different ways that outcomes can be compared. Importantly, they need to be compared to outcomes for women of similar risk status (e.g. compared to other low risk women in the same hospital received 'standard care'). Dependent on resources and expertise, a simple audit of outcome data (without a comparison group) may be sufficient.

Consumer feedback can be elicited through postpartum survey either via postal survey or, more easily, by email survey using a web-based service. Survey responses are then easy to export into an Excel spreadsheet and analyse.

There are a number of validated tools which can assess 'maternal satisfaction'. Additional open questions which allow women to jot down their thoughts including particular concerns are also useful [18].

Importantly, clinical outcomes and consumer satisfaction need to form part of a cycle of continuous improvement for the service.

05 Cultural change - shared vision and shared culture

Moving from conventional maternity care to midwifery continuity of care requires new processes, procedures and sometimes, clinical skills. However midwifery continuity of care is unlikely to be successful without significant cultural change within maternity services. Different roles, especially for midwives, and different relationships between caregivers (midwifery, medical and management); require a different organisational culture. Staff, especially at the leadership level, need to be sensitive to cultural issues and diligent about pursuing the required changes.

Women and families receiving care also have adaptations to make. An obvious benefit is having a known caregiver responsible for primary care and coordination of care. However, for some, there may be challenges in adapting to a framework of informed choice.

The foundation for achieving effective cultural change is engagement with experts in the model you are seeking to establish. This will be with midwifery leaders, midwives experienced in continuity of care and consumers. The state or territory Nursing and Midwifery Office as well as the Australian College of Midwives (ACM) are key contacts. Engaging external expertise in establishing, working in and sustaining midwifery continuity of care will be invaluable in dealing with barriers and is an essential step in supporting cultural change.

This section outlines some of the changes that may be needed to ensure success.

The usual or traditional maternity care systems

In much of usual care, medical doctors take a lead role in providing antenatal care, with women seeing midwives and sometimes specialist obstetricians periodically at hospital-run antenatal clinics. In labour, a different group of midwives and doctors will provide hands-on intrapartum care. After birth, while in hospital, yet another group of midwives will provide postnatal care. This occurs within a shift work model.

On discharge from hospital, some postnatal care may be provided by a further group of hospital midwives or by child health nurses and/or GPs. Details vary across health services.

The usual, or 'medical model' has been considered normal practice since the early 20th Century. However, it has significant limitations, particularly from the woman's perspective. Care is significantly fragmented, with women frequently seeing 25 or more caregivers [20]. Consistent care is difficult for women to access when responsibility for care is distributed among so many caregivers.

Moving to midwifery continuity of care

Midwifery continuity of care requires not only organisational change but a change in thinking and orientation for practitioners and managers who have been working in traditional models. There will be benefits to women, community, staff and health service provision through the reorientation of care delivery to that of woman-centred continuity of midwifery care models. Delivering care within midwifery continuity of care requires a process of cultural change and carries significant challenges on the path to major benefits for staff and the community.

Understanding some current issues in maternity care

The midwifery profession is now acknowledged as a distinct profession separate to nursing. The Australian Health Practitioners Regulation Agency (AHPRA) records midwives and nurses in separate registers. Increasing numbers of midwives are graduating from direct entry programs, without nursing skills or nursing registration.

New clinical governance processes need to be developed to accommodate and support evolving clinical practices and work arrangements. Services which continue to pursue traditional nursing management and governance strategies will struggle to support new models and retain staff with a midwifery professional identity.

Cultural changes for midwives

Midwives have often worked in models where the person deemed responsible for all clinical decision making is a doctor. Midwives may be unaccustomed to a role where they need to make decisions for which they are responsible and accountable. Some midwives flourish in systems which require increased autonomy and accountability while others are reluctant to take this step. A structured approach to midwifery professional capacity building (covered in Section 9) is essential to ensure midwives have the skills and confidence to make the transition to providing care across the full scope of midwifery practice.

The move to midwifery continuity of care means that the midwife provides the care seeking clarification, advice or information to support her own decision making. The midwife may also get clarification, advice or information about the decisions made by the doctor in the woman's care. Under this primary health model, the midwife is responsible for the primary care of the woman until care is transferred to a doctor.

Under this primary health model, the midwife is responsible for the primary care of the woman until care is transferred to a doctor.

Changes for women to understand

Women's understanding of the way care is provided in midwifery continuity of care depends on their previous exposure to this model. Some women are comfortable in the role as central decision maker. Other women, particularly those with little experience of the health system or with a range of cultural or social barriers to communication and health, may lack confidence in health care decision making. These women often see the health professional as the expert who makes these decisions in health care.

The midwifery partnership model [57] views the woman as the expert on herself, her body and her physical, psychological, social and cultural circumstances. Midwives in continuity of care models need to support the woman to gain confidence in this partnership. A significant amount of time may be spent supporting women to develop skills in informed decision making, requiring the midwife to be knowledgeable in evidence-based maternity care and able to share information that is non-threatening, unbiased and appropriate to the woman's personal context.

Widely disseminated information within the community enables women to begin to understand the benefits of midwifery continuity of care as articulated through the partnership model. Growing understanding enables women in the community to more actively engage in the developing model.

There are a number of mechanisms to inform and engage the community including:

- developing an 'options' booklet outlining the model of midwifery continuity of care. However this must not be used to persuade a pre-determined direction of a service but a tool to ensure open and honest communication.
- having focus groups, feedback sessions or discussion meetings or information sessions within the community.
- using a social media campaign.

Working alongside a local consumer organisation will be an asset in any cultural change process. If you appoint consumer representatives to steering committees, or if they are involved in clinical networks and other communication processes, they can help collaboration between caregivers and provide a better understanding of consumer perspectives.

Views and beliefs within the maternity unit

It is important to meet to discuss and outline the views and beliefs within your maternity unit. This provides an opportunity to transparently outline various stakeholder perspectives. It is important to develop a shared unit philosophy on continuity of midwifery care. Continued engagement to build and maintain collegiality, unity and ownership of the model is important.

Ensuring medical engagement and support

Successful implementation of MGP is only possible with collaboration in maternity care across the whole team. Collaborative maternity care has been the focus

of federal maternity reforms and within this framework collaboration has increased importance in health care.

It is essential to engage a range of medical practitioners in understanding and developing the midwifery continuity of care model. Medical staff are likely to understand and accept midwifery continuity of care, if they understand how it works and are engaged and consulted early in the development process. The workforce and capacity issues in maternity care affect all professions and most doctors involved in obstetric care can see the benefits of a stronger primary care system and improved continuity of care [58]. There is also increasing recognition of consumer preference for this model, the health benefits for women and the cost benefits for the service. Rural doctors recognise that maintaining maternity services in rural areas is critical and that these services are frequently at risk due to workforce demands.

Care is best provided by qualified health professionals who work collaboratively within a high quality, tiered health service, to ensure that women receive appropriate and timely care. Collaboration in maternity care requires defined roles and responsibilities. The National Health and Medical Research Council [56] found that:

Collaboration aims to maximise a woman's continuity of carer by providing a clear description of roles and responsibilities to support the person who a woman nominates to coordinate her care (her 'maternity care coordinator').

It is important that communication with medical colleagues is extensive and frank and that problem-solving is approached with good-will and respect on both sides. The NHMRC document on National Guidance on Collaborative Maternity Care provides some useful principles and strategies [56].

Staff engagement

Some staff may not be knowledgeable of midwifery models and what these models mean for midwives and women. Some staff may view or treat MGP midwives differently to other staff or MGP staff may view themselves differently. Midwifery continuity of care models are a gold standard where they work with other models, not alone.

Midwifery continuity of care models are a gold standard where they work with other models, not alone.

Engagement may also include rotation of core staff into the model as this could break down barriers and address myths. This has benefits and limitations. While capacity-building and opportunities for relief are important, continuity of carer is a fundamental principle for midwifery models. Any strategy which limits the time midwives spend in the model potentially means that midwives are not staffing the model for a full pregnancy. This may reduce the effectiveness of the model, the satisfaction of the staff and the skills that staff develop providing continuity of care.

A strategy for engaging and involving staff not working in the MGP is to ask for expressions of interest to fill any periods of leave which cannot be covered within the group. Having a specific rotational position which allows for a year in MGP will provide an opportunity for midwives wishing to develop skills in continuity of care to gain some experience. For example the Malabar MGP in Sydney (a program specifically for Aboriginal and Torres Strait Islander women) has a 12-month rotational position for an Aboriginal midwife.

06 Clinical Governance

Clinical governance is a means to ensure that health services are accountable for continuously improving the quality of services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.

Effect clinical governance ensures that health services are clinically safe.

These elements of clinical governance include [59]:

- the policies and processes of a service
- the way we measure and manage the quality and performance of the service
- how and to whom we report this information
- how we continually improve the services we provide.

Guiding quality assurance, the clinical governance specifically:

- focuses on best practice clinical services, designed for online and phone
- sets principles that outline accountabilities
- assists us and our service providers to review and continually improve services
- outlines the infrastructure needed for effective coordination, monitoring, evaluation and reporting of service quality.

All services must have clinical governance processes. Midwifery models require appropriate clinical governance as do all health services.

Risk management is an essential part of clinical governance.

Midwifery models require appropriate clinical governance as do all health services.

Risk management

A robust system of risk management is required. In midwifery continuity of care models, a foundation stone is the partnership between the midwife and woman. Communication between the midwife and woman, ensuring informed choice, is the foundational strategy for risk management in midwifery continuity of care models. There are also numerous issues that can impair the ability to develop and sustain midwifery models.

Standards Australia (Standards Australia and Standards New Zealand 2004 AS/NZS 4360) [60] indicates the process of risk management is:

- communication and consultation
- establishing the context
- identifying the risk
- analysing the risk
- evaluating the risk
- treating the risk
- monitoring and review

Communication and consultation

Communication and consultation must occur at every level. The requirement for communication and consultation includes mechanisms to ensure that all stakeholders have been involved in risk management for the new model.

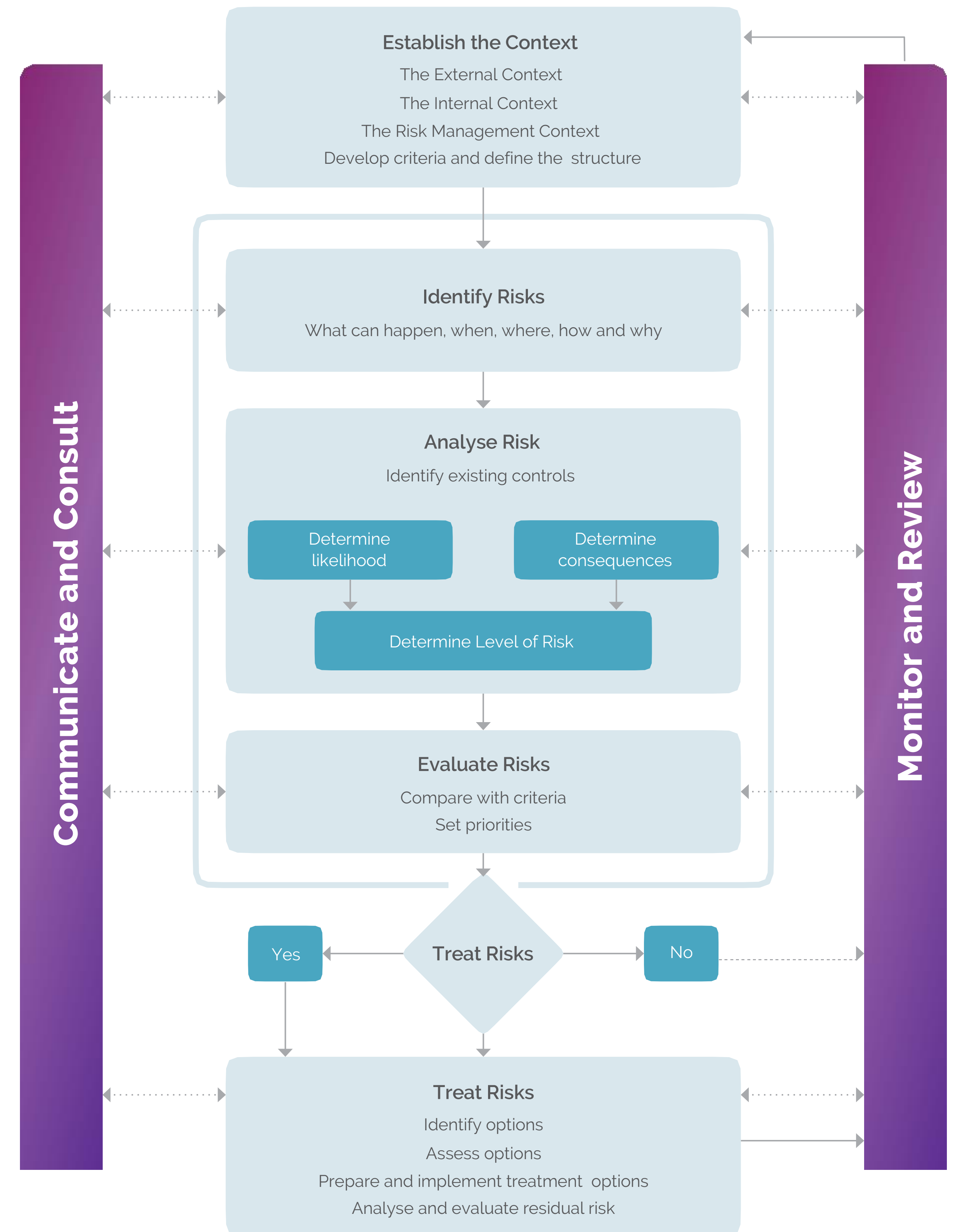
Establishing the context

The process of establishing the context of risk within the midwifery continuity of care model is a part of the preliminary stage of development. The context could include which risks are being assessed (e.g. human resource risks, risks to women using the service, risks to the organisation). In new midwifery models of care, the context of risk can also be the actual newness of the model within the health facility [61].

Identifying and analysing the risk

During initial planning for the model, a process of mapping the risks in relation to care has been suggested. It is important that risks are analysed using a framework as suggested in Figure 1.

Figure 1: A process of mapping the risks in relation to care



(AS/NZS 4360:2004)

For care to be woman-centred, the people managing and delivering care need to hear directly from women about their needs and care. Clinical governance includes processes for consumer participation in care.

Evaluating the risk

Any new service model must be evaluated during and after implementation and this will require additional support and funding. Risks identified by the previous section as being significant will be reviewed during the implementation process.

Treating the risk

A range of specific risk management strategies will be needed within midwifery continuity of care models. Examples of some strategies to manage risks for the women are:

- use of standardised documentation (e.g. pregnancy health cards, clinical pathways)
- regular case reviews including normal care and care involving major clinical interventions
- notification and review of incidents
- multidisciplinary participation in clinical audit.
- Further examples minimise risks for the service:
- active multidisciplinary forums within and across the maternity unit that include consumer representatives
- provision of adequate staffing including adequate time allowed for continuing professional development.

This list is by no means exhaustive and further discussion around strategies is contained in Section 11 Collaboration and also in the resources section.

Monitoring and review

Monitoring risks is an ongoing process. There can be difficulty in comparing and benchmarking against other services due to a lack of consistent data and analysis. The establishment of a risk register which is audited on an ongoing basis is one mechanism for review of risk at the local level.

The steering committee for the local model has an important role in clinical governance and should receive a report at each meeting. A sample clinical governance report template is provided in Appendix 11.

Existing state or territory government processes should be used to assist with reviewing the service such as incident and complaints system, local or regional mortality and morbidity reports, midwives' outcome statistics, financial reports and attendance to key performance indicators identified in the model of care document.

Consumer participation and informed choice

For care to be woman-centred, the people managing and delivering care need to hear directly from women about their needs and care. Clinical governance includes processes for consumer participation in care. This occurs at the system level and at the individual level and should be audited as part of routine clinical governance audit.

The Australian Commission for Safety and Quality in Healthcare states:

Standard 2 of the National Safety and Quality Health Service Standards requires the involvement of consumers in the organisational and strategic processes that guide the planning, design and evaluation of health services. The actions identified in Standard 2 build on emerging evidence of the benefits partnering with consumers can bring to health services. For example, involving consumers in service planning, delivery, monitoring and evaluation is more likely to result in services that are more accessible and appropriate for consumers [62].

At the system level, services should engage consumers in the development and ongoing oversight of their maternity services including new models of care. Including consumer representatives on hospital or district committees and steering groups is a primary strategy for consumer engagement. When consumer engagement is highly developed, consumer representatives may be included on selection panels for key maternity care staff in clinical audit groups and in service reviews.

Processes to support women's informed choice and consent include [62, 63]:

- consumer representation on local committees and in development of policies, models of care and guidelines
- ensuring all staff are aware of women's rights and clinicians' responsibilities regarding choice, consent and shared decision making
- maintaining current, evidence-based written information for women on common procedures and choices
- comprehensive antenatal education for women as individuals or in a group
- continuity of caregiver, especially having a known midwife for intrapartum care
- routine formal feedback surveys and processes

Clinical audit

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes and outcomes of care are selected and evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery.

Key elements of clinical audit include [56]:

- processes that identify, as much as possible, 'near misses' occurring in care provided, so there is recognition of the possible implications these incidents have for becoming serious adverse outcomes
- morbidity and mortality review that is multidisciplinary preferably represented or led by all staff involved
- analysis of more serious adverse outcomes via tools such as root cause analysis
- engagement with patient safety officers
- assessment of the impact on 'core maternity indicators', for example breastfeeding rates or smoking cessation advice and decreased smoking rates in pregnancy

Key Performance Indicators

Clinical outcome comparison and benchmarking with other services provides the most relevant and straightforward evaluation of a model. Key performance indicators will be decided by the steering committee and will be relevant to the local context (see Appendix 10).

Research and development

MGP provides an ideal setting for ongoing research and development in midwifery care. It is important that midwifery models maintain links to universities and participate in research and publication of innovations and outcomes.

The Australian College of Midwives provides ongoing support to research. See: http://www.midwives.org.au/

Professional development

Continuing professional development is essential both from a regulatory perspective and from a governance perspective. Midwives' individual professional development and capacity building for midwifery as a whole is discussed in Section 9.

Credentialing

Within the medical profession 'credentialing' refers to a process which verifies the education, experience and clinical skills of a medical practitioner seeking employment or access to a hospital or health facility. Within midwifery, the term has been loosely used to describe determining clinical competence in a range of skills.

The Australian Commission on Safety and Quality in Health Care (ACSQH) has produced a national guideline on credentialing. It is important that credentialing processes within any service are consistent and that they are also consistent with processes to credential medical or allied health practitioners.

Credentialing of endorsed midwives is discussed in Section 13.

Complaints management

Processes are required for women to provide feedback about their care and for midwives to raise concerns about the model, unit or other elements of care. Several complaints processes exist for both. Information regarding complaints management can be found on state and territory health department websites.

Processes are required for women to provide feedback about their care and for midwives to raise concerns about the model, unit or other elements of care.

Evidence-based clinical guidelines

The Commonwealth Department of Health has published antenatal guidelines: National Evidence-Based Antenatal Care Guidelines [64, 65] which should be used to provide antenatal care. The ACM National Midwifery Guidelines for Consultation and Referral [39] are also important to use. ACM has also developed transfer from homebirth guidelines for those models which provide a homebirth service [66].

Midwives will practice in accordance with state or territory guidelines, and these should be used to inform local hospital protocols. If local guidelines are required due to unavailability of national or state guidelines, development processes should be multidisciplinary, include continuity of care midwives and consumers and have a process for regular review and be updated as new evidence becomes available.

The development of policies and clinical guidelines for MGP models requires critical analysis of current documents and adaptation if necessary. All policies and clinical guidelines need to be living documents which require updating as new evidence becomes available.

MGP provides an ideal setting for ongoing research and development in midwifery care. It is important that midwifery models maintain links to universities and participate in research and publication of innovations and outcomes.

07 Developing a business case for midwifery continuity of care

Some health services will require the development of a Business Case in order to implement midwifery continuity of care. In reality, midwifery continuity of care is just a new way of arranging the roster systems to enable women to receive care from midwives they know. Therefore, it should not require significant additional funding except to start-up and potentially invest in some up-skilling and professional development for the midwives.

This section provides some suggestions on how to develop a Business Case should that be required. It is important to remember that the salary scales and costs will vary by state and territory and by health service.

Midwifery continuity of care is a cost effective model

The cost efficiency of midwifery continuity of care in Australia was demonstrated by Tracy et al [67] with caseload care costing an average AU$566.74 less per woman than standard midwifery care. This figure cannot take into account benefits of caseload midwifery which are difficult to express in monetary value such as the emotional wellbeing and confidence of the new mother and higher rates of breastfeeding and the impact thereof on maternal and infant short term and long term health.

The cost savings are probably related to:

- flexible care delivery which is responsive to demand
- increase in spontaneous labour rates with decreases in obstetric interventions and associated reductions in costs
- decreased length of stay so decreased demand on bed occupancy
- decreased readmission rates
- increased staff satisfaction in caseload with improved retention of workforce

Midwives working in a midwifery continuity of care will often be paid an annualised salary in recognition of flexible patterns of work required. The annualised salary is the ordinary rate of pay and an all- purpose loading (approximately 35 per cent), which is in compensation for ordinary hours worked and in consideration of all other penalty rates and allowances the midwife would have been entitled to under the Award if not working within the caseload arrangement. No backfilling is required in normal circumstances (e.g. annual leave).

For example, in 2006 the Mater Mothers' Hospital introduced an MGP for young mothers in an all risk model based on a caseload of 35 women annually per midwife. Savings of $577 were identified for each woman accessing this care, and used to offset costs for equipment.

Section 8 of this handbook provides information about industrial issues and awards in continuity of care models.

Business planning

Once the vision for the maternity service and model has been determined, a service business or operational plan may need to be developed.

Matching supply of midwifery resources to a service is an integral part of a business plan. Developing a clear and complete outline in planning for the service will provide longevity and limit the need for repetitive business cases as the service grows.

This approach to workload management focuses on balancing demand and supply of resources to meet the identified demand. Service Demand = meeting women's needs by considering factors such as:

- acuity
- activity
- targets
- layout and work environments
- supply
- service quality
- consumer and staff safety
- model of service delivery
- financial outcomes
- initiatives and policy direction and directives
- public/private interface.

Each stage of the process should not be considered in isolation or as separate from the desired outcome of developing a business/operational plan. Therefore, the business plan will identify specific needs of a service and assist to determine issues such as:

1. ***if one FTE midwife can carry a workload of 40 women per year or if the profile of the service identifies this caseload should be reduced***
2. ***upskilling requirements of midwives***
3. ***orientation period to the model.***

Lobbying with partners and stakeholders for changes proposed within the business plan may be essential to gain support.

Ensuring key health target areas are being addressed and the proposal aligns to best practice quantitative and qualitative evidence makes for a strong business plan and provides measurable indicators that can be matched for evaluation of the service. An example of a measurable indicator is 'one-to-one' midwifery care in labour.

The framework for a business plan is depicted in Figure 2.

Including establishment costs

Many of the current midwifery models have been established by realigning resources and reconfiguring work patterns from traditional models with little or no additional cost. Other models have invested additional resources to set up continuity models to serve expanding birth numbers. Some areas have channelled funding for the universal postnatal contact service to continuity models rather than add an additional component to the traditional fragmented service.

Local overhead costs should be reviewed as these vary between services and have been reported to sometimes be overinflated. Where birth centres exist, it is suggested that this space should be reviewed to ensure capacity is maintained at 160 births per birth centre room per annum to optimise cost savings.

Additional resources including mobile phone / pager, computer use / remote access, stationary and administration support will need to be costed in the model. For private motor vehicle usage, refer to hospital policy reimbursement for motor vehicle usage. Midwives should seek individual tax advice as they may choose to claim their private motor vehicle use as a work related tax deduction on their personal tax return rather than be reimbursed through the pay system.

Figure 2: Example of headings that may be used in a Business Case

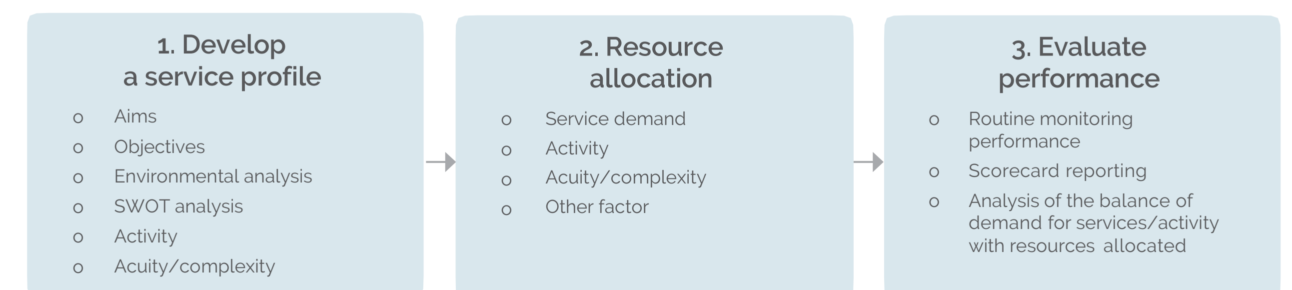


Table 2: An example of a comparison of costs for core and caseload midwives (Qld Health data)

Cost	Clinical Midwife – Core NG6-04	Clinical Midwife – Caseload NG6-04
Salary and Wages	$79 431	$103 260 (annualised at 30% loading)
Overtime @ 10%	$7 943	-
Penalties @15%	$11 915	-
Clinical non lab expense	$6 233	$6 233
SSP	$2 542	$2 542
Other Allowances	$2 339	$2 339
Annual Leave back filling & Leave Loading	$8 813	$1 406 (no backfilling)
LSL Levy	$1 847	$2 188
Sick Leave Backfill	$3 050	-
Training Days	$915	$915
Superannuation @ 12.75%	$13 748	$13 282
Workcover Premium @ 1.5%	$1 892	$1 838
Professional Development	$1 500	$1 500
Rural Area Nursing Incentive Package Allowance	$2 000	$2 000
Grand Total	$144 168	$137 503

Midwifery continuity of care is sustainable within current funding models. Depending on local overhead cost, existing maternity services should be able to use casemix to convert a proportion of births into a new model of care with no additional recurrent funding.

Comparing staffing costs

One of the main concerns often expressed by health service managers is that midwifery continuity of care 'cost too much'. We have undertaken a comparative analysis based on the salary costs of a midwife in the Queensland public health system. These exact numbers and rates will very in other states and territories but we include the Queensland analysis as an example to show that midwifery continuity of care need not be more expensive.

This example is based on a comparison of wages and on-costs between a Clinical Midwife (Qld health system - NG6-04) who works full-time shift work; and a Clinical Midwife (Qld health system - NG6-04) who carries a caseload of 40 women per year.

Considerations when implementing caseload (group practice) model

Midwifery continuity of care is sustainable within current funding models. Depending on local overhead cost, existing maternity services should be able to use casemix to convert a proportion of births into a new model of care with no additional recurrent funding.

The aim should be to always establish a continuity of care model within existing budgets to ensure the sustainability of the service. However, funding may be required to manage and facilitate the transition into the new model. Focus needs to be directed onto the long term impact of such a service rather than only concentrating on the short term cost.

When considering the establishment of Midwifery continuity of care, it is essential to demonstrate:

- the health system will support the availability of the model for women
- there is a critical mass of midwives willing (or who are able to be supported) to work within such a model of care
- the model is self-sustaining in the face of resignations and departures from the facility (succession planning is integral)
- there is support and collaboration with relevant medical colleagues such as obstetricians, general practitioners and obstetric registrars (may be off-site support)
- the ACM's National Midwifery Guidelines for Consultation and Referral are understood by all practitioners
- the clinical governance structures around the model meets the best practice requirements.

08 Industrial Issues

Midwives providing midwifery continuity of care in public health services are covered by special provisions within the state or territory industrial Award. They do not work shifts, they organise their work time according to the needs of their women and as negotiated within their MGP and their line manager. In most settings, the midwives are paid an annualised salary.

Key elements of the annualised salary award for midwifery continuity of care

An annualised salary means that midwives are paid a loading (approximately 30-35%) on top of their usual award rates. The loading compensates midwives for not receiving penalty allowances, holiday leave loading and other items normally paid to shift-workers listed in the award. The midwives receive standard annual leave, family leave, maternity leave, professional development leave and all other aspects of health professional awards.

The annualised salary arrangements vary across the country. Local agreements for annualised salaries and associated working arrangements are negotiated between stakeholders. The issues that are agreed usually include whether there are dedicated days off each week or fortnights, the number of hours that midwives can provide continuous labour care (usually 12 hours).

In most public health settings, the midwives are paid an annualised salary.

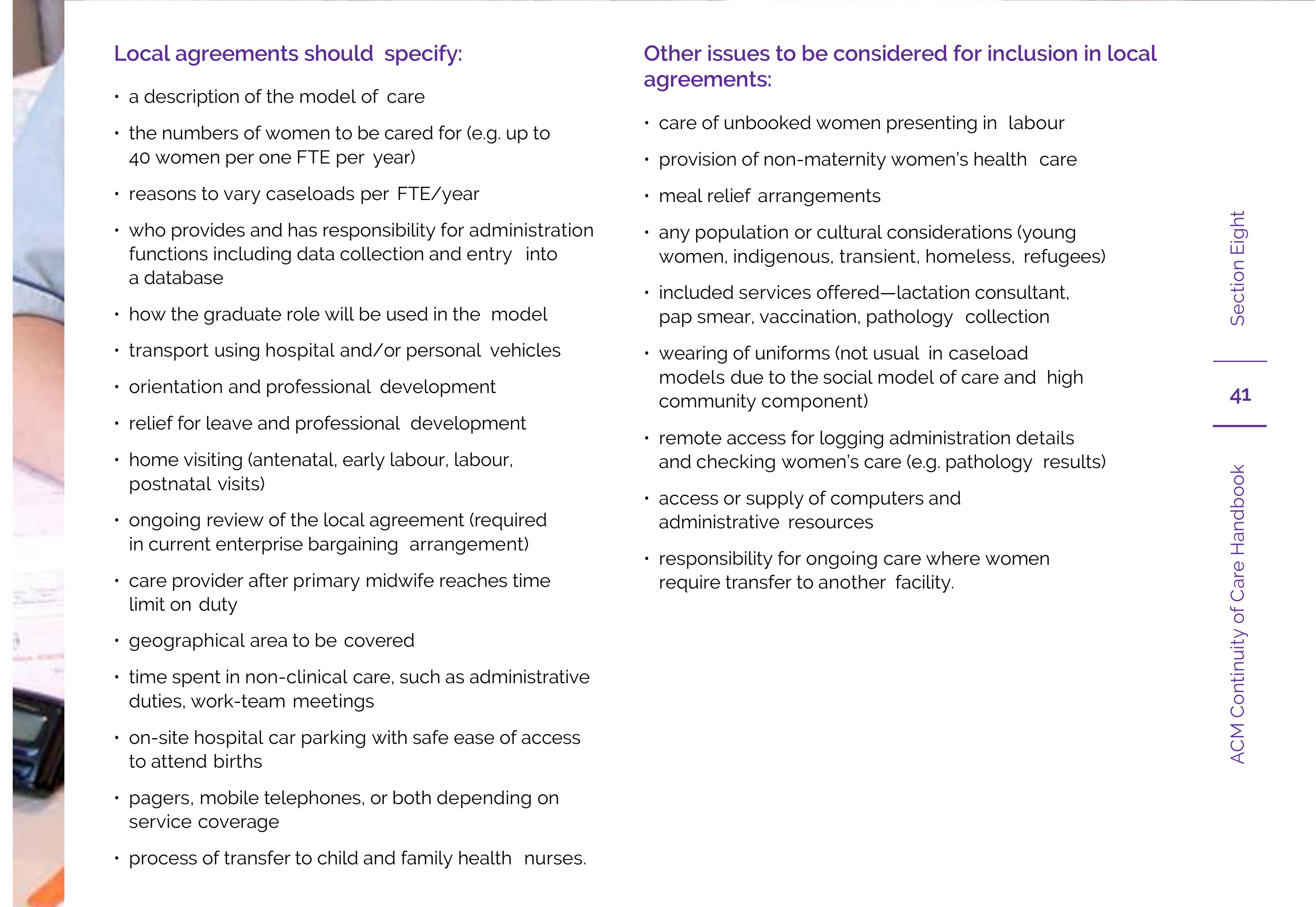
Negotiating a local agreement

A working group or steering committee is usually established before a midwifery model of care is developed. This group includes local midwives with an interest in working in the model, local midwives who may be affected by the model, managers, unions, universities and other key stakeholders to consider the appropriate midwifery model.

The Award usually requires local agreements to be developed to support the midwifery model of care. An early step in most settings would be to raise the development of a midwifery model of care at the state or territory branch of the ACM. A working party could then be established to draft the agreement with appropriate representation from management staff, midwifery staff and the states' or territories' unions.

Staff representatives would include both those midwives with a desire to work in the new model and those who may not be employed in the model but have concerns about how any new arrangement will impact them and the flow of care. For example, core maternity staff in metropolitan services or an emergency department in rural services would want to know if implementing a new or different service would equate to more, similar or less workload. Staff need to be consulted on how the model will affect communication and referral pathways within and outside the organisation. Once completed, local agreements are signed off by the CEO and the union.

The box below provides examples of some of the issues to be covered in a local agreement. The agreement should consider how the work will be practically undertaken, the resources that will be provided and the level of remuneration that can be expected.



Local agreements should specify:

- a description of the model of care
- the numbers of women to be cared for (e.g. up to 40 women per one FTE per year)
- reasons to vary caseloads per FTE/year
- who provides and has responsibility for administration functions including data collection and entry into a database
- how the graduate role will be used in the model
- transport using hospital and/or personal vehicles
- orientation and professional development
- relief for leave and professional development
- home visiting (antenatal, early labour, labour, postnatal visits)
- ongoing review of the local agreement (required in current enterprise bargaining arrangement)
- care provider after primary midwife reaches time limit on duty
- geographical area to be covered
- time spent in non-clinical care, such as administrative duties, work-team meetings
- on-site hospital car parking with safe ease of access to attend births
- pagers, mobile telephones, or both depending on service coverage
- process of transfer to child and family health nurses.

Other issues to be considered for inclusion in local agreements:

- care of unbooked women presenting in labour
- provision of non-maternity women's health care
- meal relief arrangements
- any population or cultural considerations (young women, indigenous, transient, homeless, refugees)
- included services offered—lactation consultant, pap smear, vaccination, pathology collection
- wearing of uniforms (not usual in caseload models due to the social model of care and high community component)
- remote access for logging administration details and checking women's care (e.g. pathology results)
- access or supply of computers and administrative resources
- responsibility for ongoing care where women require transfer to another facility.

Dependent upon previous experience, midwives may need a reduced workload in the first weeks of working within a continuity model while they are supported by an experienced colleague, identify their resources, adjust to processes and learn time management in the new role.

Auditing an agreement

Given no one size will fit all maternity locations or client needs, formal agreement is required to monitor and audit staff wellbeing and satisfaction. This is required for safety and sustainability, helps to inform refinement of the model and supports workforce planning. The certified agreement stipulates that new models survey staff at six months. A survey tool has been used in a number of services to ascertain midwives' needs in respect of industrial satisfaction.

Determining the caseload numbers

In the process of determining the local agreement, it is paramount to ascertain the level of midwifery care the population will require. For example, more time may be needed to accommodate the needs of Indigenous women or young women compared with the general maternity population.

Within the certified agreement, one FTE usually equates to a midwife caseload of up to 40 women per year. However, agreement should be reached on a safe achievable case load per FTE for populations requiring more of a midwife's time. For example, this might include building trusting relationships with Indigenous or homeless women to encourage their access to care across the continuum for both themselves and their babies.

Rural and regional services have extra considerations in determining caseload levels:

- travel times for antenatal and postnatal appointments
- clinical capability of unit including birth services and potential times required to provide birth care
- availability and access for consultation and referral of care and time taken to transfer care
- additional time required to complete clinical tasks due to less efficient equipment or lack of equipment
- time required to support and mentor graduate colleagues into continuity of care roles, particularly if model is isolated from other midwives or support services
- services provided in addition to maternity care, including:
    - *lactation consultancy services*
    - *pap smears*
    - *pathology collection*
    - *vaccination services*
    - *healthy hearing screening*
- longer postnatal hospital stays if women are far from home.

The number of women per FTE midwife per year should be determined by counting the number of women who book, not the number of births. If births are counted instead of bookings, the work caring for women who are transferred prior to birth or during labour, or who miscarry, is not accounted for. This is particularly important in rural models. Women with complexities will receive their midwifery care (and often GP obstetric care) in the rural facility antenatally and postnatally, but may birth at a referral hospital (with or without their caseload midwife).

Including orientation and professional development

Local agreements should make provision for orientation of midwives entering the model and ongoing professional development (covered in more detail in Section 9). All staff awards should have provision for professional development leave and a professional development allowance.

Dependent upon previous experience, midwives may need a reduced workload in the first weeks of working within a continuity model while they are supported by an experienced colleague, identify their resources, adjust to processes and learn time management in the new role. This may not be possible in some models, such as rural units providing care to the whole local population. In some facilities, transfer to a new model will involve new or better relationships within the broader community, including local leaders, community services (health and non-health) and private health services. Orientation should also provide for initiating and supporting the development of these relationships.

Access to professional development will vary according to location, with rural services generally requiring additional relief periods due to the necessity to travel for educational opportunities. The easiest way to help midwives access these professional development opportunities is to allocate study leave either side of annual leave when the midwife's birthing caseload allocation would usually be reduced. In areas where support services are in place to accept maternity clients in the absence of MGP midwives, it is beneficial for the group or a subset of the group to attend annual education together. Given that social support for midwives in these models is important, taking advantage of group opportunities can assist and sustain team building.

09 Professional development and capacity building

In order to provide the level and scope of care detailed above, midwives moving into a continuity model have particular professional development needs that need to be planned for. Midwifery continuity of care requires midwives to maintain competence across the scope of practice for a midwife. This is not advanced practice – it is usual scope of practice. For this reason, and because philosophical orientation is so important, new graduates can be ideal recruits.

Midwives in continuity models have increased autonomy, accountability and competency requirements in their clinical practice relative to many conventional models. Planning and preparation for midwifery continuity of care models must include adequate professional development and upskilling. It is not possible to simply rely on award provisions to provide this level of support.

A continuing professional development plan for the group, as well as for the individuals within the MGP, is essential. Midwives who have worked in a variety of contexts and across the full scope of midwifery practice will be more readily able to make the move into a MGP. However, all midwives can expect a level of upskilling in both clinical and non-clinical elements. Mentoring programs to assist in the transition to working in a caseload or team model are pivotal to ensuring midwives can easily make the adjustment.

Professional development

All midwives are responsible for their own ongoing professional development and competency. National registration requires all registered midwives to provide evidence of continuing professional development (CPD) and provide annual documentation of the number of hours spent on CPD.

Midwifery awards contain two elements which assist midwives with professional development: a leave entitlement and a professional development allowance. Section 8 – Industrial issues covers the award.

The ACM has a formal continuing professional development program (MidPLUS) and a peer review process called Midwifery Practice Review (MPR) which provides good starting points for midwives and managers looking at how to develop plans for professional development.

A staged approach to professional capacity-building

Midwives preparing for group practice may approach professional development in a number of stages, starting in the planning phase of the model:

- develop an understanding of the philosophy of midwifery continuity of care models
- examine their own beliefs
- meet with an experienced continuity of care midwife and manager to undertake a clinical skills assessment
- review non-clinical skills with the support of a mentor.
- write a professional development plan using the ACM MidPLUS professional development plan or the professional development pro formas of the place of employment
- spend time with midwives already providing midwifery continuity of care prior to implementation
- arrange support by a midwifery mentor in a formal mentoring process
- undertake Midwifery Practice Review or equivalent professional review process within a time frame decided by the midwife and manager
- mentor to encourage the midwife to reflect and evaluate the clinical outcomes in the continuity of care model after a period of time.

Midwives providing continuity of care develop and maintain skills across the full scope of midwifery practice. They particularly have expertise in physiological birth and working with women in partnership. Midwives may not have these skills on entry to continuity of care models, and therefore need support from managers and colleagues to develop them.

Moving into continuity of care

Working in continuity of care provides midwives with a unique opportunity to explore and understand pregnancy, labour and birth and the post-birth period on a new level.

For midwives moving to a continuity model of midwifery care there are obvious changes in place of work, the pattern of work hours and level of responsibility. As well as these practical changes, continuity models require an appropriate philosophy of health care.

The shift to working in this way requires the midwife to evaluate, and perhaps challenge, their beliefs about midwifery and the partnership with women. Potentially the most useful way to make this transition is to spend time with other midwives working this way and to speak with women who have received this care.

Major differences in philosophy between midwives and their managers create stress for all staff and for women receiving care. It is important that midwives and their manager clearly articulate and document their philosophy at the establishment stage, with consumer and multidisciplinary input.

Undertaking Midwifery Practice Review

The Australian College of Midwives' Midwifery Practice Review (MPR) process is a professional review process developed by midwives for midwives [68]. It is currently the only professional review endorsed by the Nursing and Midwifery Board of Australia.

Midwives undergoing MPR firstly develop a professional portfolio which documents their professional development, clinical outcomes, their reflections on their practice and a synopsis of this portfolio. The MPR process provides an opportunity for midwives to reflect on their practice in relation to the NMBA Competency Standards for the Midwife [52], to develop documentation about their context of practice, to discuss their professional development and to create a plan for future ongoing professional development.

The professional review is a formal process where the midwife has a structured conversation with formally trained and accredited reviewers—one midwife and one consumer. The midwife's professional development plan is discussed within the review and is considered by the reviewers relative to the information they have gathered. The MPR is formally written up and the midwife being reviewed and the reviewers all sign the documentation. MPR is conducted every three years.

Clinical skills assessment

The clinical skills of midwives working in continuity of midwifery care models need to cover the continuum of care and match the degree of responsibility and autonomy characteristic of this work.

Some of the clinical skills that midwives may not be familiar with providing are:

- perineal suturing
- speculum examination
- intravenous cannulation
- communicating as a lead carer
- ordering and assessment of pathology and diagnostic imaging
- initiating medications.

Midwives working in continuity of care will need a range of skills that promote physiological birth. These skills include using a variety of non-pharmacological methods of pain relief in labour including water immersion and water birth, and management of physiological third stage.

Midwives working within continuity of care models need to have had sufficient recent exposure to a wide variety of clinical situations. Multidisciplinary emergency skills activities such as maternity emergency training and neonatal resuscitation programs provide the midwife with opportunities to practice skills, in a simulated environment, in order to gain confidence.

There are a range of professional development activities provided by professional bodies such as the Australian College of Midwives and a range of private organisations which may assist in upskilling.

Midwives preparing for continuity of care models may benefit from spending time working in an existing continuity of care model. An alternative is to have an experienced continuity of care midwife working within the new group practice. This transitioning process can provide upskilling in clinical and non-clinical skills.

Upskilling of midwives can also include informal processes where midwives spend time engaging with

Midwives and managers working within continuity of care need to be acutely sensitive of the effect of words, the power relationships as experienced by women, and to use language which helps women to maximise their sense of power.

consumers and consumer organisations or time where midwives review available resources such as DVDs or other web based resources on relevant areas, such as physiological birth.

The next stage, after midwives have gained the skills required, is for them to build confidence in their practice and their ability to be responsible for decision making and for coordinating care. This confidence may take some time to develop after they commence working in the model.

Addressing communication and language

Midwives' communication with each other needs to be transparent, respectful and extensive in nature, particularly at the outset of the implementation of the model. Midwives meeting frequently will develop an understanding of accepted group boundaries and will identify any specific needs of individuals within the group. They will also develop a range of strategies to support each other and knowledge of the skills each individual midwife has around communication.

The language we use as maternity care providers has a big influence on the care we provide and on the experiences of women and their families. Women do not usually want to be called 'patients' or 'ladies', or want to be 'delivered' or 'managed' or described at 'failing' at labour or breastfeeding? When performing invasive procedures, it is essential that providers seek permission in a way which recognises that the woman has a choice. All maternity care providers need to use language that helps the woman feel in control, instead of feeling intimidated by a powerful institution and its staff [69].

Midwives and managers working within continuity of care need to be acutely sensitive of the effect of words, the power relationships as experienced by women, and to use language which helps women to maximise their sense of power.

Some midwives working in midwifery continuity of care models will find themselves in a leadership role, either within the model, within the wider health service or in their profession. They may also be required to provide additional levels of political advocacy and lobbying in development and maintenance of the model. Midwives may be supported by specific leadership training or supported by midwifery leaders.

Critical analysis and application of evidence to practice is a further skill for midwives in continuity of care models.

Developing a professional development plan

Drafting a professional development plan is a personal process, essential to each midwife's practice. The MidPLUS program (ACM) and local level professional development processes provide a range of tools to assist midwives. Midwives can undertake this process independently or within their employment.

All maternity care providers need to use language that helps the woman feel in control...

A professional development plan requires the midwife to:

- identify areas for professional development
- formalise these into learning needs when necessary
- look at the way the midwife learns best
- identify ways that the midwife can use their preferred learning method to fill the gaps in their professional development
- document a process for undertaking professional development and a timeline to do so
- show how learning will be evaluated.

Midwives should have flexibility to self-identify their professional development plan or goals for the first twelve months of working in continuity of care. However it is important that they focus on gaining the full repertoire of skills required to work autonomously in a continuity model.

Support from managers and leaders

Managers supporting midwives to upskill for work in midwifery continuity of care can also update their own skills. Many managers are not midwives or they may not have practised across the full scope of these models. Unions or the Australian College of Midwives can provide support and advice to managers about many aspects of these models. There are also a number of successful models across Australia where managers

or previous managers can be engaged for support. Managers who are registered nurses and/or midwives will also have regulatory requirements from the Nursing and Midwifery Board of Australia and will therefore also be engaged in reflective practice. Skills such as effective communication and leadership are critical when establishing and managing a midwifery continuity of care.

Skills such as effective communication and leadership are critical when establishing and managing a midwifery continuity of care.

Supporting midwifery continuity of care from the perspective of a manager means:

- having a commitment to the value and importance of midwifery continuity of care, including benefits for women, midwives and the system and institution
- understanding and ability to step back and allow midwives to manage the care they provide, the way they provide care and their time
- being available to troubleshoot issues, particularly at the outset of the model
- maintaining effective communication, ability to manage and resolve conflict, ability and willingness to give advice
- encouraging reflective practice, and support the midwife in development of a professional development plan
- being willing to develop a meeting structure to ensure that midwives meet regularly to engage clinically
- being able to act as an advocate for the model and deal with philosophical and organisational disputes around the model and the ways midwives provide care.

Midwives should have flexibility to self-identify their professional development plan or goals for the first twelve months of working in continuity of care. However it is important that they focus on gaining the full repertoire of skills required to work autonomously in a continuity model.

Supporting mentoring

Clinicians and managers establishing and maintaining continuity of care models may benefit from mentoring by midwives and managers who have expertise in continuity of care. Mentoring is a process that encourages reflection, support, learning and professional development in a relationship between an experienced member of staff (mentor) and a less experienced person (mentee) [70]. The mentoring relationship is one of negotiated partnership. Key elements of a mentoring relationship are:

- to enable and develop professional confidence
- the duration and structure of the mentoring process is mutually defined and agreed by each partner
- the mentor listens, challenges, supports and guides the mentored midwife
- the mentor encourages the mentored midwife to research, explore and reflect on her practice

Professional engagement between midwives who are working in continuity of care models and those moving into continuity of care provides a valuable opportunity for informal mentoring and support but this does not address the need for formal mentoring. A system of mentoring processes where mentor and mentee make a formal commitment to work with each other and review their experiences can work well.

Supporting new graduates

New graduate midwives are prepared and feel supported to work in midwifery continuity of care models. Managers and other key stakeholders can provide high levels of support to new graduate midwives working in the models. Mentoring and professional support from managers and colleagues are key to the success of midwives being orientated into such models [71-73].

New graduate midwives are prepared and feel supported to work in midwifery continuity of care models.

Managing a flexible workforce

All staff should be supported, but due to the way midwives work in continuity models, their workloads, work hours and roles are often misunderstood. There can be a tendency for staff unfamiliar with the social models of care to think the midwives are not working if they are out in the community. Therefore managers need to develop trust in their midwives, and core staff also require education in the role of the midwife working in midwifery continuity of care models.

Evaluation of outcomes and maintenance of skills

Midwives providing continuity of care have a high level of responsibility for their practice, their decision making and for the outcomes of their care. Evaluation of outcomes provides an opportunity to review the impact of the skills of the midwives on the group receiving care. Facilitating physiological birth provides an opportunity for midwives to maintain and extend their skills in ‘normal’. It is also important for midwives to be confident and competent, especially in emergency situations, and to have effective skills in consultation and referral.

10 Midwifery practice in continuity models

Working in midwifery continuity of care can be different to working in mainstream practice. Midwives work differently; needing to work flexibly with fluid navigation between work and personal time, especially to avoid burnout. Further, midwives are required to take high levels of responsibility, autonomy and accountability as they facilitate relationships with women [17].

Working in midwifery continuity of care practice may require a change in the way midwives think, speak and provide care. The partnership between the woman and the midwife is likely to be different from any other clinical roles the midwife has experienced. Women are considered the expert in themselves and hold the ultimate power in decisions about their birth and their care.

The key elements to successfully provide midwifery continuity of care are [74]:

- an ability to develop meaningful relationships with women, midwives offer continuity of carer, rather than being on-call for women they do not know
- occupational autonomy and flexibility so that midwives are in control of, organise and prioritise their own work
- support at home and at work; this includes midwives meeting frequently to discuss practice issues, share information and to ensure that they know when individual midwives may need more.

Responsibility and autonomy

Midwives who provide continuity of care take a leading or coordinating role for individual women's maternity care. This usually provides the midwife a high level of responsibility for their practice in relation to the woman and her baby's outcomes.

Autonomy means self-determination, the ability to be self-governing. The concept of autonomy in midwifery is used to provide understanding that midwifery is distinct from nursing and medicine in that it has its own distinct body of knowledge. The midwife also has her own individual knowledge making it possible to make decisions and determine actions within the midwifery context 'in her own right' without reference to others [75].

Understanding and applying evidence to decision-making is critical. In order to be able to back up their decisions with evidence, midwives need to:

- remain up to date with research in maternity care;
- develop skills in sourcing and analysing information about maternity care – this may be the role of a few individuals within the group;
- attend professional midwifery seminars, workshops and conferences;
- engage with consumer organisations;
- find sources of high quality evidence (e.g. Cochrane database) to review and support clinical decisions
- seek support and guidance from a mentor or another midwife when uncertain as to how to proceed;
- seek a supportive forum in which to revisit clinical decisions, engage other clinicians and seek a range of information sources about the decision.

It is important that midwives are supported by an appropriate mentor in developing their skills in communication and collaboration, with an understanding of consultation and referral processes and guidelines.

Managing relationships within the MGP

A range of relationships determine the way the midwife practices in the MGP:

- the partnership between the woman and her primary midwife
- the relationship between the midwife and the other midwives within the MGP who provide back up support
- the relationships between all the MGP midwives
- the relationships MGP midwives have with people outside the model, including core midwifery staff and obstetricians (covered in Section 6 Governance and Section 11 Collaboration).

Partnerships between the woman and her primary midwife

The fundamental partnership in midwifery continuity of care models is between the midwife and the woman.

In standard maternity care, the relationship between a midwife and a woman is bound by many conventions, as the 'boundary' between the professional or 'expert' and the woman receiving care is clear. In models where the same midwife provides care for the woman throughout pregnancy, the experience of labour and birth and to six week post birth, sometimes over a number of years and through a number of pregnancies, the relationship is usually very different.

The fundamental partnership in midwifery continuity of care models is between the midwife and the woman.

The context in which the care is provided has a profound impact on the relationship between the midwife and woman. This partnership changes the way midwives provide day to day care. With the focus on woman-centred care the midwife provides care in consideration of the needs of the woman more than the needs of the institution, and also at times more than the midwife's own needs. Strategies around maximising continuity while balancing the midwife's needs are presented below.

Working together with the other midwives

A key element of MGP is the way in which midwives work together to provide care. Arrangements between midwives to provide backup care for each other's women are crucial to the sustainability of continuity models. A common mechanism to achieving this is by midwives working in a practice partnership of two or three midwives. These midwives meet each other's women antenatally and go on-call for each other to allow time off-call or rest at times of increased activity.

Some MGPs do not divide their caseload midwives into partnerships of two or three, preferring to have a backup midwife from the MGP named for each individual woman. The benefits of this are working flexibly with a range of colleagues, spreading on-call and off-call time over a number of midwives and women being able have both midwives of their choice. The benefits of a consistent partner are being able to schedule time off opposite each other, getting to know a set group of women both as a primary and back up midwife and getting to know intimately the way another midwife works.

When setting up the MGP, trust between partner midwives is essential. Having a similar philosophy is a good starting point. Partnerships where both midwives are at the same life stage (e.g. small children) work well for some, but equally partnership where midwives are at different stages of life (e.g. one with small children, one with grown children) sometimes allows more flexibility.

There are a range of decisions to be made between the partners:

- how to organise on- and off-call time
- when, where and how often each midwife meets their partner's primary care clients
- how informal and formal communication within the pair will occur
- what information you are providing women and how women communicate with their midwife and back up midwife
- organisation of leave and professional development.

The needs of midwives working this way are paramount and if difficulties arise between colleagues it is important for those supporting the caseload to quickly recognise this and find ways to resolve the situation.

Interactions within the whole MGP

The ability for all midwives to interact within the MGP relies on solid communication and shared philosophy. A larger group of midwives—greater than six or eight—will make it more likely that differences will occur. Effective management depends on good governance and, potentially if the MGP is very large, possibly having a midwife who manages the MGP.

Again, a range of decisions need to be made at the level where the pairs of midwives are interacting with the whole group:

- what support the pairs provide to other partnerships within the group
- rostering of leave and backup during times of leave
- similarities and differences in organisation of day to day care
- meetings and organisational requirements.

Being advocates for women

Midwives working in continuity of care models may therefore appear or be labelled as more outspoken when they are only fulfilling their professional role ensuring women are understood and provided with informed choice. Some staff (midwives, obstetricians, managers) may find this level of partnership challenging. It may pose a particular challenge where the continuity of care midwife provides care for a woman who chooses care contrary to existing policy. A clear understanding of the woman's right to make informed choices is necessary for all staff. 'Informed choice' situations should be used to enable review of policy and to develop shared understanding of the needs and rights of women with unconventional preferences or needs.

Time management for MGP midwives

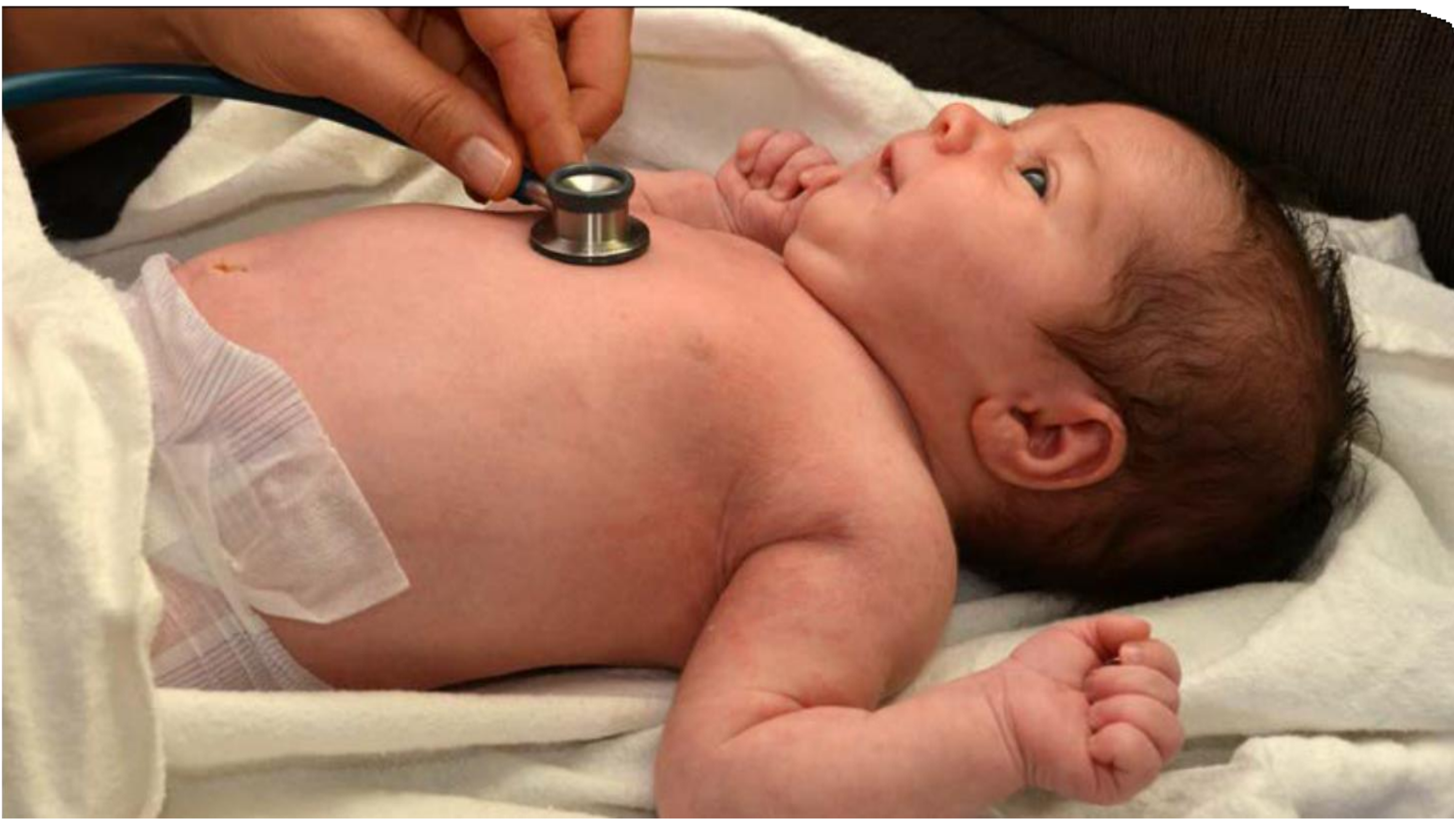
Good time management processes are essential to sustain midwifery continuity of care. Managers need to be flexible and supportive, allowing midwives to develop systems that meet their needs. Each group practice needs to negotiate mutually beneficial systems and adapt these over time.

Individual midwives need to learn the time management skills that make caseload practice sustainable and enjoyable.

The most important element is an agreed way to work within the MGP. Midwives are innovative in organising time management within their group practices, in ways which meet the needs of midwives and their families, while delivering care to women when they need it.

Midwives may be concerned about levels of fatigue and time on-call. Burnout is a significant problem when workloads are not manageable. However it is not just about time on- or off-call. Stressors such as trying to deal with organisational conflicts such as opposition to the partnership with women, difficulties communicating with staff, arguments about patterns of work and midwives wanting to be on-call for their named women all contribute to burn out.

Midwives working together in an MGP need compatible work arrangements. If midwives in an MGP have different on-call or off-call arrangements then imbalance will occur.



> Antenatal and postnatal appointments need to be scheduled in a mix of short and long appointments, using opportunities for information sharing but ensuring that time in appointments is used productively.

Appointment scheduling

Midwives in caseload models work no rostered shifts. Antenatal and postnatal appointments need to be scheduled in a mix of short and long appointments, using opportunities for education but ensuring that time in appointments is used productively. Appointments need to be flexible to allow the midwife to change them when she needs to attend a woman in labour, or an emergency arises. The midwife will self-manage this time, generally in consultation with her partner or back up midwife.

To maintain flexibility of time management, it is desirable to avoid scheduling entire days of continuous appointments. A few hours of scheduled appointments on three days per week should be adequate to cover antenatal care and allow for time for unscheduled care. Where midwives do routinely book whole days of appointments they will find that they may frequently need to move the entire day's schedule and therefore need to discuss this with their clients so as to avoid frustration.

Some midwives prefer to provide appointments at the same time as their partner midwife so that if one of them is called away, the other can continue but provide slightly shorter appointments.

After discharge from hospital initial postnatal appointments will all take place in the woman's home until breastfeeding is established. After a period of time women may prefer to do some travelling again for later postnatal appointments; however this needs to be negotiated to the woman's needs and capabilities.

Call out and phone calls

Midwives are required to attend to women for a range of issues during the after-hours period. These range from non-urgent issues, such as queries about different elements of care, through to emergencies. Midwives need to develop triage strategies to ensure their home life is not constantly interrupted:

- provide women with a guide of what are acceptable times to be contacted for non-emergency queries
- clearly outline what constitutes emergency situations.
- clearly outline other circumstances in which the midwife wants immediate contact to be initiated
- consider use of a pager for emergency situations only so that the midwife's mobile can be turned off for periods of time
- develop a triage system for non-urgent off-call contact with between partner midwife/s
- limit phone time to five minutes when out of hours.

Plan a caseload over the next 6 - 12 months

Midwives providing continuity of care will benefit greatly from planning their caseload work around six months in advance. There are a number of considerations for midwives when allocating women to midwives, accepting a woman on to a caseload, or discussing with a woman whether a midwife is available to provide their care:

- indicate any periods where the midwife will be away and/or require a complete day or subsequent days off
- consider professional development leave
- block off leave well in advance
- consider the mix of nulliparous and multiparous women each month
- be aware that after a particularly busy period, where there have been unexpected elements, it is important to take additional down time. Management support for this element is critical.
- geographical location of women to midwife
- mixture of women with low risk and high risk issues or A, B and C categories.

The most important element of having a mix of personal and professional time is to create trusting relationships between the women for whom the midwife is the primary midwife and the midwives providing back up. The ability to hand over care of a woman with confidence to the backup midwife is the indication of success.

Leave within the MGP needs to be considered in relation to the whole group. Unexpected leave does provide periods of increased load and therefore increased stress. Having a manager or clinical midwife able to fill periods of unexpected leave may assist with this.

Managing on call for labour and birth

Most of the midwife's on-call time is for women in labour. Good practice points for time management for birth care include:

- Discussing the signs of early labour with the woman in the antenatal period to ensure that women realise how much time may elapse with contractions before 'active' labour commences and the midwife is needed continuously.
- When early labour phone contact is initiated, the midwife must spend time on the phone discussing with the woman what is happening. If possible spend time counting and assessing contractions on the phone for women who may not be in established labour.
- Provide home assessment in labour to encourage women to rest if latent phase of labour is long or if the midwife is unsure if the woman is in labour.
- The midwife should rest when possible whilst the woman is in early labour.
- If a woman is in early labour during the day, the midwife should not complete a full clinical day as the woman is likely to labour overnight.

Managing non-clinical activities

Midwives need support from other staff in performing non-clinical duties. Administration and record keeping is a significant part of any model and dedicated administrative support must be available. A consistent state/territory wide data collection system is an essential requirement to assist midwives with data collection and evaluation. Other non-clinical tasks include cleaning, sourcing and maintenance of equipment.

It is important for continuity of care midwives to be able to focus on their clinical workload and essential documentation. Administrative jobs such as filing, making and changing appointments, tracking results and ensuring that note keeping and meetings are made and dealt with are important jobs, but dedicated administrative time should be available for these jobs. Midwifery models do not 'fit' with traditional methods for allocating workloads. Administration needs to be as streamlined as possible. Mechanisms such as using computers at home, being able to record data in electronic systems and electronic record keeping are beneficial.

Documentation

Documentation is a specific aspect of communication within the midwifery continuity of care model. Shared documentation in the form of pregnancy hand-held records, local specific pathways and processes and locally-developed, evidence-based protocols will vary slightly from model to model. However for the purpose of data collection and audit the aim should be to have consistent documentation and key performance indicators across models.

...for the purpose of data collection and audit the aim should be to have consistent documentation and key performance indicators across models.

Administrative jobs such as filing, making and changing appointments, tracking results and ensuring that note keeping and meetings are made and dealt with are important jobs, but dedicated administrative time should be available for these jobs.

11 Collaborative maternity care

The best outcomes in maternity care occur when there is effective collaboration between health practitioners. In cases of poor outcomes, the vast majority are found to have problems in communication as a root cause while only a small minority result from inadequate skills.

Good collaboration does not require every practitioner to be involved in every woman's pregnancy, nor does it mean one health practitioner being responsible for the practice of another. It is about women and their babies accessing the care they need, when needed, from caregivers who communicate and work effectively together. The NHMRC Collaborative Guidance for Maternity Care provides direction to Australian clinicians providing maternity care [56]. This should be referred to by those providing maternity care and used to guide collaboration between all caregivers, both within and outside the service.

Communication as the first stage of collaboration

Collaborative maternity care needs to be consciously built by service leaders. There is a long process of developing pathways of communication and trust prior to collaborative maternity care working well. There are some processes to fast track this communication that can be undertaken as a part of the planning and development of midwifery models of care. Section 4 outlines the steps to commence processes of engaging stakeholders. Section 5 outlines cultural change and Section 9 outlines professional development for midwives. These are important elements of building collaboration.

Collaborative maternity care may start with communication with internal stakeholders and additionally in engaging external stakeholders.

The development of clear communication pathways has been identified in Section 4 as a fundamental process within the model. Trust by other clinicians in the midwives providing primary care as autonomous practitioners is essential. Senior staff, as leaders of the respective professions, must model and set clear parameters around acceptable processes and behaviour.

Maternity care coordinator

The NHMRC identified a need for women to have a known 'maternity care coordinator' who is 'the person nominated by a woman to coordinate her maternity care' [52]. This is a useful mechanism to ensure communication processes are effective, as one clinician takes a leading role in ensuring communication and decision making occurs in a coordinated manner. In a MGP model, the woman's caseload or named midwife would take this role. The maternity care coordinator is responsible for ensuring the woman is provided with the care required and consults, refers and transfers care when appropriate.

For some units this presents a significant change in the way midwives and medical staff provide care, and may also change the line of responsibility for decision making in a woman's care.

Consultation and referral

The National Midwifery Guidelines for Consultation and Referral [39] provides the framework for decisions regarding consultation, referral and transfer of women's care. These guidelines have been endorsed by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and are recommended by a number of health departments across Australia.

The pathway for communication needs to be appropriate to the experience of the doctors and midwives. Midwives in continuity models should have a direct communication pathway with senior medical staff, such as a consultant obstetrician or a GP-obstetrician. It is not appropriate for junior medical officers to be seen as the first line of communication for midwives wanting to consult and refer.

There are also different ways of organising medical support within larger hospitals, such as allocating specific medical staff to support the midwives in continuity of care models. In services where organising care in this way is possible, communication is streamlined and the woman experiences both continuity of midwifery care and medical care. This is extremely desirable from a woman's perspective. The box below provides an example of collaborative care from a primary maternity unit.

Box 2: Example of collaborative care

Mary presents to a primary maternity unit, pregnant with her third baby. She has had two previous caesarean sections. Jenny is the MGP midwife providing Mary's care. Jenny considers Mary's situation within the context of the Clinical Services Capability Framework in that state. Jenny explains to Mary that regardless of her choices around her birth (planned vaginal birth or planned caesarean section), there will need to be consultation with and referral to Tweed Hospital the for birth care. Jenny then completes the necessary booking for Mary and considers Mary's situation in relation to any further indicators within the ACM Consultation and Referral Guidelines. Jenny will complete the required paperwork including a referral to Tweed Hospital for a consultation to discuss birth care. Jenny explains to Mary that she will continue to provide primary maternity care to Mary locally, but that Mary will also need secondary care in Tweed Hospital for her birth.

Development of consultation and referral pathways for use within an MGP would include a range of documents for local processes. The essential documents would include:

- a map which details consultation, referral and transfer processes both within a service and to another service
- an outline of a case review process that enables discussion of women's cases where consultation and/or referral may be required. A weekly or fortnightly case review process with midwives, onsite obstetric staff and/or medical staff from secondary or tertiary referral facilities is recommended
- a form to enable documentation of consultation, referral and transfer of care. A mechanism to ensure outcomes data is captured is also necessary
- clear documentation of discussion and plan for ongoing care where a woman refuses recommended care.

Multidisciplinary case review

A process of regular multidisciplinary case review is very helpful in developing collaborative relationships. Obstetric support should be engaged to establish a case review process early in the development of the model. It is important to develop a clear process for reviewing care requirements.

Collaborating with other facilities

Some MGPs will not have on-site obstetric or medical staff, or access to local obstetric care may be intermittent. In these situations processes for consultation and referral will depend on collaboration with caregivers in other facilities. Trusting relationships and effective communication pathways will need to be developed to ensure women have access to the right care at the right time.

When medical support is some distance away, decisions regarding potential place of birth need to be made in a timely fashion. Planning these processes should take account of the potential for births to occur unexpectedly at any site or for women to make choices in their care that are outside recommendations.

Case conferencing and consultation and referral can occur at a distance through phone conversations, video links, webcam or in a face to face arrangement as possible.

The box overleaf provides another example of effective collaboration and consultation.

Box 3: Another example of collaborative care from a primary maternity unit

Face-to-face regular meetings occur between MGP midwives in a small rural town with a primary maternity unit and the consultant obstetrician from the referral hospital in the larger town 60kms away. Together the interdisciplinary team review and determine the appropriate level of care and birth place for each woman at booking and across her pregnancy, consistent with the ACM Consultation and Referral Guidelines. Women in the town who book for maternity care are aware that their care may be shared with or transferred to Cairns, in consideration of their obstetric or medical history, or in response to indications that develop during pregnancy or labour. When a midwife observes deviations in the woman's pregnancy that require attention prior to the next planned case conferencing session, or deviations occur in labour, telephone consultation occurs using the SBAR tool (see Appendix 13). This enables clear communication of the woman's Situation, Background, Assessment and Recommendation so that the birth suite registrar in Cairns can provide advice or liaise with the obstetric consultant if required. Because no local obstetric support is rostered, Mareeba midwives are experienced in assessing timeliness and mode of transport requirements for transfer out of this rural site. However if local escalation is necessary to manage care on-site, the midwives have developed communication channels within the hospital and with local GP obstetricians.

Collaboration with private providers

Services will have different needs regarding engagement of clinicians outside of the facility. A metropolitan hospital might initially involve those staff working in the maternity area only, whereas a rural service would be best to include all staff at the hospital.

Rural hospitals reliant on local GPs for obstetric and anaesthetic support would view their relationships as vital to the model and ensure inclusion at each stage of planning together with membership of management groups. Alternatively a metropolitan hospital might see GPs as external stakeholders not intimately involved with service change and provide them with periodic updates. Communication mechanisms need to be suited to local needs.

Some suggestions for involvement of GPs include:

- providing an overview of the proposal to a standing meeting of GPs
- conducting forums with existing GP groups
- developing a flyer that is updated regularly (this could be sent to a range of groups)
- distributing a regular newsletter
- one on one meetings with key GPs or other stakeholders
- lunch time meetings
- developing an intranet or internet site.

A range of mechanisms can be used to support collaborative processes with clinicians outside the service:

- review of clinical cases with collaborating GPs should occur from time to time throughout the woman's pregnancy regardless of need for consultation and referral
- consultation and referral processes should be developed in conjunction with collaborating GPs and other clinicians based outside the service
- information should be shared between clinicians by sharing documentation including results for pathology and imaging
- use of the NHMRC Guidance on Collaborative Maternity Care (2010) can assist practitioners in the planning and implementation phases to identify their roles
- defining the 'maternity care coordinator' as per the NHMRC Guidance may assist practitioners to ensure that responsibility for ensuring completeness of care and records rests with a single practitioner, although each clinician retains their professional accountability.

Engagement with private midwives will also vary depending on the circumstances. In some communities private midwives may be valuable members of reference for management groups, bringing experience of caseload practice. Potentially, public hospitals may develop continuity models which involve endorsed midwives providing some care privately.

Other public health and community services

Consultation and referral with a range of public health and community services will be essential for good care. Midwives will refer fluidly to a range of allied health practitioners, including physiotherapists, continence services, dieticians and psychology services. Community services including child health nurses are a fundamental part of the care for a majority of women. Processes for requesting consultation and referral will vary from service to service and should be clarified at the planning stage.

Midwives will refer fluidly to a range of allied health practitioners...

Retrieval services, Royal Flying Doctors Services, ambulance services

Engagement of emergency transport services is essential for timely and appropriate transfer services. Staff in the model will need communication channels and an understanding of the limitations of different modes of transport under various conditions of weather, the local environment, and women's and/or babies health conditions and retrieving agency distance.

Representatives from both local emergency services and at the partner referral site, along with experienced clinicians from any linked sites, should discuss the various likely scenarios and how these can be managed. Local agreements should be determined.

12 Sustaining and evaluating

Midwifery models of care need to be developed in such a way that they are able to be sustained. Strategies to enable long term viability will be discussed throughout this section. Strategies to build sustainability into the initial planning of the model were covered in Section 3.

Communication within the model is the basis for successful implementation. Establishing effective communication within the organisation is an essential first step to developing a model. The plan needs to include the steps that all stakeholders will take when communicating with each other.

Issues for managers

The foundation of the model needs to include a shared understanding about meeting the needs of the woman and the midwife. Managers need a clear understanding that their role is to actively enable midwives to determine the way in which they work. Managers often report that midwives indicate they 'don't want to' or 'can't' work in continuity of care models. It is important that the midwives understand the model well and that they have the support of a manager who provides the flexibility that is required for midwives to adapt to the model and respond to clinical responsibilities.

Issues for managers include:

- recruitment of committed midwives who have an understanding of work-life balance, are comfortable to seek the support of their manager, and have the clinical skills to provide care across the continuum in line with the model of care provided
- the ability to trust the midwives to manage and make appropriate decisions about their practice
- an expectation that midwives will attend the majority of the births for their own caseload women, but have the opportunity to have care provided by known back up midwives
- appropriate consultation about model-specific issues (demography of clients and geographic area to cover, determining numbers of women in each midwife's caseload)
- support for midwives when the woman makes an informed decision that conflicts with unit policy or consultation and referral guidelines [38]
- support and integration with core staff where these are in place
- recognition that the midwifery workforce is a fluid one. For instance, a midwife might not be able to work in a caseload model at a given time because of the commitments of a young family, but in a couple of years the midwife's family commitment change so the midwife will review that decision. The manager needs to be able to respond to staff moving regularly in and out of core and caseload models of care.
- midwifery models are challenging for managers who are used to close on-site contact with their staff, managing rostered shifts and counting hours. Continuity of care models are not driven by the needs of the service but by the needs of women and therefore may be perceived as more difficult to 'manage'. They are not difficult, but do require flexibility in management, flexibility with staffing arrangements and flexibility in how care is delivered.

Sustaining midwifery continuity of care

The ability to sustain midwifery continuity of care models relies on several elements:

- the ability to sustain the midwives
- communication and good working relationships with colleagues
- safety and quality within the service.

Midwife managers have a responsibility to ensure midwives practice self-care including:

- regular scheduled days off-call
- arrangements for times where a midwife is unavailable (when not off-call)
- robust cover arrangements for unexpected leave or relief
- a system for provision of collegial advice and support
- regular supervision/mentoring/support for the midwife with a focus on self-care.

The requirement for communication and good working relationships with colleagues is essential for longevity. Situations where models are under threat of closure are often due to a lack of communication or lack of a developed working relationship between colleagues—particularly medical colleagues involved in the model or providing backup. Several strategies for dealing with this are outlined in Section 11 but can be summarised as:

- direct engagement and involvement of medical colleagues in development of the model
- regular scheduled communication and case review on a cycle of two to four weeks
- formal and informal processes of welcoming new members of the collaborative team
- management support for midwives, particularly those having difficulty communicating or consulting and referring to colleagues
- case review with a range of members of the team, specifically where poor outcomes occurred, where communication has broken down, where collaborative care worked well or where the woman made decisions outside unit/professional guidance
- regular meetings with core staff and other members of the wider team.

Ensuring quality and safety

Safety and quality is another element that is often put forward as being a reason to change or close midwifery models. Obviously safety is paramount however it is rare that significant safety issues arise in a well-developed or well-maintained midwifery model of care. Sustainability can be greatly supported by the informed and supportive management and availability of outcome data to support the model's safety record. Some steps to ensure sufficient transparency of the model's processes and outcomes include:

- collection and reporting of data relating to key performance indicators, including outcomes that may be problematic
- support of staff including appropriate leave, numbers of staff, numbers of clients, working environment
- transparent processes where care falls outside of agreed pathways that support the midwife and woman involved.

Ensuring retention and managing burnout

Retention of midwives in midwifery models of care is important. Midwives tend to leave models where they feel a lack of support, receive poor communication or feel undervalued. Therefore, it is important for managers to ensure enough flexibility for midwives to choose the way they work but provide enough mentoring and supervision to ensure midwives are using self-care mechanisms to support the way they work.

It is important that any burnout is identified and addressed. It is possible that involvement of personnel external to the unit may be required. The unit needs to have strategies in place to ensure midwives who are fatigued or demonstrate signs of burnout are managed carefully. Any management strategy which creates additional stress for remaining colleagues is unlikely to deal with this issue.

Midwives may or may not be able to verbalise strategies to deal with stressors associated with the caseload role or their personal life. A professional mentor or in-house psychologist could be helpful particularly if midwives express feelings of fatigue or frustration and these concerns appear to be related to internal processes. Additionally, engagement of external midwifery continuity of care experts to strategise and find solutions with midwives is important. Regular processes which encourage discussion about support at home, stressors within the home and problem solving strategies to reduce overall stress are vitally important and should be factored into the model.

Evaluating outcomes

Evaluating outcomes and collecting sufficient information to support the model is critical yet it is a step that may not be undertaken well, or may not be undertaken at all. Adding an administrative or research load to the midwives caseload in recording and evaluating outcomes is inappropriate. A process to collect data from that which is already entered by the clinician is essential. Provision of dedicated time for evaluation of data is also required. Models with few or no clear data collection systems typically have difficulty demonstrating their safety record. This can be a significant barrier to sustainability.

13 Endorsed midwives and midwifery continuity of care

A range of Australia-wide reforms made in 2010 were intended to improve women's access to continuity of midwifery care in the private system. These were:

- A range of antenatal, intrapartum and postnatal MBS rebates has been enabled by the Commonwealth, for services of endorsed midwives (previously referred to as Medicare Eligible Midwives) in private practice
- The Endorsement for scheduled medicines has been created by the NMBA, enabling access to Medicare provider numbers
- The Endorsement for Scheduled Medicines allows midwives to prescribe and order investigations and tests
- A range of medications are subject to PBS rebates when prescribed by endorsed midwives
- Reforms of states' and territories' drugs and poisons legislation has occurred to legalise prescribing by endorsed midwives
- Commonwealth-subsidised professional indemnity insurance was made available to endorsed midwives but homebirth was not covered.

These reforms represented a major reform to Australian maternity services. However, only several public maternity services have implemented a credentialing framework and granted visiting rights for endorsed midwives. For further information please refer to the ACM's guide to implementing visiting access for Endorsed midwives.

Scope exists for facilities to establish hybrid models in which antenatal and postnatal care is provided privately by endorsed midwives and for some rural or remote facilities to access Medicare rebates for antenatal and postnatal care by endorsed staff midwives under Section 19.2 of the Health Insurance Act 1973.

Endorsed midwives

Endorsed midwives are able to provide MBS-rebatable services. An endorsed midwife has completed additional requirements, as legislated by the Commonwealth Government, to receive an endorsement on registration by the Australian Health Practitioners Regulation Authority (AHPRA) [76].

To apply for endorsement for scheduled medicines a midwife must be able to demonstrate all of the following.

1. Current general registration as a midwife in Australia with no conditions or undertakings relating to unsatisfactory professional performance or unprofessional conduct
2. Registration as a midwife that is the equivalent of three years' full-time clinical practice (5,000 hours) in the past six years that is either:

- across the continuum of care, or
- in a specified context of practice

from the date when the complete application seeking endorsement for scheduled medicines is received by the NMBA.

3. Successful completion of:

- an NMBA-approved program of study leading to endorsement for scheduled medicines, or
- a program that is substantially equivalent to an NMBA-approved program of study leading to endorsement for scheduled medicines as determined by the NMBA.

The benefits of endorsement currently apply mostly to midwives in private practice. One organisation whose specific remit is to support private practice midwives is Midwives Australia.

The benefits of endorsement currently apply mostly to midwives in private practice.

Medicare provider numbers

Once a midwife has an endorsement, they are able to apply for a Medicare provider number. This enables women receiving the endorsed midwife's services to access MBS rebates for antenatal care, birth care in hospital and postnatal care.

MBS rebates are available for a range of midwifery services.

Collaborative arrangements

At the time of writing payment of MBS rebates for services of endorsed midwives is conditional on the midwife providing the service under a 'collaborative arrangement' with one or more 'specified medical practitioners or if they are credentialed as part of an access agreement to a hospital. More details of what constitutes a collaborative arrangement can be found in the ACM's Implementing Visiting Access for Endorsed Midwives: A guide for hospitals and health services.

The requirement for 'collaborative arrangements' does not give doctors responsibility for the practice of endorsed midwives as they are separately regulated health practitioners. According to statements in Parliament, the requirement for 'collaborative arrangements' is not intended 'to provide a right of veto over another health professional's practice' (Australian Government, 2013). The purpose of the requirement, as described in the legislation, is to provide for consultation, referral or transfer when the woman's care requires it (Australian Government, 2013).

Professional Indemnity Insurance

All private practice (self-employed) midwives require insurance to cover all aspects of the care they provide. The only exception is intrapartum care in the home, which is exempt from the insurance requirement until 31st December 2019.

Publicly-funded homebirths, under current arrangements based in states and territories, will be able to continue. However, midwives who are working under such arrangements should ensure they are covered by their respective employer's insurance arrangements.

Endorsed midwives can purchase the government-subsidised insurance package from Medical Insurance Group Australia (MIGA) insurance. The MIGA product does not cover birth in the woman's home, but does cover private birth care in hospital. The MIGA product requires midwives to either have a 'collaborative arrangement' or, if this is not in place, to communicate a care plan to the woman's booking hospital and to ensure receipt of acknowledgement of the care plan.

MIGA insurance does not cover care of an admitted public patient in hospital.

Credentialing

With endorsed midwives providing Medicare-rebatable services, there is now a need for credentialing processes for midwives, similar to those for visiting medical officers (VMOs). Credentialing will be required as part of any visiting access agreement for endorsed midwives, who have a collaborative arrangement, to provide care to women who are admitted as private hospital patients. In this process the midwife will be formally assessed on competence, performance and professional suitability.

Visiting access

For women to be able to receive continuity of carer from their endorsed midwife, mechanisms for visiting access by endorsed midwives to public hospitals are necessary. All Australian states and territories have committed to facilitating women's access to in- hospital care by endorsed midwives in the National Maternity Services Plan [54].

At the time of publication, a number of states have a framework for developing a visiting access agreement although these have not been widely taken up as yet. The components of an agreement include:

- A document outlining the agreement between the hospital and the endorsed midwife in private practice.
- A credentialing process, including an application form, a credentialing committee, a statement of credentialing and a process to review the conduct of the credentialed midwife if a problem occurs.

A range of other processes would need to be ensured so the midwife is able to admit private clients; have access to orientation and professional development; organise parking; and access patient information systems.

Endorsed midwives could potentially provide intrapartum care in private hospitals, in private midwifery practice. This would require cooperation with private obstetricians and supportive hospital management.

Different models of care

The following parameters must be considered for MBS-rebatable midwifery care:

- Midwives must be NMBA endorsed and have Medicare provider numbers.
- Midwives must carry professional indemnity insurance and practice within associated requirements.
- Midwives must provide services within private practice (with limited rural and remote exceptions under Section 19.2—see below).
- Care must be within a 'collaborative arrangement'.
- Intrapartum care outside a hospital is not MBS-rebatable.
- Intrapartum care in hospital must be for a woman who is an admitted private patient.
- Midwives providing care in hospital must be credentialed by the hospital.

Over time endorsed midwives will need to maintain currency across the full scope of midwifery practice.

The Medicare funding is relatively new and associated midwifery models of care are still being established.

Within these parameters, the following models are possible:

- Private MGP models providing midwifery continuity of care
  - o *Midwives in private MGPs obtain collaborative arrangements, credentialing and visiting access to provide Medicare-funded intrapartum care as a visiting practitioner. National standardised documentation and processes would be ideal in supporting this model.*
- Solo midwives with a Medicare provider number providing midwifery continuity of care
  - o *Midwives in solo private practice will require the same arrangements and use the same documentation, processes and pathways as midwives in private group practices.*
- Midwives providing an element of midwifery care
  - o *The opportunity also exists for midwives to provide one element of care—such as only antenatal or only postnatal care. While the endorsed midwife has to be current across the full scope of midwifery practice, the midwife may provide one element in private practice and maintain currency in the remaining elements in employed practice.*
- Hybrid private and public models
  - o *Women may be able to receive continuity of midwifery carer with their midwife in private practice for antenatal and postnatal care, and with their midwife working in employed public hospital practice for intrapartum care. This model will depend on good collaboration between private midwives and public hospital management.*
  - o *Rural GP-obstetricians frequently work under arrangements of this type.*
- Midwives employed by private obstetricians or GP-obstetricians
  - o *Some private specialist obstetricians or GP-obstetricians may employ endorsed midwives in their practices. These midwives could potentially provide care in private hospitals as well as doctors' rooms.*

Rural and remote public facilities

Section 19.2 of the Health Insurance Act 1973 allows specific public facilities to be enabled by the Commonwealth minister to work under different rules. Section19.2 allows public hospital employees to provide MBS-rebated outpatient services in declared rural and remote locations. In these locations endorsed midwives might work as employees while providing MBS bulk-billed outpatient care.

Aboriginal Medical Services or other entities

An endorsed midwife employed in an Aboriginal Medical Service (AMS), which also employs a GP-obstetrician, would meet the requirements for 'collaborative arrangements'. Such a midwife could also be employed by a public facility for provision of intrapartum care.

Private hospitals

Endorsed midwives could potentially provide intrapartum care in private hospitals, in private midwifery practice. This would require cooperation with private obstetricians and supportive hospital management.

Possible implications for maternity services

It is hard to predict how the gradual introduction of endorsed midwives into the maternity care system will affect public maternity services.

Possible options include:

- Midwives working in public MGP models will find gaining endorsement much easier than many midwives in other models and consequently may have more options for practice.
- Women could be referred, by public hospitals or hospital clinicians, to endorsed midwives for antenatal or postnatal care (if by a doctor, this may create a 'collaborative arrangement').
- It is conceivable that employed endorsed midwives could be granted 'right to private practice', like doctors and create new revenue options for public facilities.
- Contractual arrangements with endorsed private midwives might be used to provide services when public facilities are running at or over capacity.

14 Frequently asked questions

This section provides the answers to a number of questions that have bene posed over the years. They may be useful when pre-empting some of the issues that health services will raise. The evidence for these answers are contained in the handbook itself.

1. How is midwifery continuity of care different?

Differences for women who are receiving midwifery continuity of care are:

- knowing their carer(s), thus feeling safer and more confident
- having access to a known carer 24/7
- receiving responsive, personalised care
- having carers who understand and support their choices
- having carers with a more thorough understanding of their circumstances, needs and preferences, strengths and capabilities
- being more satisfied with their care
- better clinical outcomes.
- knowing their carer means knowing the midwife's name, phone/contact number, when to call and how to call, who she works with and when she will visit.

There remains limited opportunity for most women accessing public health services to know their carer(s) especially those who will be at their labour and/or birth.

2. What is different for midwives working in continuity of care models?

Differences for midwives are:

- the ability to work to the full scope of midwifery practice across the continuum of the woman's childbirth experience
- getting to know the women they care for
- midwives work autonomously but not independently of the broader health team
- the level of clinical decision making under the midwife's own responsibility is significantly increased
- there is an opportunity to work across and between the woman's home, community and hospital sites
- midwives work flexibly across 24/7 under safe industrial arrangements
- high levels of job satisfaction.

The meaning of midwife is to be 'with woman'. However, there are barriers within mainstream care to fulfil this educationally prepared professional role. Studies report that in practice, midwives in mainstream or traditional models may spend relatively little time directly supporting or working with women.

Midwives working in continuity of carer models are required to work to their full scope of midwifery practice. Partnering with women, they provide ongoing care across the continuum. They link with other maternity carers in response to the woman's needs. This leads to improved clinical effectiveness. Midwives make clinical decisions under their own responsibility and consult and refer to obstetricians and other health professionals as required. This is not a specialist role, but the role midwives have been educationally prepared for.

3. What are the cost implications for establishing a midwifery continuity of care model?

New models can be resourced within existing budgets with little or no additional cost. Where additional positions are required for a new service, managers can often access existing positions within their budget that have been vacant and realign these existing resources to the new model. More commonly however, proportionate resources can be redirected from antenatal, intrapartum and postnatal (including home visiting) budgets to the new model where the care will now be provided.

Where areas find that they are under-resourced for their level of activity within their mainstream maternity service, any additional secured budget can be invested in establishing or expanding a continuity of care model. Due to additional savings from reduced sick leave in continuity models, a proportion of existing budgets for on-call or agency and relief staff can also be redirected to the new continuity model. Where budgets are developed for refurbishment or for new maternity facilities, provision should be made to cost birth space and associated staffing costs for a continuity model of care.

It has been found that in alternative birthing facilities, reduced unnecessary interventions occur including lowering the caesarean section and induction rates compared with care provided in a general birthing area.

As throughput of women increases in continuity models, greater savings can be realised due to reduced usage of theatre, special care and maternity beds, reduced antenatal presentations and lower postnatal readmission rates. MGP models can be established within existing budgets (sometimes with minimal start-up funds) through evaluating whole of service resources and redirecting existing funds to continuity of care models.

4. Managers/doctors/GPs/midwives in my area don't want to develop a midwifery continuity of care model. What will happen?

The issues surrounding organisational resistance are addressed in Section 5 Building a Supportive Cultural Environment. Considering the positive outcomes of such care, it will be an inadequate response for services to actively refuse to develop models. Resistance to change can be endemic and therefore this document offers a range of mechanisms to develop thinking and action (see Section 5). Resistance to change is often based on a lack of understanding of the model or a lack of exposure to successful, functioning examples.

A lack of knowledge and exposure to midwifery continuity of care can be addressed in a straightforward fashion. The midwifery continuity of care model is well explained throughout this handbook. Please refer to the last question in this section for further assistance.

Midwives here don't want to work in midwifery continuity of care, what do I do?

Again, the reasons for midwives reluctance to change may include a lack of knowledge about the model. Inviting midwives who have worked or are working in midwifery continuity of care models, and consumers who have experienced continuity of midwifery care, to speak to midwives within the service is one initial strategy for commencing the process. There may be a need to recruit experienced continuity of care midwives to provide support to the service for a short period to assist in the transition.

These models are new to most midwives and managers and it is really important to recognise our own limitations and use the support which is available. The local Nursing and Midwifery Office is well placed to provide support and advice...

I can't be on-call—I have small children/family needs/carer issues, but the entire unit is moving to continuity of care. What can I do?

Not all midwives may feel ready or able to work in continuity models. It is important to understand the source of any reluctance or apprehension and determine it is not a symptom of internal workplace pressure to resist change or due to myths surrounding what it is like to work in a caseload or continuity model. A number of midwives in Australia working in continuity models and specifically MGP models have shared their stories of how they have adapted and coordinated their professional and personal lives around family needs [38].

Midwives have the opportunity to schedule on-call time, as they do with shifts, and to fit appointment times around their other commitments. Many midwives with young families comment how smoothly caseload work can work around their family life if they are organised appropriately.

What is the difference between 0.5FTE caseload vs 0.5FTE shift work?

A caseload midwife providing care as a 0.5FTE employee provides care for up to 20 women per annum, approximately two women per month. Allowing for the occasional on-call situation of backing up a colleague, midwives will be required to attend births in an unplanned fashion twice per month and are probably likely to have two or four more urgent call-outs per month that cannot be postponed to routine care. The remainder of the time the midwife can provide care at her convenience, scheduling visits at times that best suit other commitments such as family. A midwife working as a 0.5FTE employee will have two eight hour shifts one week and three eight hour shifts on the second week. The midwife may have some control over timing of these shifts, depending on hospital workforce circumstances. In some rural units, midwives expect to be on-call to some extent even in a shift-work model.

For managers it is important to identify barriers and actively work toward ensuring they are addressed. If midwives remain unclear about how to develop a flexible model to meet their needs, engaging an experienced continuity of care midwife to provide guidance is an important step. It is appreciated that experienced midwifery managers may not have the skills to easily transition to managing a continuity model or readily identify the flexibility required to support continuity of care midwives. Therefore, regardless of expertise, it is recommended that managers develop their own networks and engage with the local union for advice and support.

For managers it is important to identify barriers and actively work toward ensuring they are addressed.

I want more information and support in developing a continuity model. Where can I find colleagues who are experts in continuity of care?

These models are new to most midwives and managers and it is really important to recognise our own limitations and use the support which is available. The local Nursing and Midwifery Office is well placed to provide support and advice, with both their own staff and referral to experts in other facilities. The Australian College of Midwives is also able to facilitate linkages between midwives to share knowledge and experience.

I am nervous about providing antenatal care from a community-based setting. What happens if I need to contact a doctor quickly?

Providing care in a community-based setting requires good processes for seeking urgent review from doctors. Midwives have skills to identify deviations from normal regardless of where care is provided and this requires prompt action in accordance with consultation and referral guidelines. If women are already experiencing complexity in their pregnancy, it is likely they will be receiving medical care at a secondary level and midwives should make phone contact with the woman's doctor. Community-based clinics should have pre-established lines of communication with obstetricians or GP-obstetricians for urgent as well as non-urgent referral.

Glossary

This glossary includes all relevant definitions from the NHMRC's National Guidance on Collaborative Maternity Care. Thanks to NHMRC for allowing use of their work.

ACM:

Australian College of Midwives:
www.midwives.org.au

AHPRA:

Australian Health Practitioner Regulation Agency, the new (2010) national body regulating health practitioners:
www.ahpra.gov.au

ALSO:

Advanced Life Support in Obstetrics:
www.also.net.au

Caseload midwifery:

Refers to the model where the woman has a 'primary' or 'named' midwife, providing the majority of pregnancy, birth and post birth care [38]. This model is also referred to as a 'continuity of carer model' or 'one to one' midwifery care.

Caseload:

The actual number of women a caseload midwife is 'carrying' or providing care for (i.e. her workload).

Clinical privileging:

The process by which a health care professional is granted permission by a health service (e.g. a hospital) to provide care services within defined limits. These limits are based on an individual's qualifications, experience and registration status.

Collaborating partners:

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.

Collaboration:

A process where two or more independent professionals work together with the woman to achieve common goals by sharing knowledge, learning and building consensus.

Collaborative agreement or arrangement:

An informal or formal recognition of the terms of a collaboration.

Collaborative practice:

A group of maternity care professionals who collaborate with each other and with women in the planning and delivery of their maternity care (see also Section 1.1, NHMRC National Guidance on Collaborative Maternity Care).

Continuity of care:

A situation where a woman is cared for by a group of professionals who share common ways of working and a common philosophy.

Continuity of carer:

Care provided, or supervised, over time by the same trusted carer (usually including backup arrangements).

Coordinator of care:

The person nominated by a woman to coordinate her maternity care.

Core midwives:

Work rostered shifts to provide midwifery care within a facility (in contrast to caseload midwives who may work in a range of settings and attend as required by client's needs).

CPD:

Continuing Professional Development.

Endorsed midwife:

(Previously referred to as Medicare Eligible Midwife) Is able to provide Medicare-rebatable services. She has an endorsement for scheduled medicines by the Nursing and Midwifery Board of Australia (NMBA), which is granted after application and meeting the NMBA Registration Standard: Endorsement for scheduled medicines.

Family:

The woman's spouse, husband, de facto, partner, sibling, kin, parent, guardian or community.

Informed choice:

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.

Informed consent:

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 (NHMRC Guidance).

Informed refusal:

When a woman refuses a recommendation about her care after a process of information exchange that involves providing the woman with sufficient, evidence-based information so that she can make a decision that reflects self-determination, autonomy and control.

Midwifery Group Practice (MGP):

The organisational or management unit in which caseload midwives usually work. The purpose of the MGP is to support the practice of the caseload midwives within it and to facilitate communication and management.

Midwifery Practice Review (MPR):

According to the Australian College of Midwives: Midwifery Practice Review is a formal, transparent, nationally consistent peer review mechanism that supports midwives to regularly reflect on their portfolio, their own midwifery practice and future professional development plans or identified needs.

Maternity care professionals:

Registered clinicians who provide care for women during antenatal, intrapartum or postnatal stages of maternity care (e.g. midwives, GP obstetricians, obstetricians and GPs).

NHMRC:

National Health and Medical Research Council:
www.nhmrc.gov.au

NMBA:

Nursing and Midwifery Board of Australia:
www.nursingmidwiferyboard.gov.au

Primary care (or primary health care):

The first level of care accessed by the consumer, without referral. Midwives and GPs provide primary maternity care.

Primary midwife:

Each woman receiving caseload midwifery care will have a 'primary midwife' who provides the majority of her midwifery care and is her maternity care coordinator. 'Known midwife' and 'named midwife' have the same meaning. The woman will probably describe her primary midwife as 'my midwife'.

Team midwifery:

A model of maternity care in which a woman receives all of her midwifery care from a team of midwives (six to eight midwives, sometimes more). The team midwives work normal shifts and rotate across antenatal, intrapartum and postnatal stages of care [38]. In effect, the whole team carries a case load collectively. The woman does not have a known primary midwife.

Woman-centred care:

Focused on the woman's individual, unique needs, expectations and aspirations rather than the needs of institutions or maternity service professionals. This type of care recognises the woman's right to self-determination in terms of choice, control and continuity of care.

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Knowing your midwife - being cared for by, and able to build a rapport with, the same midwife during pregnancy (or even pre-conception), through labour and birth, and into the early weeks of mothering - has benefits for mothers, babies and society.

Appendices

Appendix 1: Case Study

Royal Hobart Hospital Midwifery Group Practice (RHH_MGP), Tasmania

Ana Navidad, MGP Coordinator

Service Location

Royal Hobart Hospital (RHH) is situated in the city of Hobart and is the tertiary referral centre for all of Tasmania.

The Midwifery Group Practice attends women booked to birth at the RHH (with work presently being done towards expanding to offer publically funded homebirth, work in progress).

The Midwifery Group Practice house (with four clinic rooms) is located in the northern suburb of Glenorchy. Midwives also see clients at several other community health centres closer to where women live, from as far as Cygnet/Huonville; Sorell and New Norfolk, as well as various other clinics closer to town.

The 36 week visit is done in the woman's home with significant support people present for final birth planning and education/preparation for bringing the baby home early.

Background issues

Consumer, midwifery and management support and demand for introducing a caseload model for the RHH grew over approximately 10 years. The Mersey Hospital commenced the first MGP pilot programme in Tasmania in 2010.

Actions

In April 2011 a project officer was employed from within the RHH Women's and Children Services (WACS) budget to scope and implement a caseload model of care.

- A steering group was formed with participants inside the agency.
- Weekly 'Thursday Think Tanks' were held for all midwives or interested parties to contribute and find out more about the progress and shaping of the model.
- Community Forums were held for interested members of the community (consumers, consumer group representatives, community midwives).
- Maternity Coalition (MC) Tasmania were closely involved and consulted with during and after the development of MGP.
- Wide consultation and networking with Mersey MGP (North West Tasmania) and MGPs across Australia was undertaken.
- A state-wide caseload industrial agreement was negotiated and finalised in June 2012 (30% loading; with caseload of 35-45 to allow for differing geographies/ complexities; 6 weeks annual leave to acknowledge on call/public holidays).

The midwifery group practice model of care was developed and implemented on July 7th 2012 as the Royal Hobart Hospital Midwifery Group Practice (RHH MGP).

A business case was submitted to the Chief Executive Officer of RHH who approved the following depending on the sustainability and safety of the model after 12 months of implementation:

- 10 FTE midwives (including 1.0 full time Coordinator) from existing maternity FTE
- Ongoing positions in MGP were conditional on a review after 12 months (with permanency as clinical midwives in RHH ongoing).
- KPI's and budget to be monitored.

A recruitment process was undertaken and all the positions were successfully recruited.

Model Description

The RHH MGP commenced as a normal risk/no exit model for women with an opt-out available to all women if they decided the model did not suit them. The RHH MGP has a home based postnatal care component which equates to shorter length of stay (4-12hrs) if mother and baby are both well (approximately Day Two following caesarean section). Postnatal care in the home is on average until Day 10-14.

Women are risk assessed according to the National Midwifery Guidelines for Consultation and Referral at booking and throughout pregnancy as required.

Within the first 12 months an increasing number of women with risk factors sought out MGP model of care (e.g. with twins) and their requests/cases were brought to the MGP Obstetric Champion (Head of Department, Obstetrics and Gynaecology) and Maternity Nurse Unit Manager for clinical case-by-case consideration.

The RHH MGP commenced as normal risk eligibility, with the intention that after initial establishment of effective/ safe processes/systems it would become an all-risk/ collaborative care model, which it became in December 2014. It remains an option for women with moderate to high risk pregnancies, but in order to maintain access for normal risk, this is usually only allocated based on the woman requesting the model, and/or on referral or recommendation by the medical team.

Following the first 10 month evaluation report, the model was signed off as an ongoing service, and the practice was expanded from 10 FTE to 15 (plus the 1.0 midwife clinical coordinator). This FTE equates to caring for approximately 500-600 women per year (an average of 30% of all birthing women booked for the RHH).

Entrance to Service

Women are referred by their General Practitioner to RHH and either select MGP as their preferred model of care (MOC) or are triaged to MGP if deemed from initial referral to be normal risk and where no other midwifery model of care preference has been identified. Alternatively, following initial booking in with the women's health clinic, they will be offered and allocated to MGP if opting in.

Women's Allocation to the Model

Following referral to the service the MGP Coordinator allocates the woman to a midwife depending on the following criteria:

- Availability of midwife two weeks either side of the woman's EDB (no booked leave) to optimise the chance of availability for labour and birth.
- Capacity within the midwife's caseload.
- Maintenance of an acceptable balance of multigravida to primigravida in the midwife's caseload.
- Allocation according to risk classification and balanced workloads according to acuity/complexities

The allocated midwife makes contact with the woman to set up an initial booking-in appointment as close to 12 weeks gestation as possible.

The National Midwifery Guidelines for Consultation and Referral determine if the woman then follows the initial midwife booking in with a consult with RHH medical team, or if her case is brought to the fortnightly MGP clinical review meetings.

Geographic Limits

There are no specific geographical requirements for women choosing to book into the service. Although the community/home visiting program for antenatal and postnatal care is restricted to a 30 minute radius from where the midwives run other community clinics (or live). Most geographies for those women seeking the model will and can be negotiated case-by-case ensuring a balance of workloads is considered.

Continuity of Care

The RHH MGP is to date achieving 85% continuity of carer (with the woman's primary or back-up midwife). There is a 98-99% continuity of care from another MGP midwife, with some precipitous births supported by core staff until a MGP midwife arrives. Occasionally, staffing issues within MGP have meant assistance from core staff for inpatient labour care.

The 15 FTE are currently made up of 19 individual midwives with two job shares (one per team) and minimum FTE 0.8 FTE. Currently there are two teams within an overall practice. Each team are made up of 3-4 "pods" of 2-3 midwives backing each other up. The work falls via a "totem poll" to the next pod on call, or across teams as required.

In all cases women have the mobile telephone number of their midwife, to contact a midwife across twenty-four hours a day. Women are educated to know what would be an appropriate call or enquiry of her midwife after hours.

Telephones are diverted to a colleague when a midwife is off call. Telephones are diverted to night duty staff (2230-0700) on maternity unit overnight for the initial phone triaging and the midwife/back-up is phoned on a personal number (by maternity staff) if they are required to attend.

Antenatal Visits

Visits are flexible and in-line with the woman's needs but are guided by the Antenatal Care Schedule - Routine Low Risk guidelines of between seven and ten visits across the pregnancy. General schedule of visits as per gestational weeks are: booking-in 12-14, 20, 28, 34, 36 (home visit), 38, 40, and 41.

A Saturday full day antenatal class is offered twice a month to women booked to birth at RHH. Although women from other models can choose this "express class", versus week day/night series of classes option held by other staff midwives, the two Saturday classes per month are facilitated by two MGP midwives (morning and afternoon session). The MGP clients are encouraged to attend this session as another opportunity to meet other MGP midwives. The classes are rostered as a non-call work day (W) for the morning session midwife, with an on call (if available) afternoon midwife. Should the second midwife be called to clinical work the W person comes prepared to run the whole session.

Postnatal Visits

These are also responsive to the woman's needs, with early discharge (for the well woman and baby) being an agreed part of the programme. This usually comprises of discharge Day 0 for normal vaginal/instrumental birth (4-12 hours) with home visits daily until day 3, then on day 5, day 7, day 9-10 for possible discharge, and or up to day 14.

The number of visits per family will vary according to needs (on average six). It is expected that the midwives facilitate ongoing care for the women with the woman's General Practitioner and maternal and child health nurse prior to discharge from the model.

Communication and Clinical Decision-Making

The ACM National Midwifery Guidelines for Consultation and Referral 3rd Edition (2015) forms the basis for decision-making within the model.

All rostered on midwives from MGP (not attending births or on rest) attend a two-hour weekly practice meeting Wednesday 0800-1000. This usually includes a one-hour inservice/guest speaker, with the other hour being general practice business, workload and general communication.

Each fortnight one-hour of the practice meeting is a Clinical Review meeting with one of two MGP champion obstetricians. Communication is pre-prepared and structured using ISBAR format. These clinical reviews enable some continuity with two staff specialists and are aimed at joint care planning (where saving the woman an additional visit is reasonable), review of investigation results or general collaboration on women's cases.

A Daily Work Coordinator (DWC) is allocated from each team for 2-3 days in a row. All midwives text their planned daily work, any calls to labour, times leaving ward or general safety communication both with their own teams DWC and cc MGP Coordinator for overview. This DWC will assist with relief plans at end of 8-12 hour labours, or delegate must see appointments and assist with rescheduling etc. The MGP Coordinator is available and often helps on high acuity days for either or across both teams. The DWC role can be handed over to a colleague during labours/rests or as time management to someone with more availability.

Each MGP documents their presence on the Maternity Unit daily staff list and is expected to communicate with the shift coordinator as well as handover before and after each episode of care for inpatients with the core midwife allocated to their clients.

Budget

RHH MGP runs from within existing maternity budget and FTE. The model was scoped to be cost neutral at worst and cost saving due to improved clinical outcomes and reduced length of stay. Midwives use their personal vehicles and are reimbursed the departmental kilometre allowance as "required users" for all MGP work related travel and this remains within budget also.

Midwives' Allocation

Midwives have women allocated pro-rata according to their FTE. The Tasmanian industrial agreement negotiated a sliding scale for FTE 1.0 of 35-45 women per caseload, to allow for geography and clinical complexities across models.

The industrial agreement also includes differing caseloads for new graduates and clinical coordinator.

Our MGP has first year unpaid student placements from July to February each year from the UTAS postgraduate midwifery program. This December will be the second one year new graduate position intake for MGP (12 month position assigned with close mentorship as back-up).

The work plan allows midwives to have

- a period of at least eight hours, within any 24 hour period, continuously free of duty other than on-call and re-call;
- an average of four days off duty per fortnight, with at least two consecutive days free of planned work and on-call or re-call;
- Midwives are not permitted to work more than eight days in succession
- Not required to work longer than eight hours but can choose to work up to but not over 12 hours to meet the needs of the client.

Consumer feedback

Detailed 26 question survey was sent in two evaluation rounds for RHH MGP:

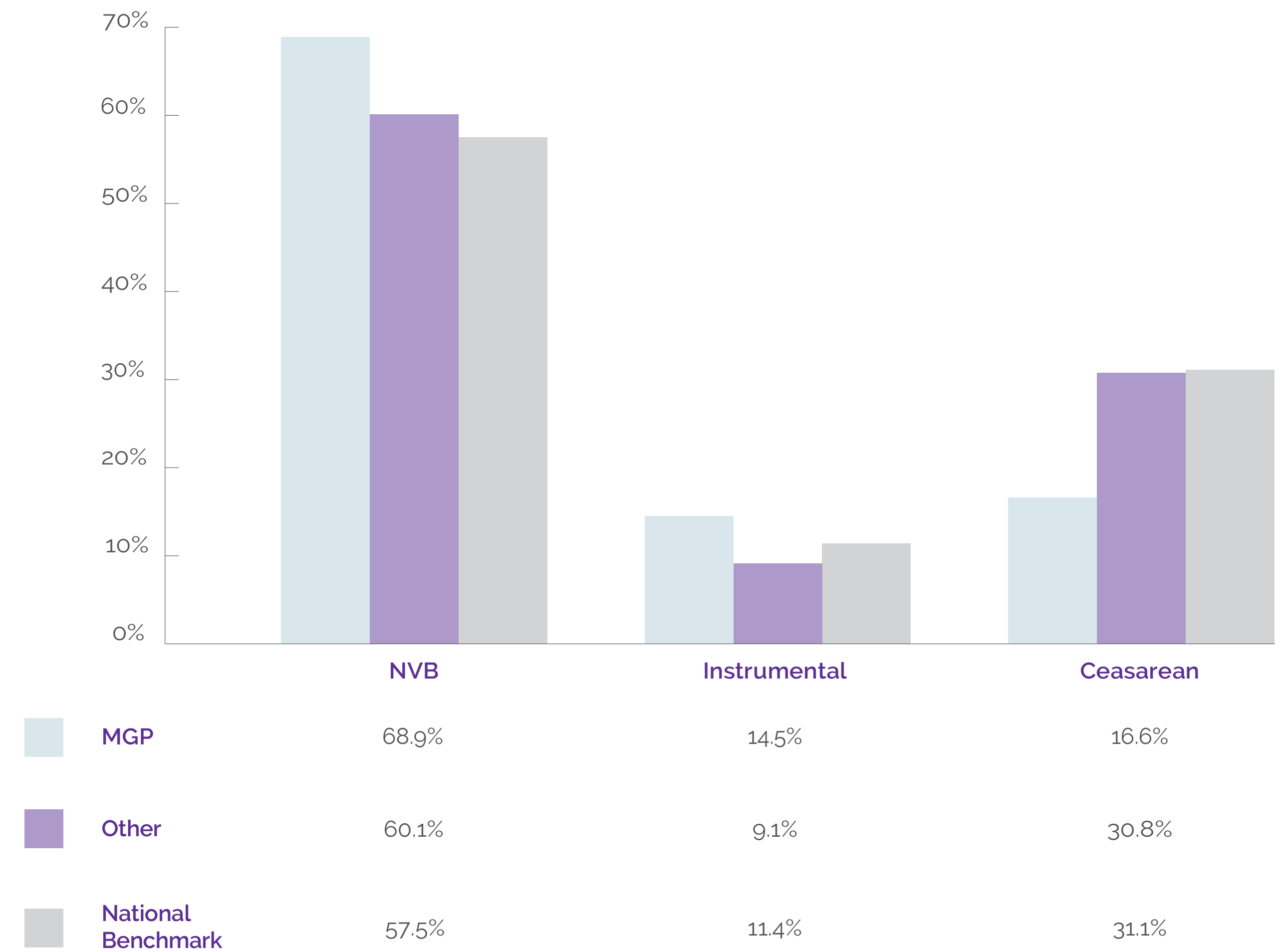
- Response rate was 25-30% over both surveys (nearly 200 responses)

Overwhelmingly positive:

- Confirmation that MGP was delivering on its key elements
- 2013 = 60% nulliparas, 40% multiparas
- 2014 = 49% nulliparas, 51% multiparas
- 94.5 % - would choose MGP for another baby
- 97.8 % - would recommend MGP to other parents
- 94.4% - most of care provided by primary or back-up midwife
- 87%- primary or back-up available for labour & birth (93.3% had a known midwife attend)
- 93.7% satisfied with care received by others when care handed over.

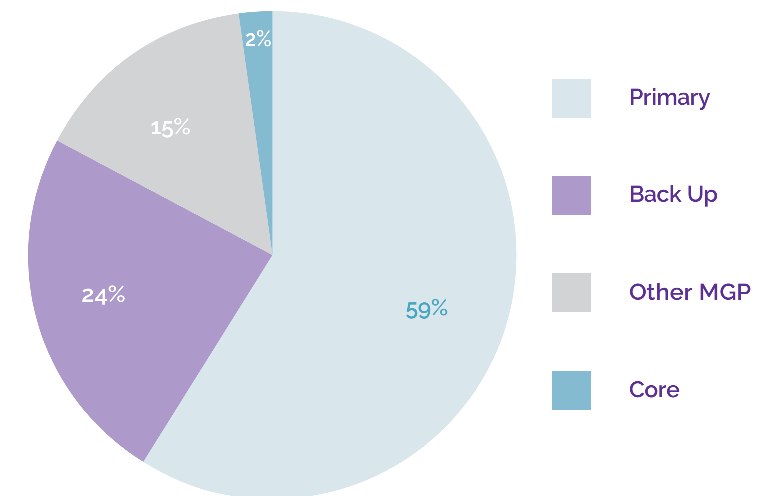
Clinical Outcomes

Clinical KPIs 9 May 13 - 8 Jul 14 (14 months) Total n=2170 (MGP 489 vs Other 1681)



Midwife Attendance for Labour and Birth

MGP Continuity 83.6% Primary or Back up (93.3% MGP mw) 8 July 12 - 8 July 1`4



Appendix 2: Case Study

Goondiwindi Midwifery Group Practice (GMGP).

Kerryanne Maddox, NUM

Service Location

Goondiwindi Hospital is situated on the northern bank of the Macintyre River, which forms the border between Queensland and New South Wales. It is at the junction of the Newell, Cunningham, Leichhardt, Barwon and Bruxner highways, being 4 hours from Brisbane and over 2 hours from Warwick, Dalby and Toowoomba. Goondiwindi is managed by the Goondiwindi Regional Council which includes the previous shires of Waggamba, Texas and Inglewood.

Service Boundaries (Population of 12,000)

6 000 people live in the town of Goondiwindi. This increases during the cotton chipping and harvesting season. The catchment of Goondiwindi (old Waggamba Shire) lies along the southern border of Queensland, covering an area of 13 872 km^2 with a population of around 3000. The Moree Plains Shire in northern New South Wales supports a further 3000 people. All these surrounding catchment areas use Goondiwindi as the major centre for their health care, business, shopping and entertainment. Across the Macintyre River are the townships of Boggabilla and the Toomelah Aboriginal Community who use Goondiwindi Health Service for their General Practice, acute, specialist and maternity/ birthing needs.

Background issues

The shared care model of maternity care that was operating at Goondiwindi Health Service was at risk and was in danger of closing due to the factors outlined below.

High risk presentations

The Goondiwindi Health Service Capability profile for Maternity Services was Level 1, providing for:

- deliveries later than 37 completed weeks gestation
- elective and or emergency vaginal and assisted deliveries

There are a significant proportion (50% June 05 – May 06, GHS Birthing Statistics) of high risk presentations and deliveries including: instrumental deliveries, emergency LSCS, augmented/induced labour; IUGR, young primipara (first pregnancy), grand multiparas (a woman who has given birth 5 or more times) that present, some without previous antenatal care and or refusing to leave local community. Factors contributing included a high Indigenous population, close proximity to the QLD /NSW border, the isolation of some rural properties and the distance required to travel by road to the nearest referral centre: QLD Toowoomba 2.5hrs; NSW Moree 1.5 hrs.

Workforce issues and increasing demand for services

There was no scope for midwives to practice in a continuity of care model. Midwives were often redeployed to other patient groups, which was an unattractive option for many midwives. Given this, the Health Service was unable to recruit and retain midwives. Goondiwindi Health Service had limited capacity and resources to change the current model of fragmented midwifery care and there was limited access to ongoing professional development to maintain midwifery skills and competence of the maternity clinicians, with distance creating a barrier. There had been an average of 90 births/ year for the three years to 2005 (QH perinatal data collection). Data for 2006 indicated that the delivery rate was expected to increase.

Culturally Appropriate Care

There was an inability to provide culturally appropriate services to Aboriginal and Torres Strait Islander women. This led to an increasing number of indigenous women presenting for delivery having had minimal antenatal care. Indigenous health workers were not involved directly in maternity care.

Unstable Maternity Service provision

A Queensland Health review of Goondiwindi Maternity Services was undertaken in 2003 and strongly recommended the need to continue the provision of services. In 2004 the Maternity Service at Goondiwindi was at extreme risk of closing down due to midwifery shortages and the dissatisfaction with the model of care. Clinicians (Midwives and General Practitioners) were not satisfied with the fragmented antenatal and postnatal maternity care being offered to women. There were also reports of women being dissatisfied with the maternity care available in Goondiwindi, with many women choosing to birth away from home.

Actions

In 2005/2006 Funding was acquired from CPIC (Clinical Practice Improvement Centre) to appoint a project officer to scope and implement a model of care that was suitable for the community of Goondiwindi. A steering group was formed with participants from outside agencies including:

- Australian College of Midwives (ACM)
- Australian Rural Nurses and Midwives (ARNM)
- Maternity Coalition (MC)
- Queensland Nurses Union (QNU)
- General Practice - Goondiwindi Medical Centre (GMC)

The midwifery model of care was developed and implemented in March 2008 as the Goondiwindi Midwifery Group Practice (GMGP).

A business case was submitted to the District Manager in 2008 who approved the following depending on the sustainability and safety of the model after 12 months of implementation:

- Temporary N04 NUM position at 20hrs/week
- Permanent N02 caseload midwives at 120 hours/week
- Temporary N02 caseload midwives at 40 hours /week
- Temporary positions were conditional on a review after 12 months before being made permanent.
- KPI's to be monitored.

A recruitment process was undertaken and all the positions (permanent and temporary) were successfully recruited.

A local service agreement was signed by the District and the QNU that determined the agreed caseload and conditions:

"The caseload will equate to an employee working 38 hours per week, that is, a full-time Midwife under Schedule 2, and will be based on a full-time Midwife providing full care to 35 - 40 clients in a 12 month period. Part-time employees will be designated a caseload on a proportional basis.

A rural/remote caseload model providing an extended service, such as lactation consultant, pap smear and / or immunisation provider, in addition to antenatal and postnatal care for at risk women may have a caseload of less than 40 per year per full-time midwife.

The parties acknowledge that the caseload of a Midwife may vary depending upon the nature of the Midwifery service, the skill mix of the Midwives within the midwifery service and the risk profile of the clients. During planned or unplanned staff leave of one week or less caseloads may increase to a maximum of 46 clients. However the Midwife caseload will not exceed an average of 36 clients annually".

12 months of maternity delivery under this model of care has proven to be safe and sustainable. In 2009 the temporary positions were made permanent consolidating the sustainability of this model.

Model Description

The GMGP provides an all risk antenatal and postnatal service for all women who choose to have maternity care delivered locally. As the Goondiwindi Health Service is a low risk birthing service, women are risk assessed according to the National Midwifery Guidelines for Consultation and Referral at booking and throughout pregnancy as required.

30% of the Goondiwindi Health Service maternity bookings are indigenous (QLD Average 4.5 %) and 30% of the bookings are from NSW. All women who choose to birth in Goondiwindi are eligible and are booked into the model as this is the only available option due to birthing numbers. Women who choose to birth elsewhere for no medical or obstetric reason are excluded from the model of care and their antenatal care is provided privately. If the risk stratification assessment shows a client is outside Goondiwindi Health Service's capacity, antenatal and postnatal care is still provided but the intrapartum care is managed in a referral hospital.

Entrance to Service

Women can self refer, are referred by their General Practitioner or are referred from the emergency department to the model. A midwife who has a vacancy within her workload is allocated the woman to contact, conduct a history and first visit, and confirm that the woman fulfils all the criteria for entrance to the model. This midwife then continues care with the woman.

Women's Allocation to the Model

Following referral to the service the NUM (Midwifery) contacts the woman and performs an initial booking screen using the GMGP Team Leader Screening Tool either by telephone or drop in.

The NUM allocates the woman to a midwife depending on the following criteria

- Availability of midwife 2 weeks either side of the woman's EDC (no booked leave) to optimize the chance of availability for labour and birth.
- Capacity within the midwife's caseload.
- Maintenance of an acceptable balance of multigravida to primigravida in the midwives' caseload.
- Allocation according to risk classification.

The allocated midwife makes contact with the woman to set up an initial consult/booking-in appointment as close to 12 weeks gestation as possible.

A screening tool is used to determine any risk factors. GMGP use the MR63 Midwife Initiated Risk Evaluation Form.

Geographic Limits

There are no geographical requirements for women choosing to book into the service. The community/home visiting program for antenatal and postnatal care is restricted to a 30 minute radius from the Health Service. It is worth noting that the Toowoomba and Darling Downs Rural Services Expert Panel have developed an information brochure/consent form outlining services offered in all rural health facilities within the district. This form will be given to all women in rural towns, including Goondiwindi, to ensure that they are aware of the capability of services available to them for all aspects of their maternity care including birthing should they be required to travel away for any components of their pregnancy care.

Continuity of Care

It is intended that women be afforded midwifery continuity without compromising the intention of low risk women birthing within the service, and to maximize use of the dedicated health service space. Therefore women who develop risk factors, in consultation with the GP obstetricians are referred to staff specialist obstetricians at Toowoomba Hospital for planning of care. This may be a shared arrangement with an obstetric team or on a consultation basis with an obstetric team. For women who have unresolved risk factors at time of birth, it is expected that they will travel and birth at the referral centre that they have had shared care with. After birth these women will return to Goondiwindi to the care of their known Midwife and GP and will be linked into other health service providers as required.

In most cases women have the mobile telephone number of their midwife to contact across twenty-four hours a day. Women are educated to know what would be an appropriate call or enquiry of her midwife after hours.

Telephones are diverted to a colleague when a midwife is off call.

Antenatal Visits

Visits are flexible and in line with the woman's needs but are guided by the Antenatal Care Schedule - Routine Low Risk guidelines of between seven and ten visits across the pregnancy.

Postnatal Visits

These are also responsive to the woman's needs, with early discharge an option for those women who wish and who are within the approved driving distance from Goondiwindi Health Service of 30minutes. Each woman has the option of home visits daily until day 5, then on day 7, then weekly until 5 weeks. The focus is on healthy family adaptation to early parenting and breastfeeding support whilst providing referrals to appropriate services as identified. The number of visits per family will vary according to needs. It is expected that the midwives facilitate ongoing care for the women with the woman's General Practitioner and maternal and child health nurse prior to discharge from the model at six weeks post birth.

Communication and Clinical Decision Making

The ACM National Midwifery Guidelines for Consultation and Referral 2nd Edition (2008) forms the basis for decision-making within the model. The GP obstetricians provide obstetric advice and guidance.

Each week a meeting is conducted which involves the midwives, early childhood nurse, social worker, management, indigenous health and the GP obstetricians. Communication is open and honest. The environment is conducive to the valued sharing of information. Any suspected high risk cases are discussed with the obstetric staff specialist in Toowoomba. This phone advice is shared and a local plan of care is formulated.

Updating the Nurse Unit Manager of the ward and Team Leader of each shift is vital as a midwife is not always present within the hospital setting. The Team Leader is considered the contact person if a maternity client requires assistance. The Team Leader will then contact the appropriate midwife as necessary. The midwives must remain diligent with this level of communication to optimize women's care and relations between other hospital staff and GMGP midwives.

Budget

Clinical supplies and non-labour costs remained relatively the same as the previous year, however there was patient educational material required that had not previously been used in the health service.

Midwives' Allocation

Midwives have women allocated prorata according to their FTE

Clinical Outcomes

- In the first twelve months one hundred and thirty (130) women birthed at the Goondiwindi Health service. This compares to one hundred and eight (108) births in the year preceding the introduction of the Goondiwindi Midwifery Model of Care and equates to a 27% increase.
- Five babies were pre-term (K32 to K36) equating to 3.8% of births and 2.8% of bookings.
- No maternal or neonatal mortality occurred and no significant maternal or neonatal morbidity resulted from care provided by the group practice midwives and health service GP obstetricians
- Unassisted vaginal births have increased from 53.3% to 66.7% since the year preceding the model. This is attributed to the increased confidence and knowledge that the women have gained through the "trust birth" classes and the close relationship they developed with the midwives. Although no statistical data was collected, the midwives noted that the women were presenting to hospital more confidently in later stages of labour after phone contact with their known midwife.
- Forceps assisted deliveries decreased from 3.9% to 0%.
- The emergency Caesarean Section rate remained similar to the year preceding. It is to be noted that three (3) or 21% of the emergency sections that were performed two (2) were booked but progressed into labour early and one (1) was a planned VBAC (vaginal birth after caesarean) for Toowoomba Hospital who went into labour in Goondiwindi .
- The elective LSCS rate decreased by 15.5% (n11). Two (2) of these were primiparous with breech presentation babies. One (1) was not offered ECV as the amniotic fluid level was too low and the other declined the opportunity to travel to Toowoomba for ECV (ECV is not offered at Goondiwindi Health Service).
- Perineal status is relatively unchanged.
- Induction of Labour rates were also relatively unchanged.

Clinical outcomes were difficult to compare with other midwifery models as there are no other rural sites within Qld with active midwifery models of care in place. We have compared our 1st 12 months data with the 12 months preceding the introduction of the model, with Mareeba's first 12 months of caseload midwifery and with Queensland State data obtained from Perinatal data collection.

	Goondiwindi HS April 07 to March 08 (pre model)	Goondiwindi HS April 08 to March 09 (n = 178) (1st 12 months)	Qld State total
Mode of Delivery			
Unassisted Vaginal	53.3%	66.7%	56.8%
Forceps	3.9%	0%	1.8%
Vacuum	1.94%	7%	7.4%
Elective LSCS	31%	15.5%	20.9%
Unplanned LSCS	9.7%	10.8%	-
Perineal status			
Intact	75%	71%	29.3%
First degree/tear/graze	6%	3%	30.3%
Second degree	12%	20%	24.6%
Third and Fourth degree	3%	1%	1.6%
Episiotomy	4%	5%	11.6%
Induction of Labour at Term	14.7%	14.7%	22.2%
Gestation at birth			
K32 to K36	4.85%	3.8%	
K37+	95.15%	96.2%	
Transfer Admit to SCN (Toowoomba)	Term 6%	1.2% (n1)	
Transfer Admit to NICU (Mater, Royal Children's)	2% (n2)	2.4% (n2)	
Transfers			
Antenatal	0%	1.5% (n2)	
In labour	Data not available	0%	
Post birth	1% (n1)	2.3% (n3)	1.2%
Breastfeeding			
At hospital discharge	76.7% (July to March)	77.7%	87.7% (April-Nov)
At 4 – 6 weeks	No data	50.7%	No data

Breast Feeding

Table 4a - (First Twelve Months) - Breastfeeding at Discharge and at 6 weeks

Infant feeding at discharge from hospital

Bottle Fed	Exclusive Breast Fed	Partial Breast Fed	Unknown
19%	77.8%	3.2%	0%

Infant feeding at 6 weeks or discharge from GMGP

Bottle Fed	Exclusive Breast Fed	Partial Breast Fed	Unknown
41.5%	50.7%	6.9%	0.9%

Midwife Attendance for Labour and Birth

Although our data shows that in 51% of cases the allocated midwife was the accoucheur or present all women were attended by a midwife who they were known to. Throughout the pregnancy women are introduced to all midwives within the model. During times of extended leave, when midwives were replaced, the relief midwife was not noted as the known midwife if she was the accoucheur. This has also underestimated the actual percentage of known midwives present at and/or accoucheur at birth.

The on call roster has been developed to minimize fatigue levels, increase available appointment times but not necessarily increase Know Your Midwife (KYM) rates. Originally the roster had a midwife on call from 0600 to 1800 hours and then a second midwife on call from 1800hrs to 0600hrs. This was not successful with the midwives finding they were on either 1st or 2nd call for 80% of the time. It made it very difficult to arrange appointments around being on call and the probability of "If I am called out during the night I can't book any appointments for the morning".

The work plan now allows midwives to have

- a period of at least 8 hours, within any 24 hour period, continuously free of duty other than on call and recall;
- an average of 4 days off duty per fortnight, with at least two consecutive days free of planned work and on call or recall;
- Midwives are not permitted to work more than 7 days in succession other than where the Midwife is recalled to work;
- one day off free from duty and on call per 7 days, one to two nights on call from 1800hrs to 0600hrs and be on call for their women during the day;
- Not required to work longer than 8 hours but can choose to work up to but not over 12 hours to meet the needs of the client.

As the midwives are managing their workload and time more efficiently they are remaining on call for some of their women. This will eventually show an increase in the actual KYM rate but not by a great margin.

Consumer feedback

Environment

100% (n31) of respondents felt happy about having their baby locally in Goondiwindi and 77% (n24) felt that having a choice to receive antenatal care either in their home, the community or at the hospital made a positive difference to them.

Midwifery care – continuity of carer

97% (n30) of respondents felt that having one midwife allocated to them during their pregnancy was beneficial. 77% (n24) commented that care in labour was excellent with 19% (n6) saying it was good.

Service model

87% (n27) of respondents felt it was beneficial to see their midwife in the community in the postnatal period.

100% (n31) of respondents said there was no wait time for appointments.

Summary

The survey results demonstrate families are very satisfied with their care and they support the current midwifery model of care. There is clear evidence that there has been improved consumer satisfaction in the areas of environment, midwifery care-continuity of carer, service model, waiting times, education and knowledge since the introduction of the Goondiwindi Midwifery Group Practice. In general consumers surveyed reported that they were happier with:

- having a choice of where their antenatal and postnatal care was delivered,
- having no excessive waiting times,
- care and education provided during pregnancy,
- care and education provided during labour and birthing,
- care and education provided in the postnatal period,
- breastfeeding education and assistance.

There was an increase of 20.5% attendance at labour and birthing classes for women and their support persons.

Consumers who were surveyed also reported increased confidence in caring for their newborn and better parenting skills.

Overall there was resounding support for the model and the personalized care provided by the midwives.

General Hints:

- Smaller facilities should plan for "bookings" rather than "births". There is a lot of time spent with women antenatally and then if they end up birthing elsewhere it is unreasonable that it is then not a "stat" for your service. We only talk in terms of "women booked" not "women birthed".
- We recommend rural models that are dealing with all risk antenatal care allocate 1 FTE midwife per 35 women, not 1:40. We have discovered that many extra hours are spent dealing with some complex social and emotional issues as there are not necessarily other referral services available.
- Difficulty in back-filling while caseload midwives are required to meet professional development demands. The model budget should include Professional Development backfill.
- Our LSCS patients are cared for overnight by the general ward staff if there are no medical or surgical complications, the ward staff are not busy and the ward staff feel confident to care for a LCSC women. A very detailed handover is printed for the general staff required to assist with the LSCS overnight. If at any time they require a midwife's assistance or advice they call the on-call caseload midwife.
- Good communication cannot be stressed enough. We have mandatory meetings each Monday where all midwives, early childhood nurse, social worker, indigenous health worker and the GP from clinic attend. These sessions range from discussion of client issues to general meetings.
- Every month a case review is presented and every month a "training and education session" is given. These sessions range from mock obstetric emergency drills to presentations on new documents, procedures or state-wide guidelines. These sessions are strongly recommended and attendance encouraged.

Appendix 3: Case Study

Mareeba Midwifery Group Practice

Sandra Eales Acting Midwifery Unit Manager,
CNC Midwifery

The Mareeba Midwifery Group Practice (MGP) operates in a rural hospital in Far North Queensland. Approximately 25% of women who access the service identify as Aboriginal or Torres Strait Islander. Each year the midwifery service provides antenatal care to approximately 200 – 220 women, care in labour and birth to about 150 women and provides postnatal care to in excess of 300 individual women.

A small paediatric unit is co-located in the maternity unit where maternity and paediatric inpatients are cared for by core staff. A midwife and enrolled nurse are rostered each shift, whose staffing and workload arrangements are separate to the MGP midwives who are not rostered to shifts.

The Mareeba Maternity service as it exists today has developed and evolved over many years in response to local needs. The primary catalyst for evolving towards a midwifery model was to maintain a local maternity service in an environment experiencing an increasing shortage of doctors. In 2005 when the last local doctor providing obstetric care resigned, the maternity service was closed because the District was unable to recruit another doctor with obstetric skills. However women in the community were already comfortable and confident with midwifery care and so with their families campaigned alongside midwives to reopen as a midwifery unit. Following this grass roots campaign the unit was re-opened in June 2005 as a pilot site for a "primary care model" of maternity service which does not rely upon local obstetric cover.

Consultation and referral occurs with the obstetric team at Cairns Base Hospital (CBH), which is approximately 60 minutes away from Mareeba Hospital by road. The women are screened at booking consistent with the consultation and referral guidelines (ACM, 2008) in relation to Categories A, B or C and then case-conferenced with either the Medical Superintendent or a visiting obstetrician from CBH. An agreed management plan is outlined for individual women who may require a shared care arrangement with specialists at CBH, or for care that is to be provided locally or in Cairns for any other deviation from "normal".

While there is generally no emergency caesarean capacity (no obstetric or anaesthetic service on call) a couple of local GPs do periodic planned caesareans. The local GPs are supportive of Mareeba maintaining the local maternity service.

- Since the reopening of the unit as a "standalone" midwifery unit, an average of 145 women/year continue to give birth in Mareeba.
- Approx 70% of Category A & B clients birthed in Mareeba as planned at booking without changing category or developing criteria/complications.
- Approx 11 % women who planned to birth in Mareeba (at commencement of labour) were transferred intra-partum.
- 97% of women who birthed in Mareeba received continuity of carer. The other 3% of women who presented for birth were unknown to Mareeba MGP, having booked elsewhere or having no antenatal care.

Since March 2009 the service has functioned with 5 FTE (6 midwives), working on an annualised salary and flexible working arrangement as caseload midwives. However an additional 1 FTE is required due to being an 'end of line' service providing care for women not allocated within the midwives caseload, e.g. women transferred back from private and public facilities in Cairns and other unbooked or unscheduled occasions of service (refer Tables 1-4). A mentoring program for graduates or midwives new to caseload commenced in 2010 to support succession planning and sustainability and will be evaluated in the near future.

Major role responsibilities of MGP

6 caseload midwives, totalling 5 FTE, provide comprehensive care through pregnancy, birth and puerperium to women who access the service. Using the *ACM National Midwifery Guidelines for Consultation and Referral*, midwives screen women at booking then consult and refer as required to obstetric team at Cairns Base Hospital.

Each caseload midwife provides comprehensive care for 30 low risk women/year and share care of some higher risk women in partnership with Cairns Base Hospital obstetric team, i.e. providing care antenatally and/or postnatal follow-up. The "reduced" caseload has been negotiated for this particular service as midwives have an extended role in the rural community.

Caseload midwives provide support (through close call roster) to the Mareeba Maternity-Paediatric unit in times of high acuity and for emergency stabilisation and transfer of high risk maternity clients who present to the hospital. The midwives in the MGP also provide

- Lactation Consultation
- Immunisation including BCG & mantoux testing as required
- Women's Health (Pap Smear provider)

Each caseload midwife also maintains her own professional portfolio, e.g. evidence-based practice and research, education, consumer participation and facilitation, etc..

Philosophy Of Midwife Group Practice

The Mareeba Midwifery Group Practice (MGP) has been developed on a social model of health, which understands that the health of individuals and communities are the result of complex interacting social, economic, environmental and personal factors. The MGP aims to create a family-centred environment where childbearing women may access professional midwifery care throughout pregnancy and give birth in safety. The midwifery group practice honours birth as a profound life event and a normal healthy physiological process in a woman's life. The service is founded on respect for women and belief in the value of women's work of bearing and rearing each generation. Midwives in the service promote and protect breastfeeding and support women (and their families) in the transition to parenthood for up to six weeks after the birth.

Normality of Birth: Midwives in the practice consider women in pregnancy, during childbirth and early parenthood to be undertaking healthy processes that are profound and precious events in each woman's life. The unit works on a philosophy that pregnancy and childbirth is a normal physiological event and promotes a low technology approach to childbirth. There is emphasis on early antenatal education to promote healthy lifestyle and empowerment. The unit provides a safe, nurturing environment that promotes active birth and is conducive to pregnancy and birth progressing along a natural course.

Partnership: Midwives view their relationship with the woman as a partnership which, in collaboration with other health care providers and her family, empowers and supports the woman in pregnancy, birth and early motherhood. This partnership is based on mutual trust and respect with an emphasis on safety for the mother and her baby.

We also recognise every woman's responsibility to make informed decisions for herself, her baby and her family with assistance, when requested, from health professionals.

Continuity of Care: It is our aim that women and their partners receive a continuity of midwifery care service, within a caseload model, throughout the antenatal period and during labour and birth, with home visiting being provided for a period after birth ensuring the woman receives her entire care from a known midwife.

Holistic Care: We promote a family-friendly, woman-centred, holistic approach which recognises each woman's social, emotional, physical, spiritual and cultural needs, expectations and context as defined by the woman herself. Midwifery care aims to encompass the needs of the woman's baby, and includes the woman's family, her other important relationships and community, as identified and negotiated by the women herself. Consultation occurs with other health professionals and community groups as needs are identified.

Nurturing Environment: Care provided by the group practice aims to follow each woman across the interface between hospital and the community so all women remain connected to their social support systems; the focus is on the woman, not on the institutions or the professionals involved. Empowerment of women and social support may be incorporated into care provision through such means as group antenatal care and facilitation of postnatal support groups as well as by providing care in the woman's own environment when possible.

Informed Choice: We recognise the woman's role as decision maker in her own pregnancy and birth, and our responsibility to provide her with accurate information to enable her to choose options for her care by providing her with a full understanding of the risks and benefits of particular care strategies.

Evidence-Based: The MGP aims to provide a high level of safety through using evidence-based practice, and providing evidence-based information to women.

Practice is informed by scientific evidence, by collective and individual experience and by intuition.

Ongoing review of Service: We aim to review the service including audit of clinical outcomes and the client-population we serve at six months and thereafter each 12 months.

Mareeba MGP Activity

Table 1

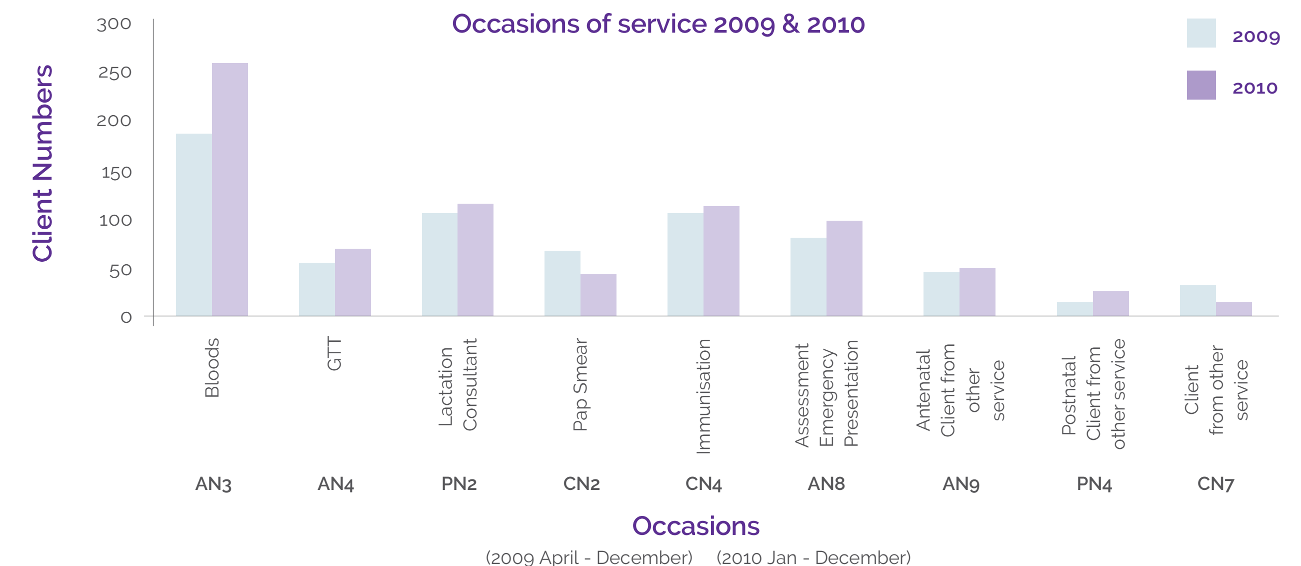


Table 2: Planned and Unplanned Activity

	Booked Clients For Comprehensive care 5 FTE = 150	Planned Sharecare or Partial Care 5 FTE = 50	Births in Mareeba	Unbooked births	Women cared for in labour i.e. births in Mba + intrapartum transfers
2009	167	48	127	3	127 + 14 = **141**
2010	173	48	125	7 3 x No AN care 4 x booked other service	125 + 18 = **143**
Total For 2009 & 2010	340	96	252	10	284

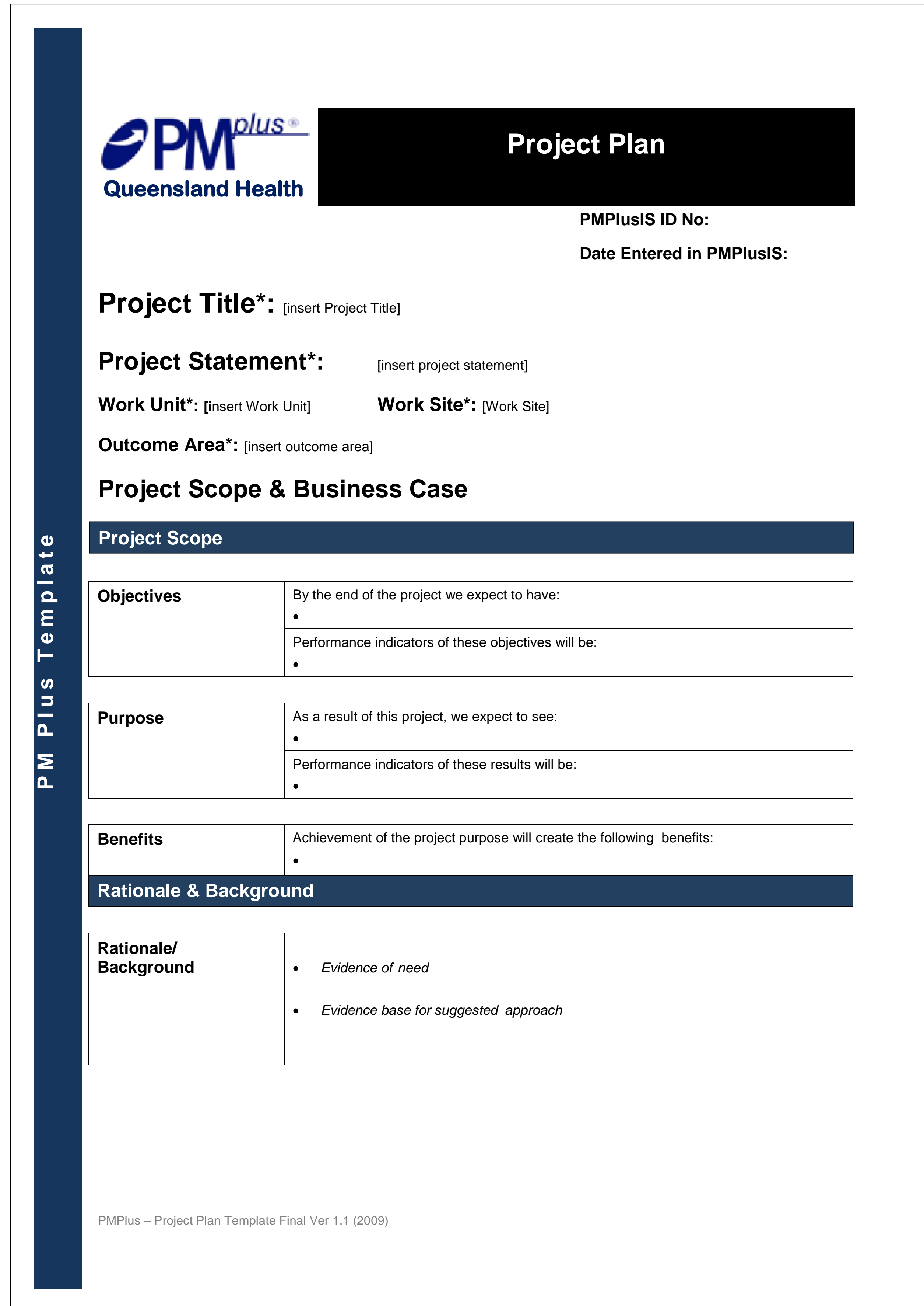
Table 3: MGP Workloads

	Antenatal Bookings			Births	Inter-hospital Transfers (68% were Cat C on presentation)	Occasions of Service	Emergency Presentations
	MGP	Share CBH	Partial care e.g. Misc< K20, relocation				
2010	173	30	18	125 (incl 7 not booked)	63 (23 of these were MGP Cat A/B on presentation)	3997	98
2009	167	24	22	127 (incl 4 not booked)	51 (14 of these were MGP Cat A/B on presentation)	3069 (Apr – Dec)	79 (Apr – Dec)

Table 4: Clinical Outcomes Jan 2009 – July 2010

	Total	Spontaneous vaginal birth	Assisted vaginal birth	Caesarean Birth	5 Min Apgar < 7
Birthed in Mareeba (include Cat C)	216	202 (93.5%) Cat C - 4 BBA – 6 (2 attended @ home by m/w & QAS) No ANC – 2 Booked other - 1 incl. Priv pt booked for C/S	6 (2.7%) Forceps – 2 Ventouse - 4	8 (3.7%) Elect - 7 Emerg - 1	2 (6,5,8 & 7,5,10) both babes recovered well with minimal intervention 1 SCBU t/f For prematurity
Intrapartum transfers (Cat A- planned birth in Mareeba)	24	9	2	13	1 (B/O woman t/f in early labour for epidural)
MGP Intention to treat at commencement of labour Jan 2009 – July 2010 Cat A (176) & B (22) & assisted vaginal (6) & emerg C/S(1) + I/P Transfers (23)	**228**	**206** (90.3%)	**8** (3.5%)	**14** (6.1 %)	**2 + 1 = 3** (2 SCBU for mec obs)

Appendix 4: Template for Project Plan- Introducing Continuity of Care



PM Plus Template

PMplus® Queensland Health

Project Plan

PMPlusIS ID No:

Date Entered in PMPlusIS:

Project Title*: [insert Project Title]

Project Statement*: [insert project statement]

Work Unit*: [insert Work Unit] **Work Site*:** [Work Site]

Outcome Area*: [insert outcome area]

Project Scope & Business Case

Project Scope

Objectives	By the end of the project we expect to have: • Performance indicators of these objectives will be: •
Purpose	As a result of this project, we expect to see: • Performance indicators of these results will be: •
Benefits	Achievement of the project purpose will create the following benefits: •

Rationale & Background

Rationale/ Background	• *Evidence of need* • *Evidence base for suggested approach*

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PM Plus Template

Assumptions	•
Constraints	•
Exclusions	•
Summary Activities (High Level Work Breakdown Structure)	•
Related Activity/Projects	•

Partners/Clients/Stakeholders

Internal Partners/Clients/ Stakeholders* *(Other QH Divisions/Districts/Work Units involved)*	**Nature of Involvement**	**Brief Description of the Management Strategy to be used**
{Working with}		

External Partners/Clients/ Stakeholders *List Commonwealth, State, Local government, Private sector, Non Government Organisation, Other – multiples OK, one entry per line)*	**Nature of Involvement and Brief Description of the Management Strategy to be used**	**Amount ($) Provided**
{Partners External}*		
	TOTAL*	***{External Total}***

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PM Plus Template

Project Key Dates & Milestones

Timeframe	Commencement Date*	Completion Date*
Overall*	*{Overall Commencement}*	*{Overall Completion}*
Concept Phase*	*{Concept Phase Commencement}*	*{Concept Phase Completion}*
Planning & Definition Phase*	*{Planning & Definition Phase Commencement}*	*{Planning & Definition Phase Completion}*
Implementation Phase*	*{Implementation Phase Commencement}*	*{Implementation Phase Completion}*
Finalisation Phase*	*{Finalisation Phase Commencement}*	*{Finalisation Phase Completion}*
Proposed PIR*	*{PIR Commencement}*	*{PIR Completion}*

Key Milestones during Implementation Phase	Milestone No	Milestone Description	Commencement Date	Completion Date

Overall Project Budget & Cost Management

Project Costs	Financial Year*	Non Labour Costs*	Temp FTE ($)*	Total $*	Perm FTE*	%*
	Total*					

Resource Contribution from Partners/Clients/Stakeholders	

Estimated Margin of Error	

Post-project Cost Implications	

PM Plus Template

Major Risk Analysis

Major Risks	Likelihood	Consequence	Management Strategy

Project Governance

Structure (Steering Committee, project organisational chart, etc.)	

Project Management Roles & Responsibilities	Role	Name(s)	Responsibilities
	Project Manager		
	Project Sponsor		
	[etc.]		

Key Decision Points & Dates (ie. higher authority)	Key Project Phases/Documents	Higher Authority for Approval/Sign-off	(Planned) Dates
	Concept initiated		
	Concept phase completed		
	Approval of project plan		
	Release of project funds		
	Pre-implementation review (if relevant)		
	Status Report 1*		*{ Planned Submission Date}*
	Status Report 2*		*{ Planned Submission Date}*
	Status Report 3*		*{ Planned Submission Date}*
	Status Report 4*		*{ Planned Submission Date}*
	Status Report 5*		*{ Planned Submission Date}*
	Status Report 6*		*{ Planned Submission Date}*
	Status Report 7*		*{ Planned Submission Date}*
	Issue/change request		N/A
	Implementation phase completed		
	Project completion report		
	Finalisation phase completed		

PM Plus Template

Time and Cost Management

Internal Budget Source	Non- Labour Costs*	Planned Temp FTE ($)*	Total ($)*	Planned Perm FTE*
Base*	*{Non-Labour Costs / Base}*	*{Temp FTE / Base}*		*{Perm FTE / Base}*
Strategic Initiatives / Operational Imperative*	*{Non-Labour Costs / Strategic Initiatives / Operational Imperative}*	*{Temp FTE Base / Strategic Initiatives / Operational Imperative}*		*{Perm FTE / Strategic Initiatives / Operational Imperative}*
Other*	*{Non-Labour Costs / Other}*	*{Temp FTE / Other}*		*{Perm FTE /Other}*
Total	*{Non-Labour Costs / Total}*	*{Temp FTE / Total }*		*{Perm FTE / Total }*

Key Milestones	Commencement Date*	Completion Date (Initial Due Date)*	Non Labour Costs ($)*	Temp FTE ($)*	Total $*	Perm FTE
Milestone 1* – *{Description}*	*{Date}*	*{date}*	*{$}*	{$}	*{Total}*	
Milestone 2* – *{Description}*	*{Date}*	*{date}*	*{$}*	{$}	*{Total}*	
Milestone 3* – *{Description}*	*{Date}*	*{date}*	*{$}*	{$}	*{Total}*	
Milestone 4* – *{Description}*	*{Date}*	*{date}*	*{$}*	{$}	*{Total}*	
TOTAL						

WBS Item/Strategy/Activity (or attach a schedule)	**Accountable Officer/s**	**Duration**	**Months**											
			July	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**April**	**May**	**June**

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PM Pl us Tem pl at e

Human Resource Management

Accountable Officer	Work Days/Weeks Required	Temp FTE	Perm FTE	Skill Development Requirements
TOTAL				

Non Labour Costs

Timeframe	Year 1	Year 2	Year 3	Year 4	TOTAL
Marketing	$	$	$	$	**$**
Publication	$	$	$	$	**$**
Travel	$	$	$	$	**$**
Training	$	$	$	$	**$**
Other (Specify)	$	$	$	$	**$**
TOTAL	**$**	**$**	**$**	**$**	$

Communication Management

Project Communication			
What	How	With/To Whom	When/How Often

Records Management		
Document Type/Name	Electronic Location	Hardcopy Record Location
Project management documents		
Project reference documents		
[etc.]		

Risk Management

Risk	Likelihood	Consequence	Prevention/Reduction Strategy	Contingency Plan

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PM Plus Template

Evaluation

Project Evaluation Methodology (Process and Impact Evaluation)	Achievement of objectives will be determined by the following performance indicators:
	Data capture processes that need to be developed/implemented for the performance indicators are:
	Project management effectiveness will be reviewed through:

Post Implementation Review (PIR) (Outcome Evaluation)	The likely post implementation review strategy will be:

Recommendations & Decisions

Recommendations (Project Manager)

Next Step	☐ *Progress to Implementation** ☐ *Cease* *Comments:*		
	Prepared By	*Name*:*	*{Manager/Name}*
		Title:*	*{Manager/Title}*
		Work Unit / Site:*	*{Manager/Location & PHU/Unit}*
		Date:*	*{Prepared Date}*
		Phone Number:*	*{Manager Phone Number}*
		Email:*	*{Manager Email}*
	Cleared By (if applicable)	*Name*:*	*{Sponsor Name}*
		Title:*	*{Sponsor Title}*
		Work Unit/Site:*	*{Sponsor/Location and PHU/Unit}*
		Phone Number:*	*{Sponsor Phone Number}*
		Email:*	*{Sponsor Email}*
		Signed:*	*{Sponsor Decision}*
		Date:*	*{Sponsor Recommendation Date}*
		Comments:	

PM Plus Template

Approval/Decision (Higher Authority)

Next Step	☐ Progress to implementation phase* *{ Recommendations & Decisions / HA Decision}* ☐ Revise project plan and resubmit ☐ Cease *Comments:*

Governance	**Project Manager***	
	Project Sponsor*	

Resources	☐ Approved ☐ Not approved ☐ N/A		
	Amount	$	
	Parameters of Project Manager Authority	**Time:**	**Parameters of Project Manager Authority**
		Cost:	
		Quality:	
		Other:	
	Approved By	**Name*:**	*{Higher Authority Name}*
		Title*:	*{Higher Authority Position}*
		Work Unit / Site*:	*{Higher Authority for Plan Approval/Location &PHU/Unit*
		Phone Number*:	*{Higher Authority Phone Number}*
		Email*:	*{Higher Authority Email}*
		Signed:	*{Higher Authority Decision}*
		Date*:	*{Recommendations & Decisions/HA Decision Date}*

*Indicates a mandatory field to be entered into PM PlusIS

Months 1-6

Activity	Actioned by	Status	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
Project reports to District Lead /OCNOMidwifery Advisor	Project Officer		monthly	monthly	monthly	monthly	monthly	6 month summary
Mapping of Present Service Demographics of : • Population • Service	Project Officer			Finalised and present to Steering Committee				
Commence project and send out expression of interest to establish Steering Committee: Chair established	Project Officer			Finalised				
Steering Committee terms of reference	Project Officer			Endorsed by steering committee				
Steering committee monthly meetings	Project Officer			monthly	monthly	monthly	monthly	monthly
Project Plan Developed	Project Officer		Supported by CEO and Sponsor	Endorsed by steering committee				
Risk register	Project Officer		Commence	ongoing	ongoing	ongoing	ongoing	ongoing
Philosophy & Model of Care Document	Project Officer				Workshop model and develop philosophy	Endorsed by Steering Committee		
Recruitment of midwives for model	Project Officer		Commence				Midwives employed	
Clinical governance review	Project Officer				Endorsed by steering committee	Disseminate to service	Monitoring by Steering Committee	ongoing
Guideline development if required	Project Officer					Endorsed by steering committee	Disseminate to service	
Service line agreement drafted	Project Officer					Endorsed by steering wcommittee	Disseminate to service	
Midwife work arrangements and local agreement	Project Officer					Local agreement developed with union		Finalised
HR/IT processes	Project Officer							Finalised
Promotion- to facility, community of new service	Project Officer		Public relations involvement		ongoing	ongoing	ongoing	ongoing
Organisational culture	Project Officer						Inter-disciplinary team building workshop	Ongoing monitoring
Plan and Upskilling of staff	Project Officer				Plan finalised		Upskilling occurs	Upskilling occurs
Resources- consumables identified and ordered	Project Officer		Identify resources-consumables		Orders sent		Resources arrive	
Resources- rental of community, facilities, car leases etc	Project Officer			Endorsed by steering committee	Legal agreement	Disseminate to service		
Key performance indicators identified and reportable (data base created, surveys written and approved by ethics committee)	Project Officer		Commence negotiation for access/ development of data base	Develop mechanisms & support for recording &reporting		Endorsed by steering committee	Ethics Approval / IT support	Disseminate to service /
Antenatal education prepared including consumer information of the model	Project Officer			Consistent with model of care		Endorsed by steering committee		
Commence Service	Project Officer and Midwives							Midwives workload allocated

Months 7-12

Activity	Actioned by	Status	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Project reports to District Lead / OCNO Midwifery Advisor	Project Officer		monthly	monthly	monthly	monthly	monthly	Final report summary
Risk register	Project Officer		ongoing	ongoing	ongoing	ongoing	ongoing	Ongoing
KPI's	Project Officer		monthly	monthly	monthly	monthly	monthly	Ongoing
Evaluation of service- staff and consumer evaluation	Project Officer		Develop evaluation forms	Steering committee to endorse	Send out evaluation		Collate evaluation	Disseminate
Steering committee monthly meetings	Project Officer		monthly	monthly	monthly	monthly	monthly	
Establish Management Committee meet bi monthly	Steering Committee Chair					TOR Management Committee post 12 mth point		TOR Endorsed by Steering committee
Case conferencing	Project Officer/ Lead midwives / Obstetricians		monthly	monthly	monthly	monthly	monthly- plan for sustainability	Ongoing
Promotion- to facility, community of new service	Project Officer/ PR		ongoing	ongoing	ongoing	ongoing	ongoing	
Final report Steering Committee	Project Officer / Chair						Draft report	

Appendix 6: Steering Committee – Terms of Reference

Date: ??/??/??

Date Reviewed: ??/??/??

Midwifery Group Practice Steering Committee

Terms of Reference

Description:

The Steering Committee will oversee and support the Midwifery Group Practice (MGP) at ______________________________ Hospital.

Role:

- Guide and receive reports and feedback from the MGP midwives
- Guide and receive reports and feedback from medical staff
- Guide and receive feedback from the associated consumer groups
- Act as a resource and guide decisions in relation to relevant issues
- Guide the development of further policies, practice guidelines, education and training for the MGP
- Review and support the evaluation process of the MGP model of care
- Oversee the ongoing transition process associated with the establishment of aMGP within the ___________________ Hospital Maternity Service

Committee Membership:

a) The committee shall be comprised of:

Nursing & Midwifery Director	*(name)*
Director, O&G	*(name)*
Finance officer	*(name)*
Senior Staff Specialist, O&G	*(name)*
Midwife Unit Manager, Antenatal & Birthing	*(name)*
MGP Midwives	*(names)*
Birth Suite midwife	*(name)*
Lecturer,_______________University	*(name)*
College of Midwives representative	*(name)*
Consumer representatives	*(names)*
General practitioner representative	*(name)*
Queensland Nurses' Union representative	*(name)*
Child Health nurse representative	*(name)*

It is the understanding of the committee that the membership of consumer representatives *(name)* and *(name)* are interchangeable and both represent one (1) vote on behalf of the consumer group.

It is the understanding of the committee that the membership of the MGP midwives represents two (2) votes on behalf of the MGP midwives.

(b) Others are invited on an ad hoc basis.

Procedural Guidelines:

Chair:

Midwife Manager, Antenatal & Birthing Services

Agenda:

Written in approved District format and forwarded to committee members no less than two (2) days prior to the scheduled meeting date.

Frequency of Meetings:

Meetings will be held 1st Friday two (2) monthly. Notification of the meeting will be communicated to all members no less than two (2) days prior to the scheduled date.

Minutes:

Minutes will be distributed to:

All members of the committee within five (5) working days of the meeting.

Quorum:

Meeting quorum will be 50% plus one (6) of permanent members. Proxies will be permitted. Proxies should not have voting power.

Reporting:

Reporting and feedback of proceedings to midwifery and obstetric staff of the District Maternity Service by the relevant staff members of the reference group.

Reporting and feedback of proceedings to consumers by the relevant consumer members.

Appendix 7: Example of Workplace Philosophy

Appendix 7: Sample Statement of Vision and Philosophy

Gold Coast Birth Centre Philosophy

The Gold Coast Birth Centre offers a natural approach to childbirth for women who have no identified medical or obstetric risk factors at booking in which would be expected to inhibit their ability to birth safely within this facility.
Within a relaxed informal setting, midwives provide primary care and consult and refer with other caregivers in response to the needs of women and their babies.
The Gold Coast Hospital recognises the safety of this model and supports the Birth Centre.

Client Centred Care: The Gold Coast Birth Centre views the mother and baby as an integrated unit, and puts them at the centre of care.

Normality of Birth: The Gold Coast Birth Centre works on a philosophy that pregnancy and childbirth is a normal physiological event and promotes a low-technology approach to childbirth.

Continuity of Care: It is our aim that women and their partners receive a continuity of midwifery care service, within a caseload model, throughout the antenatal period and during labour and birth, with home visiting being provided for a period after birth ensuring the woman receives her entire care from a known midwife.

Partnership: We view the relationship between the woman and the midwife as a partnership which, in collaboration with other health care providers and her family, empowers and supports the woman in pregnancy, birth and early motherhood. This partnership is based on mutual trust and respect with an emphasis on safety for the mother and her baby.

Sensitivity and Respect: The Birth Centre midwives are guided by the principle of sensitivity to the normal physiological process of birth, whilst respecting the woman and her baby's privacy, dignity, religious, social and cultural beliefs.

Holistic Care: We promote a family-friendly, woman-centred, holistic approach to birth with an emphasis on early antenatal education, evidence-based midwifery care and consultation with other health professionals and community groups as needs are identified.

Nurturing Environment: The Birth Centre provides a safe, nurturing environment that promotes active birth and is conducive to pregnancy and birth progressing along a natural course.

Informed Choice: We recognise the woman's role as decision maker in her own pregnancy and birth, and our responsibility to provide her with accurate information to enable her to choose options for her care by providing her with a full understanding of the risks and benefits of particular care strategies.

Evidence-Based: The Birth Centre aims to provide a high level of safety through using evidence-based practice, and providing evidence-based information to women.

Ongoing review of Service: We aim to review the service and the client-population we serve after 6 to 12 months, when care has been audited, along with all other maternity care within the facility.

Endorsed 4/8/05

Gold Coast Birth Centre
Steering Committee

Birth Centre Workshop Wednesday 22nd June 2005, 9am – 4pm
Maternity Conference Room

AGENDA & PROGRAM

09.00	Welcome & Introductions
09.20	Overview Birth Centre Philosophy
09.40	Thinking Partnership Exercise: Developing the Birth Centre Philosophy
10.15	Thinking Partnership Exercise: Distilling the Birth Centre Philosophy
10.45	Coffee
11.15	Scoping Model of Care
11.40	Thinking Partnership Exercise: Model of Care Dimensions
12.30	Lunch
13.30	Thinking Partnership Exercise: Operationalising the Model of Care
14.15	Working Party Committees: Objectives & Time scales
14.50	Coffee
15.20	Open Forum
16.00	Close

NB The day will start promptly at 9am

BIRTH CENTRE PLANNING DAY
THINKING PARTNERSHIP EXERCISE (PHILOSOPHY)

POINTS:

- Woman centred
- Having a known midwife
- Continuity of known carer and 2-way partnership of trust
- Respect for woman as an intelligent decision maker when given adequate information
- Birth Centre to receive ongoing support and commitment
- Women are competent to birth normally and birth is recognised as a normal physiological process.
- Consumer and staff affinity with the model of care.
- Social model over a Mechanistic model
- Safety/Risks involved reducing fear
- Integrated event. Post natal connected – parent
- One on one relationship with midwife
- Family centred access
- Ongoing evaluation of service and of women who can access the service
- Midwife to facilitate informed choices in labour
- Partnership
- Early antenatal education

DRAFT PHILOSOPHIES

Group 1:

Woman centred: recognising mother and baby as a unit
Partnership between mother and midwife: known midwife/continuity of care
Primary care from midwives
Collaboration with other care givers: Midwives
Obstetricians
Lactation consultants

Care provided over the full maternity episode: Early pregnancy
Birth
Postnatal (up to 6 weeks)

Integration with other services – hand over to community services/resources
Evidence-based safe policy, practice and guidelines
Ongoing evaluation: full spectrum of outcomes including social, long term
Professional development and education ongoing

Group 2:

The Gold Coast Birth Centre aims to provide family-centred care through a partnership based on trust, evidence-based care and advice with collegiate collaboration and commitment to providing a nurturing safe environment with pregnancy and birth supported as a natural process.

Group 3:

Family-centred continuum of care
Active birth philosophy
Partnership of mutual trust and respect
One to one relationship/partnership
Midwife as primary caregiver
Education focus on wellbeing
Respect for informed choice
Environment conducive to active birth

Group 4:

One to one midwifery care within a caseload model
Pregnancy and birth are seen as a normal physiological process
The woman and baby are seen as a unit
Women and family centred
Women's right to make informed choices through evidence-based practise
Care that is sensitive to woman's varied culture and physical needs
Facilitating empowerment through the process of pregnancy and birth

BIRTH CENTRE PLANNING DAY
THINKING PARTNERSHIP EXERCISE (MODEL)

Points:

- Midwifery Education at a consultant midwifery level
- Case reviews regularly (multi-disciplinary)
- Midwives being accountable to other midwives – self evaluation, peer review
- No admission criteria would be ideal
- Continuity across the continuum eg. Breast feeding
- Data collection be uniform across all Qld Health Birth Centres – universal data base
- Whole organisation to be brought on board – organisational culture change
- Midwives flexible working life supported be the institution
- Effective operationalism of model
- Profile of midwifery model linked to education and research
- Low risk model
- Open culture
- Selection Criteria with review
- Annualised salary and roster control
- Community based and not hospital based includes home assessment in early labour and antenatal visits
- Start low risk and review later

KEY DIMENSIONS OF BIRTH CENTRE MODEL

Group 1:

Geographically defined catchment – shrink to manage demand
No ballot
6 midwives x 40 births = 240 per year (proposed)
Total births GCH 3000 per year. Approx 2000 low risk
Access: Need for GP referrals requires clarification
Antenatal Clinic midwife – can offer options
Self referral (?)

Question??? Do we need low-risk exclusion criteria?

Continuity??? Exclusion in pregnancy
Exclusion in labour
Transfer
Can we continue follow up and care of woman when she transfers to another care model due to development of risk factors?

Group 2:

- Low risk with review later
- Caseload with Team of 2-3 midwives = 40 women per midwife = 80 - 120 women per team
- Consult with registrar as required
- Midwifery teams attached to own consultant – therefore approach that consultant's registrar for questions
- Consult with Paediatric Registrar if required postnatally
- Antenatal home assessment in early labour
- Neonatal examination by midwife
- Clear referral at 6 weeks to GP, Child Health or other services with appropriate letters.
- 6 week check with GP or midwife??
- Transfers to Labour Ward – Midwife from Birth Centre goes with them ? as a support ? as a practising midwife.
- Orientation of all staff to Birth Centre

Group 3:

- Open access
- Integrated multi-disciplinary collaborative relationships (other services)
- Organisational support: management, education, resources, multi-disciplinary, IT – accurate data base
- Flexibility of care (antenatal, intrapartum, postnatal) – Home – Birth Centre
- Integrated evaluation of planning: audits, resources – mentoring, time (work), role, response
- Culture of collaborative care
- Philosophical similarities with mainstream services
- Promote learning culture / professional development

Group 4:

- Catchment area
- Home visits antenatal, early labour, post natal
- Entry criteria
- Midwifery assessment
- Education / Evaluation
- Admission process
- Medical Coverage
- Consultation and Referral guidelines
- Guidelines for caseload midwives after transfer to Labour Ward
- Water birth policies
- Collegial relationships with other midwives
- Peer support for caseload midwives
- Regular case meetings with midwives and obstetric staff
- Issues around caseload model

Appendix 8: Example orientation program*

MIDWIFERY GROUP PRACTICE ORIENTATION

DAY 1: Monday 20th June

TIME:	TOPIC:
0800	Welcome and Introduction
0815	Immediate questions from midwives
0830	Orientation process/program
0845	MGP Governance/Local Agreement/Weekly Stats Sheet
1015	Cars/Boats and Mileage
1045	**Morning Tea**
1100	Off Call/On Call Arrangements/Holiday
1200	**Lunch**
1230	Recap of morning information
1245	Midwives MGP Work Instructions/Communication Pathways
1345	Midwives Paperwork
1445	**Afternoon Tea**
1500	Data Collection
1530	Midwifery Practice Review
1545	Recap/Feedback
1630	**Home**

DAY 2: Tuesday 21st June

TIME:	TOPIC:
0840	Russell Island
1020	Macleay Island
1200	Return to Redland Bay
1230	**LUNCH**
1300	HBCIS
1330	Indigenous Culture
1400	Child Health
1430	**Afternoon Tea**
1445	Pathology
1500	Potential Clients and contact instructions
	General info (physio clinics on Stradbroke, PPP, Family Partnership Training)
1600	**Home**

Wednesday 22nd June
Day with Logan MGP midwives x3 midwives
Family Partnership Training x 1 midwife

*Thanks to Redlands Hospital for sharing their 2011 MGP orientation program

1

Thursday 23rd June
Macleay Island + contact women
Family Partnership Training x 1 midwife

Friday 24th June
Russell Island + contact women
Family Partnership Training x 1 midwife

DAY 3: Monday 27th June

TIME:	TOPIC:
0755	North Stradbroke Island
0830	Marie Rose
	Yulu- Burri-Ba
	Point Lookout Doctors
1125/1325	Cleveland
1230	**LUNCH**
1400	Social Work
1430	ATODS
1430	**Afternoon Tea**
1445	Wellbeing
1515	Questions/Issues/Concerns
1600	**HOME**

Day 4: Tuesday 28th June

TIME:	TOPIC:
0830	Areas, Allocation, Annual Leave, On/Off Call Identifying paperwork systems, Clinical supplies and information packs
0930	Midwives own time to organise computers, clinical supplies, antenatal appointments etc
1600	**HOME**

Wednesday 29th June - Friday 1st July
Midwives own time to organise computers, clinical supplies, antenatal appointments etc
Family Partnership Training x 1 midwife

GO LIVE DATE MONDAY 4TH JULY

*Thanks to Redlands Hospital for sharing their 2011 MGP orientation program

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Appendix 9: Example of Midwives' Equipment List

Appendix 9: Sample Midwives' Equipment List

Recurrent non clinical costs

- Mobile Phone / pager (costs may be nil or minimal)
- Computer costs, including remote access
- Printer costs
- Stationery costs
- Administration costs
- Car transport options:
  - use of District vehicle,
  - lease,
  - reimbursement for use of own motor vehicle
- Clinical supplies

Equipment, non recurrent

- Clinical equipment required by each midwife:
  - Doppler
  - Scales
  - Ophthalmoscope
  - Otoscope
  - Stethoscope
  - Sphygmomanometer
  - Practice bag
  - Emergency birth kit
  - Glucometer
  - Thermometer
- Computers
- Mobile phone
- Office furniture and equipment
- Breast pump and attachments
- Client educational equipment
  - AN education & class or groups information and equipment
  - Educational DVD's
  - Reference Library
- Inflatable birth pool (in areas where birth pools are not inbuilt)
- TENS machine

Appendix 10: Draft Key Performance Indicators for Midwifery Models*

Key points

- Where possible, existing ACHS indicators have been used; however some new indicators have been developed specifically for midwifery models, to capture potential benefits, e.g. continuity, breastfeeding.
- Definitions for indicators marked as ACHS are to be according to the ACHS manual http://www.ranzcog.edu.au/fellows/pracrm/ranzcogachs-clinical-indicators.html
- Sources of indicators are listed where known.
- Please note: only women who have booked into the midwifery model are reported on in these KPIs.

Average Length of Stay Average length of stay per admission	Average length of stay, in days per admission, of women booked for care in the midwifery model.
Antenatal Visits The percentage of women receiving 5 or more antenatal visits per pregnancy.	N: The number of women receiving 5 or more antenatal visits per pregnancy. D: The total number of women booked for care in the midwifery model.
Inductions of labour for selected primipara (ACHS CI. 1.2) The percentage of selected primipara who undergo induction of labour.	N: The number of selected primipara who undergo induction of labour. D: The total number of selected primipara who were booked for care in the midwifery model.
Spontaneous vaginal birth for selected primipara (ACHS CI. 1.1), (CMIP 6) The percentage of selected primipara, booked for care in the midwifery model, who have a spontaneous vaginal birth.	N: The total number of selected primipara who have a spontaneous vaginal birth. D: The total number of selected primipara who were booked for care in the midwifery model.
Vaginal birth after Caesarean (VBAC) (ACHS CI. 2.1) The rate of vaginal delivery following primary caesarean section.	N: Total number of women delivering vaginally following a previous primary caesarean section. D: Total number of women booked for care in the midwifery model who have had a previous primary caesarean section and NO intervening pregnancies greater than 20 weeks gestation
Instrumental vaginal births for selected primipara (ACHS CI. 1.3) Percentage of women who had an instrumental birth.	N: Total number of selected primipara who undergo an instrumental vaginal birth. D: Total number of selected primipara

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	who were booked for care in the midwifery model and gave birth.
Vaginal birth Percentages of women in the model: • Who birthed vaginally • Who birthed by vaginal breech birth.	N: The number of women whose method of birth was: • vaginal birth (total vaginal births) • vaginal breech birth D: The total number of women who were booked for care in the midwifery model.
Water Immersion Percentage of women who used water immersion: • in labour • in labour and birth.	N: The number of women who used water immersion: • in labour • in labour and birth D: The total number of women who were booked for care in the midwifery model.
Caesarean birth Percentages of women who birthed by: • Caesarean section total • Elective caesarean section: • Planned/booked • Not planned/booked • Emergency caesarean section	N: The number of women who underwent: • caesarean birth (total caesarean) • Elective caesarean section with planned/booked delivery • Elective caesarean section with non - planned/booked delivery • Emergency caesarean section D: The total number of women who were booked for care in the midwifery model.
Caesarean section for selected primipara (ACHS CI. 1.4) Percentage of selected primipara undergoing caesarean section.	D: Total number of selected primipara undergoing **caesarean section**. N: Total number of selected primipara who were booked for care in the midwifery model and gave birth.
Transfer rate before 28 weeks The percentage of women whose care is permanently transferred to obstetric care (obstetrician is their primary or lead care provider) prior to 28/40.	N: The number of women whose care is permanently transferred to obstetric care prior to 28/40. D: The total number of woman who were booked for care in the midwifery model.
Transfer Reason <28 weeks	Data will be collected as actual list
Transfer rate after 28 weeks The percentages of women whose care	N: The number of women whose care is permanently transferred to obstetric

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is permanently transferred to obstetric care (obstetricians is the woman's primary or lead care provider) · Antenatal · Intrapartum · Post birth	care after 28/40: · Antenatally · Intrapartum · Post birth D: The total number of women who were booked for care in the midwifery model.
Transfer Reason >28 weeks · Antenatal · Intrapartum · Post birth	Data will be collected as actual list.
Continuity of carer (caseload models only) Percentage of women who have a named primary midwife is listed as attending their birth.	N: In a caseload model, the number of women whose named primary midwife is listed as attending their birth D: The total number of women who were booked for care in the midwifery model
Continuity of labour and birth care Percentage of women who have a midwife, who has provided at least 3 antenatal visits, listed as attending their birth.	N: The number of women who have a midwife, who has provided at least 3 antenatal visits, listed as attending their birth D: The total number of women who were booked for care in the midwifery model
Continuity of antenatal care Average number of antenatal visits attended by the midwife listed as attending the birth.	Average number of antenatal visits provided by the midwife listed as attending the birth of the same woman, for women booked for care in the midwifery model.
Perineal tears and repairs for selected primipara (ACHS) · Percentage of selected primipara with an intact perineum (ACHS Cl. 3.1) · Percentage of selected primipara with an episiotomy and no perineal tear (ACHS Cl. 3.2) · Percentage of selected primipara with a perineal tear and no episiotomy. (ACHS Cl. 3.3) · Percentage of selected primipara with an episiotomy and a perineal tear. (ACHS Cl. 3.4)	N: Total number of selected primipara: · with an intact perineum · undergoing **episiotomy** and **NO perineal tear** while giving birth vaginally. · Total number of selected primipara sustaining a **perineal tear** and **NO episiotomy**. · Total number of selected primipara undergoing **episiotomy AND** sustaining a **perineal tear** while giving birth vaginally. · Total number of selected

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· Percentage of selected primipara undergoing surgical repair for a third degree tear (ACHS Cl. 3.5) · Percentage of selected primipara undergoing surgical repair of the perineum for **fourth degree tear** (ACHS Cl. 3.6).	primipara undergoing surgical repair of the perineum for **third degree tear** · Total number of selected primipara undergoing surgical repair of the perineum for **fourth degree tear** D: The total number of selected primipara who booked for care in the midwifery model and gave birth vaginally.
Post Partum Haemorrhage (PPH) > 1000 ml The rate of blood loss greater than or equal to 1000ml, expressed as a percentage.	N: The number of women with blood loss after birth greater than or equal to 1000ml. D: The total number of women who booked for care in the midwifery model
Breast feeding at 24hrs – Percentage of women who were exclusively breastfeeding at 24 hours – expressed as a percentage	N: The number of women who were exclusively breastfeeding at 24 hours after birth D: The total number of women who booked for care in the midwifery model.
Breastfeeding at 6 weeks – No of women who gave birth who were · Exclusively breastfeeding · Partially breastfeeding · Not breastfeeding At 6 weeks postpartum– expressed as a percentage. All 3 criteria are to be measured and recorded.	N: The number of women who were: · exclusively breastfeeding · partially breastfeeding · not breastfeeding at 6 weeks postpartum. D: The total number of women who booked for care in the midwifery model.
Postnatal care The percentage of women who received 5 or more postnatal visits at home.	N: Number of women who have received 5 or more postnatal visits at home D: The total number of women who booked for care in the midwifery model.
Postnatal continuity of carer – caseload only The percentage of women who have given birth within the midwifery model of care who have received 5 or more postnatal visits from the midwife named as their primary midwife	N: In a caseload model, the number of women who have received 5 or more postnatal visits after birth from the midwife named as their primary midwife. D: The total number of women who booked for care in the midwifery model.
Clinical Events: • Clinical incidents and near misses will be recorded as per hospital policies	

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and procedures • Obstetric High risk clinical events will be identified and data collected and reported upon. • Sentinel events/RCA and HEAPS investigations will follow hospital protocols.	

Neonatal Indicators

Babies admitted or transferred to SCN or NICU excluding congenital abnormality (ACHS Cl. 10.1)	N: Total number of inborn term babies transferred / admitted to a neonatal intensive care nursery or special care nursery for reasons other than congenital abnormality D: Total number of live term babies born to women who were booked for care in the midwifery model (exclusion: babies born with a congenital abnormality).
Apgar score at 5 minutes The percentage of babies born at term with Apgar less than 7 at 5 minutes post birth. (Maternity Key Performance Driver 4), (ACHS Cl. 9.1), (CMIP 7)	N: Total number of liveborn term babies born with an Apgar score of less than 7 at five minutes post delivery. D: Total number of liveborn term babies born to women booked for care in the midwifery model.
Clinical Events: • **Clinical incidents and near misses will be recorded as per hospital policies and procedures** • **Sentinel events/RCA and HEAPS investigations will follow hospital policy.**	

Adapted from Toowoomba KPIs for eligible midwives, July 2011

Financial Indicators

Average Length of Stay (ALOS)	Average length of stay – for women booked for care in the midwifery model.
Average Length of stay (ALOS) – post transfer to mainstream	Average length of stay for women following transfer into medical care from the midwifery model.
Occupied Bed Days (OBD)	Total occupied bed days – for women cared for in the midwifery model.
Occasions of Service (OCS) midwife	Total occasions of service – for women seen in the midwifery model.
Occasions of Service (OCS) medical	Total occasions of service – for women booked for care in the midwifery model and seen by a staff medical practitioner.
Weighted Activity Unit (WAU)	Total WAU for women being cared for in the midwifery model

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Appendix 11: Clinical Governance Summary

______________________ **Reference Committee**

Clinical Governance Summary for Period / / to / /

Maternity Service Objectives Met in this report:

-
-
-
-

Report provided by______________________Tabled by ________________________

Policies Updated (all policies should be reviewed at least 2nd yearly by a multidisciplinary team with consumer involvement)		
Policy Name	*Last Reviewed*	*Status*

Incidents or Adverse Events eg shoulder dystocia, readmissions		
Broad Category	*SAC Rating if applicable*	*Status*

Clinical Audit eg incidence and management of PPH, cases referred to District Mortality & Morbidity meeting, documented management plan for non category A clients		
Audit Name	*Issues Identified / Actions*	*Status*

Quality Activities eg patient satisfaction		
Activity Name	*Indication for Activity*	*Status*

Clinical Activity						
Booking No's	***Transfers***					
Month	A/N	Indication	I/P	Indication	P/N	Indication

Case Conference			
Date	*Obstetrician*	*Significant concerns*	*Actions Taken*

Clinical Outcomes	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*
BC Births												
D/S Births												
Av A/N visits												
Indigenous												
Torres Str												
IOL												
NVB												
Waterbirth												
Op Vag												
C/S elective												
C/S unplanned												
1st/2nd° tear												
3rd/4th° tear												
Epis												
PPH > 500mls												
Breech												
Pre-term												
IUGR												
Apgar <7 at 5 mins												
Term SCN												
BW range												
Fully BF at D/C												
Av P/N Stay												
Av P/N Visits												
IUFD gestation												
Stillbirth												

Compliments / Complaints		
Broad Issue	*Actions*	*Status*
	• •	
	• •	

Professional Development		
	Completed (n,%)	*Actions to Address*
Accreditation for role (MPR)		
MACRM / ALSO		
NRP		
Portfolios		
PAD's		
Scheduled Inservices		
Multidisciplinary sessions		

Operational Issues

Case loads □ manageable □ unmanageable
Actions Required (by whom and when):
____
____
____

Staffing □ vacancies □ no vacancies
Actions Required (by whom and when):
____
____
____

Resources □required □ adequate
Actions Required (by whom and when):
____
____
____

Budget □ met □ unmet
Actions Required (by whom and when):
____
____
____

Other Issues for Mention
____
____
____

Appendix 12: Women and Neonatal SBAR Tool - SITUATION, BACKGROUND, ASSESSMENT, RECOMMENDATION (SBAR)

SBAR a communication tool for Health Professionals re issues/concerns about a clinical situation. Have available the following :

- The medical record, most recent vital signs;
- List of current medications, allergies, IV fluids and pathology, and
- Reporting pathology results: provide the date, time test was done and results of previous tests for comparison.

Examples	Explanation	Antenatal	Intrapartum	Postnatal	Neonatal
S **Situation**	- State your name and location. - The time is ..... (if at night). - I am calling about: Name. - Reason for admission. - Describe issue.	- It is – your name in - your location. - I am calling about Ms.... name. Example: - She has come in labour and is bleeding (amount). - She is having an APH.	- It is – your name in - your location. - I am calling about Ms.... name. Example: - In established labour since 02:00. - She is making slow progress and requesting epidural.	- It is – your name in - your location. - I am calling about Ms.... name. Example: - Confinement - She is having a PPH approximately 600mLs.	- It is – your name in - your location. - I am calling about baby.. name Example: - Baby is demonstrating significant respiratory distress.
B **Background**	- Gravid Para. - EDC/Confinement Details. - Problems with current pregnancy. - Ultrasound results if applicable. - Significant past obstetric history. - Significant Medical/ Surgical/Social history.	- G2 P1. - EDC 16/03/08. - 35 weeks gestation. - She has grade 4 placenta praevia. - Booked for C/S on _____ - Scan at 32 weeks showed grade 4 placenta praevia. - PHx SVD, PPH after 3 hr labour. - Is Hep C positive: Hx IV drug use.	- G1 P0 - EDC 16/03/08 - 41+ weeks gestation - Nil pregnancy complications. Nil other history. - She was admitted at 06:00. - PVE at 07:00 8cms dilated membranes intact. - PVE at 10:00 unchanged ARM performed. - Analgesia given at 10:00hrs.	- She is a Primip. - She had a Spontaneous Labour: • Nil Intervention • SVD at 12:30 • Perineum Intact • Placenta Complete • Intrapartum blood loss 200mLs • Syntocinon given • HPU post birth - Hx of mild P.I.H	- State significant antenatal/birthing history.
A **Assessment**	- Assessment findings. - Possible reasons for findings. - Procedures performed.	- Vital signs are normal if abnormal state. - PV loss: bright loss with clots approximately 300mLs - CTG normal / CTG abnormal - Describe Baseline Rate • Variability • Acceleration present • Decelerations - Contraction 3:10 lasting 45 secs - Palpation: the uterus is soft and non tender. - Vaginal assessment not done. - Placenta Praevia. - IVC inserted bloods collected.	- Vital signs are normal if abnormal state. - Clear liquor. - CTG normal / CTG abnormal • Baseline Rate • Variability • Acceleration present • Decelerations - Contraction 3:10 but variable in intensity. - Palpation: head 3/5 palpable. - Vaginal assessment at 13:00 no change - 1+ moulding 1+caput Vx -3 deflexed OP - Slow progress due to poor contraction and fetal position. - IVT sited.	- Pulse rate 120 BP 90/50 Pale - Large PV blood loss with clots. - Fundus boggy and to right. - Palpable bladder. - Atonic Uterus. - IVC inserted. IDC inse Fundal massage, IV Oxytocin commenced, PR Misoprostol given	- Observations are: - Colour - Heart Rate - Respiration - Temp - BSL - O2 saturation - General appearance/ tone/movement/ posture - Any abnormalities - O2 at____l/min
R **Recomm -endation**	- I would like to transfer (Be specific about request and time frame). - Suggestions. - Clarify orders and expectations.	- Immediately. - Prepare for emergency C/S	- Immediately.	- Immediately	- Immediately OR Contact retrieval service

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