Midwifery Continuity of Carer Model Tool-kit

NSW GOVERNMENT | Health

NSW MINISTRY OF HEALTH
73 Miller Street
NORTH SYDNEY NSW 2060
Tel. (02) 9391 9000
Fax. (02) 9391 9101
TTY. (02) 9391 9900
www.health.nsw.gov.au

Produced by:
The Nursing & Midwifery Office
NSW Ministry of Health

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Contents

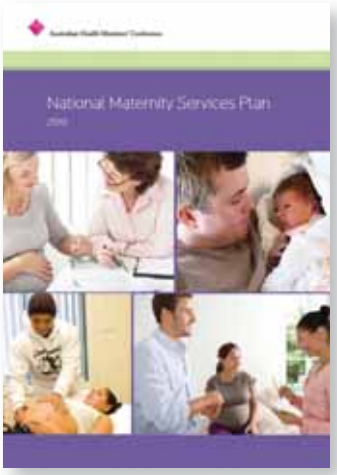

caring
Woman-centred
Supportive
Empowering
Happily-Proud
Joyous
Family-orientated
Engaged
Recognised
Approachable
Friendly
Amazing
Progressive
Choice
Excellent
Nurturing
Journey
Valued
Family-focussed
Sustainable
Accessible
Satisfying
Midwifery-led
Team-cohesive
Dynamic
Warm
Changing
Secure
Heard
Holistic
Great
Enjoyable
Equitable
About-me
Reassured
Confident
Comfortable
Welcoming
Kind
With-woman
Flexible
Open
Safe
Wonderful
Diversity
Excellence

Introduction

This Toolkit has been written to assist managers and clinicians working in NSW public health maternity services to develop and implement Midwifery Continuity of Carer models (MCoC). The aim is to improve and enrich maternity care provided to women and families in NSW. MCoC models focus on the needs of the woman and her family and places her at the centre of her care.

The core principles of woman centred care[1]:

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



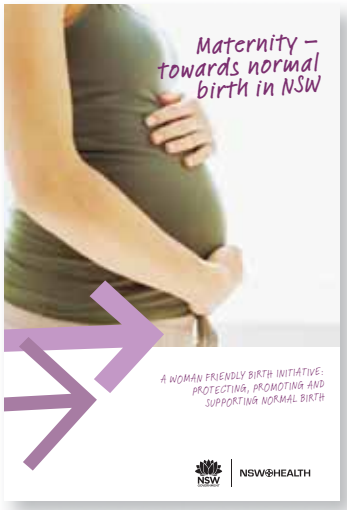
Government reports, both NSW and National[2], have identified the need to develop programs, both midwifery and medical, which focus on providing continuity of carer. Maternity services need to establish MCoC models which are: locally focussed, enhance access, increase equity to maternity care and improve recruitment and retention of the midwifery workforce[3].

As indicated in the NSW Framework for Maternity Services and the Towards Normal Birth Policy Directive PD-2010_045, the aim of maternity services in NSW is to provide safe, effective, collaborative maternity care that addresses each woman's specific needs and achieves desirable health outcomes for both mother and baby[4,5]. Within the NSW Framework for Maternity Services, a change that was identified was to expand the range of care models, including access to MCoC.

The Towards Normal Birth Policy Directive also identifies 10 key measures that recognise the importance of woman centred care to enable access to maternity services and care that will optimise maternity care experiences and health outcomes for women and families. It also requires that these measures be implemented and annually reported on by each NSW Health maternity service until 2015. More specifically, Key Measure 3 states that each maternity service is:

'To provide or facilitate access to midwifery continuity of carer programs in collaboration with GPs and obstetricians for all women with appropriate consultation, referral and transfer guidelines in place'.

[1] Homer, C.S.E, Brodie, P. & Leap, N. (Eds), (2008) Midwifery continuity of care: A Practical Guide, Sydney, Churchill Livingstone/Elsevier.
[2] Commonwealth of Australia (2009). Improving Maternity Services in Australia: The report of the maternity services referral. http://www.health.gov.au/
[3] National Maternity Plan
[4] The NSW Framework for Maternity Services NSW Health 2000
[5] Towards Normal Birth Policy Directive PD-2010_045



A MCoC model provides a woman with a primary midwife and a backup midwife for the antenatal, intrapartum and postnatal periods. These models of care are usually known as caseload or midwifery group practice (MGP). High level international evidence demonstrates the improved clinical outcomes for women and their newborns when their maternity care is provided by a known midwife[6] in collaboration with other maternity care providers such as obstetricians, neonatologist, General Practitioners (GP's) and allied health.

It is also well recognised that these MCoC models enable midwives the opportunity to work to their full scope of practice and to develop meaningful relationships with the women they care for and support[7]. Such factors have been recognised as important in successful recruitment and retention of midwives[8].

Managers and clinicians who have undertaken the development and implementation of these innovative models have found there are many processes and strategic steps needed to establish a successful and sustainable model[9].

This toolkit has been written to support maternity services as they undertake the development and implementation of their MCoC model. It also provides necessary information to enable successful and ongoing sustainability of the model. It contains helpful information about the core principles of MCoC, key steps to include in your implementation plan, lessons learnt and appendices that include useful templates and documents.

[6] Hatem, M., Sandall, J., Devane, D., Soltani, H. and Gates, S. (2008) 'Midwife-led versus other models of care for childbearing women', Cochrane Database of Systematic Referrals, Issue 4. Online: Available at: http://mrw.interscience.wiley.com/cochrane/clsrev/articles/CD004667/frame.html

[7] Kirkham, M. (Ed.), The midwife-mother relationship. London: Macmillan Press Ltd.

[8] Sullivan K. Lock, L. & Homer, C.S.E., (In Press) Factors that contribute to midwives staying in midwifery: A study in one area health service in New South Wales, Australia. Midwifery

[9] Leap, N., Dahlen, H., Brodie, P., Tracy, S., & Thorpe, J. (2011). 'Relationships-the glue that holds it together': midwifery continuity of care and sustainability. In Davis,l., Daellenbach, R. & Kensington. K. (Eds.), Sustainability, Midwifery and Birth. New York: Routledge

Understanding the broad context

It is important to be aware of and understand the NSW industrial and policy frameworks in which the model willl be designed and implemented. The key documents are outlined below.

NSW Quality Framework

A well-accepted approach to referraling systems of health care is to use the *health outcomes framework*. This framework ensures that the new model of care has a positive impact on people's health. It makes sure that any changes to maternity service provision is based on the six dimensions of quality rather than any single factor such as volume or geographical location[10].

The best examples of successful models of maternity care take into account the philosophy statement and framework of the NSW Quality Framework. The *six key dimensions* of quality described in the NSW Quality Framework that maternity services are required to demonstrate are:

- Safe and minimise risk
- Effective
- Appropriate
- Involving consumer participation to enhance acceptability
- Accessible and equitable and based on need
- Efficient in resource utilisation.

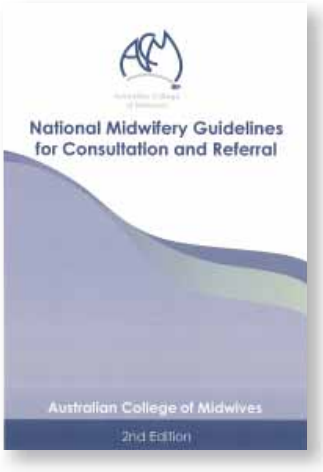
Tiered Maternity Networks

It is also critical that the development of all maternity services includes a collaborative tiered networks approach which includes robust systems and processes for identifying and managing risk.

Tiered Maternity Networks:

- Describe the organisation of maternity services from normal risk to high risk in appropriately resourced facilities. Role delineations of maternity services range from 1 to 6.[11]
- Reflect complex and the inter-dependent relationships across clinical maternity services.
- Provide guidance for escalation when risk factors are identified beyond the designated role delineation of the local maternity service[12].

National Midwifery Guidelines for Consultation and Referral



NSW Health also mandates use of the National Midwifery Guidelines for Consultation and Referral[13] (2008) PD 2010_022. The Guidelines provide an evidence-based framework for collaboration between midwives and doctors in the care of individual women. They are aimed at improving the quality and safety of health care. The Guidelines aim to inform decision-making by midwives on the care, consultation and referral of women:

- At booking
- During pregnancy and the antenatal period
- During labour and birth
- During the postnatal period

[10] Models of Maternity Service Provision Across NSW Progressing the Implementation of NSW Framework for Maternity Services NSW Health April 2003
[11] NSW Health Guide to Role Delineation of Health Services (2002) NSW Department of Health
[12] Critical Care Tertiary Referral Networks (Perinatal)Document Number PD2010_069 Publication date 23-Nov-2010
[13] Australian College of Midwives National Guidelines for Consultation and Referral (2008)

Maternity-Towards Normal Birth Policy Directive PD2010-045

This policy provides direction to NSW maternity services regarding actions required to increase the vaginal birth rate and decrease the caesarean section operation rate; to develop, implement and evaluate strategies to support women and to ensure that midwives and doctors have the knowledge and skills necessary to implement this policy.

All NSW Public Health organisations providing maternity services are required to implement the ten steps providing woman-centred labour and birth care described in this policy directive.

The Towards Normal Birth policy directive also identifies the changes to maternity care that are needed:

- Promotion of birth as a natural event for the majority of women
- Minimisation of fear, particularly women's fear, and improve support throughout labour and birth
- Importance of consistent and balanced information for women and health care providers regarding vaginal birth after caesarean section operation and the potential risks associated with elective caesarean operation
- Development of programs of care, both midwifery and medical, that focus on providing continuity of care.

Birthrate Plus®

Birthrate Plus® is a Midwifery Workforce Planning methodology from the United Kingdom (UK). It provides managers of maternity services with a framework to assess the required midwifery Full Time Equivalents (FTE) of a service based upon the needs of women underpinned by the standard of one to one care in labour and birth.

In 2011 Birthrate Plus® was adopted as the tool for assessing the midwifery workforce in NSW maternity services. It is being implemented across all maternity services of sufficient size in NSW, under the direction of NSW Health. It is a flexible tool which can also be used in the strategic planning and redesign of services.

Annualised Salary

A pilot agreement for a Midwifery Caseload Practice Annualised Salary Agreement (the Agreement) has been developed in NSW between the NSW Nurses Association and the Ministry of Health. The Agreement was published in 2008 and can be found on the NSW Health website: www.health.nsw.gov.au/policies/ib/2008/IB2008_012.html

This document describes the rates of pay, hours of work, on-call arrangements (including documentation of these hours), leave and travel entitlements for midwives who work in a MCoC (identified as Caseload Midwifery Practice in the Agreement) model where they work on an on-call basis.

In implementing this agreement, maternity services are required to gain approval from their Local Health District (LHD) as well as the NSW Nurses Association.

The Agreement has been developed in accordance with the Public Health System Nurses and Midwives (State) Award. The Agreement lists a number of clauses from the Award which are affected by the Agreement, and this is important to remember when implementing the model, so that it is clear when the Award provisions are in place, and when the Agreement overrides these. For example, clause 25 of the Award (Overtime) does not apply to midwives working under the Annualised Salary Agreement.

In accordance with the Award, the Agreement requires that LHD's provide rosters which describe on-call days and dedicated off-call days. Managers are required to monitor the working hours of midwives working in MCoC, to ensure that their workloads are reasonable. Midwives in MCoC, working with their managers, find many different ways to ensure they have appropriate leave, including dedicated days off and adequate annual leave throughout the year. Whilst all MCoC's utilise the Agreement, the way that midwives work together can look slightly different from one model to another. Agreements between all the group members and good communication are the keys to success in implementing the Annualised Salary Agreement. Examples of some rosters can be found in **Appendix 1**.

Understanding Midwifery Continuity of Carer models

When developing a MCoC model it is important to understand the definitions and core principles of this way of working. The following definitions and core principles can be applied to suit their local context.

MCoC models are where midwifery care is provided by the same midwife or by a small group of midwives for a woman. The woman is able to get to know this midwife/ small group of midwives throughout an entire pregnancy. This care begins in early pregnancy, continues through pregnancy, labour and birth, to the end of the postnatal period*.

Definitions

Caseload Midwife is a term that describes a midwife who has an agreed number of women (caseload) per year for whom she is the primary midwifery caregiver. The caseload midwife is the first point of reference/contact for these women throughout their pregnancy, labour and birth and during their postnatal period. As well as being the primary midwife for an agreed number of women each year, each midwife will also be a second or back up midwife for women who have another midwife as their primary caregiver. Midwives working in caseload practice are available over a 24 hour period for an agreed number of days/week. The midwife will require a paging and/or mobile phone system so that the women are able to contact her.

The ***Primary Midwife*** is the first point of **contact** for the woman through pregnancy, labour and birth and postnatal period. This midwife works in partnership with the woman, identifying her individual needs and ensuring that she has access to safe and supportive services. As part of this role the midwife ensures all investigations, consultations and referrals occur at an appropriate time and collaborates with other health professionals in accordance with the individual woman's circumstances and health needs.

The ***Back-up Midwife*** **(or midwives)** is the second point of contact for the woman when her primary midwife is not available. This may be due to a variety of reasons including when the primary midwife is not rostered to work, has worked her maximum clinical hours for that day or is on annual leave, study leave or sick leave.

Midwifery Group Practice **(MGP)** is where a number of midwives working in caseload practice organise themselves into a group or an agreed working arrangement. There is no ideal number of midwives in a group practice. Midwives may organise themselves in partnerships or small groups within a larger MGP, or a service may have a number of small MGPs. Regardless of the approach taken, maximising continuity of care should be the underpinning principle. The group will organise and agree their working arrangements to support one another and to ensure that care is able to be provided for caseload women taking into account days off, annual leave etc.

An ***Annual Caseload*** is the number of women per year for which a caseload midwife provides primary care. Each caseload midwife is the primary midwife for her 'own' women and provides back up for her midwife partner's women. As stated in the Annualised Salary Agreement the caseload of women per year per midwife will be calculated using Birthrate Plus®, taking into consideration:

- Whether the midwife works full time or part time
- The complexity of care required by the woman (e.g. medical, psychosocial, co-morbidities)
- The distance travelled by the midwife to provide this care

* Towards Normal Birth PD2010_045 key measure 3.3 – requires that all women receive midwifery support at home for at least 2 weeks after the baby is born (target 100% by 2015 for metropolitan/regional services; target 80% by 2015 for rural/remote services).

- Provision of total or partial postnatal care

Whilst the caseload may range between 35 and 42 women per year for a midwife working full time it is important to calculate this accurately to ensure the sustainability of the MGP.

Core Principles of Midwifery Continuity of Carer Models

- Midwives have an agreed midwifery philosophy of care, vision for the model and ways of working together
- The majority of midwifery care is provided by a primary midwife
- The primary midwife provides care from early in pregnancy (usually booking visit) through labour and birth and until two weeks postnatal.
- A back up midwife/s is available whom the woman has met on more than one occasion during her pregnancy
- One-to-one care for labour and birth is provided by the primary or back up midwife
- The primary health care approach facilitates a well mother and baby to transfer home within 4 – 6 hours of birth, with appropriate midwifery support. This may include a home visit on the day of birth.
- The interdisciplinary collaborative approach facilitates midwifery care to continue to be provided by the primary midwife even when complications arise
- MCOCs utilise the same clinical guidelines, protocols and decision-making frameworks as the rest of the maternity service to ensure consistency and continuity of care and best practice.
- Continuity of midwifery care is valuable and safe for women with varying levels of risk in their pregnancy. In fact, women with complex pregnancies may particularly benefit from receiving continuity of midwifery care. MCoCs are well-placed to provide this continuity in collaboration with other health professionals. A model can be specifically designed to meet the needs of priority groups in the local community (e.g. teenage pregnancies, obese women, women with increased psychosocial needs).
- The conclusion of the midwifery relationship is timely and facilitates the woman's transition into primary health services (eg. Child and Family Health services and GP)

It is essential that any model being designed is woman-centred, sustainable, and meets the needs of the midwives and the service. The following points have been identified as central to promoting sustainability of a MCoC model:

- The woman and her needs should be central to the model
- The need to maintain professional relationships with women, avoiding the development of co-dependency with the women in their care
- Clear reporting lines and escalation processes to line managers and obstetricians
- Regular formal and informal communication is crucial
- Transparency
- Flexibility
- Generosity of spirit between individuals
- Being aware of others
- Trust between and amongst individuals
- The developing of a shared philosophy – values clarification exercises early on in the development of the MCoC can be useful
- Succession planning

Midwives have identified key factors for achieving optimal work experiences within MCoC models. These are not only about successful relationships with the women they care for, but also the relationships they have with their peers, medical colleagues and managers[14]:

- The ability for midwives to develop meaningful professional relationships with women through continuity of carer
- Supportive relationships at work and at home
- Positive working relationships and occupational autonomy involves midwives being able to organise their working lives with maximum flexibility through negotiation. This includes:
  - Positive and supportive relationships with midwifery colleagues in MCoC model
  - Collaborative relationships with medical colleagues and midwifery peers at the hospital
  - Managers who facilitate professional development, interpersonal confidence and skills, assistance with debriefing and reflection.

[14] Leap, N., Dahlen, H., Brodie, P., Tracy, S., & Thorpe, J. (2011). 'Relationships-the glue that holds it together': midwifery continuity of care and sustainability. In L. Davis, R. Daellenbach & M. Kensington (Eds.), Sustainability, Midwifery and Birth. New York: Routledge.

Understanding the local context

There are many considerations and challenges in developing and implementing change in maternity care provision. It is important to understand that all maternity services are different and will require different approaches to develop and implement a MCoC model that best suits the needs of that service or facility. These changes require collaboration and effective communication between all stakeholders; clinicians (midwives, doctors, nurses and allied health), managers and consumers/community.

Each MCoC model will vary as it is influenced by: the needs of the local women, the community's expectations of the service, the role delineation of the facility, who the collaborating practitioners are and the geography of the catchment area. The next part of the document discusses the key steps required to set up a MCoC.

Key Steps

This section includes an overview of the key process steps to enable public maternity services to implement MCoC. The timeframe of the development and implementation of the MCoC will vary depending on the needs of the individual services and the community. The order of these key steps will also be prioritised differently by each maternity service and will overlap. Additionally, it is important that a project plan be developed that demonstrates these key steps and their timeframes.

Identify an executive sponsor

An executive sponsor is essential to enable the initial development and subsequent implementation of the MCoC model. The executive sponsor will be supportive of the model creation and have the authority and influence within their role, to promote the development and establishment of the model.

Identify a project leader

The project leader will lead and manage the day-to-day requirements of the project plan. It may be possible that a current employee of the LHD will be able to undertake this position within their current role. However, it may be necessary to appoint to this position for a defined period of time. The project leader will benefit from:

- Passion and enthusiasm for the project
- Knowledge and understanding of MCoC models and how they work
- Being an effective communicator
- Previous experience in developing a project plan
- Knowledge of change management
- Knowledge and understanding of the clinical context including the:
  - role delineation of the service
  - physical environment of the facility
  - the community setting
  - the demographics of the population and
  - the skill mix and experience of all clinical staff.

Project Plan

The project plan describes the objectives of the project, assigns tasks with deadlines, and charts progress in reaching goals and milestones. The project plan needs to include:

- Description of the project
  - Proposed service model
  - Service Objectives
  - Key stakeholders and their roles
- Identification of critical tasks
- Assignment of tasks (although it may not be possible to assign all tasks at the beginning)
- Development of a time line (a gantt chart may be useful for this)
- Accountability and reporting requirements of project lead.

Form a multidisciplinary Steering Group

To move the project forward it is necessary to establish a multidisciplinary Steering Group or Working Party. This process ensures effective consultation, collaboration and governance for the new service.

Key stakeholders

These include:

- Those who influence the current service provision e.g. midwifery managers, service managers, hospital executive
- Service providers e.g. midwives, clinical midwifery consultants (CMCs), obstetricians, general practitioners (GPs), paediatricians, child and family health nurses and other members of the multidisciplinary team
- Those most affected by the proposed service change e.g. consumers.
- Any other stakeholders affected by the model e.g. ambulance service if a homebirth service is proposed

Consultation with a diverse range of stakeholders, who are truly representative, will ensure all views are articulated, heard and considered. It is helpful to include stakeholders who may not be supportive of the model as unresolved issues have the potential to limit the success in the long term. Identifying complex or contentious issues from the beginning enables the solutions to be built into the model as it develops. Further stakeholders may be identified during the mapping process.

Local champions

Local champions are often already identifiable, due to their individual passion and enthusiasm. This will help to drive the project forward. It is particularly useful to find a local medical champion. Having champions from midwifery, obstetrics and/or general practice will not only broaden the focus of the meetings but will potentially promote collaboration. It is advantageous to engage these champions as members of the Steering Group as this will often reinforce the authority of decisions made.

Suggested membership of Steering Group

In identifying membership, It is important to ensure that key stakeholders and decision-makers are represented. The following roles are considered pivotal:

- Senior managers responsible for maternity services (e.g. DONM, health service manager or divisional manager)
- Midwifery manager/s
- Midwives
- CMC
- GPs/Obstetrician
- Paediatrician
- Consumers
- Other stakeholders as identified

Terms of Reference

The first task of the Steering Group is to develop Terms of Reference. This will enable clarity of purpose and business rules for the group to maintain momentum and accountability. The Steering Group should aim to meet regularly (initially at least monthly). Agendas should be forwarded to members prior to meetings and minutes and action logs circulated following meetings. This will promote effective communication and collaboration amongst the membership.

Appendix 2 includes a template to develop the terms of reference.

Map the woman's journey

Process mapping is a great tool to use early in the development phase of the MCoC model and will assist in identifying every step of the woman's journey and its relationship to the service. It is also important to include the baby's journey in this process, so that clear pathways are developed and the risk of separation of mother and baby, should the baby require additional care, is minimized.

It is useful to map the current journey and then the proposed journey with the MCoC model, to define the changes needed to implement the new model of care.

Mapping can be done very effectively with a whiteboard or with post it notes on a large wall. It is a great way for people to explore the changes that will need to be undertaken and engage them in the process.

NSW Health's Redesign programme offers learning packages on redesigning of services and change management. In particular, there is a section on process mapping which may be helpful for those without previous experience.

The materials can be accessed at: https://gem.workstar.com.au/

After registering on the website for the first time, the process mapping information is found under Diagnostics in the Redesign section.

Risk Assessment

The Treasury Managed Fund has facilitated the use of Australian/New Zealand Standard AS/NZS ISO 31000:2009 Risk Management – Principles and Guidelines as the standard to assess changes in maternity services, small or large. Many CMCs have undergone training in risk assessment and can assist with this process to ensure appropriate expertise to address this important aspect of model of care development.

A Risk Assessment should be undertaken to:

- assess the potential risks and threats of the implementation of the new MCoC model
- identify the existing controls that are in place to minimise and/or negate these risks and
- develop further strategies to minimise the identified risks and threats to the service.

Appendix 3 provides guidance for the steps in undertaking a Risk Assessment. This is intended to be a guide only and further information and assistance is available and should be sought prior to undertaking a risk assessment.

Writing a Business Case

A business case is usually required for any service re-design and needs to be endorsed by the hospital and/or LHD executive. The business case must clearly articulate the purpose and design of the model and how it will be resourced. The proposal must always be appropriate to the individual population and environmental context.

The use of State and National policy can assist with supporting the drivers underpinning the proposed changes. Documents which may be referenced include: the National Maternity Services Plan (2011), Framework for Maternity Services in NSW (2003), Primary Maternity Services in Australia (2008) and Maternity-Towards Normal Birth in NSW (2010).

A Business Case Template has been included in **Appendix 4**.

It may also be helpful to consider the following points:

- Consistency and coherency between different sections are more important than fitting the plan to a set format.
- Visual appearance is important:
  - Ensure the title is clear, relevant and not lengthy
  - Use a legible font size
  - Insert relevant headers and footers
  - Ensure language is inclusive and culturally appropriate
- Checklist
  - Is the formatting correct?
  - Is the document clear?
  - Is the issue clearly identified and defined?
  - Has the strategic direction of the LHD and/or NSW Ministry of Health been considered?
  - Has there been wide consultation?
  - Has an appropriate implementation plan been included?
  - Have clearly defined performance measures and outcomes been identified?
  - Does the case address existing or potential access or service provision?
  - Is the proposal able to be sustained?
  - Is there a plan documented which clearly outlines who is accountable for monitoring of the effectiveness of the proposal if approved?

Operational Plan

The operational plan describes how the model will function and outlines its day-to-day workings.

An example of an operational plan can be found in **Appendix 5**.

When writing the operational plan the following points could be considered:

- How will the new model impact on other parts of the maternity service and the broader hospital and community health services?
- At commencement of the model, how will women be recruited
- Which women will have access to the model
- How and when women will book into the model
- Where and when the midwives will provide antenatal care
- How midwives will have access to networked hospital computer data bases
- Availability of vehicles for home visits
- Working arrangements for back-up, on-call and annual leave cover
- Clearly defined processes for clinical handover
- Identification of line management
- How the midwives will communicate with:
  - Women
  - Each other
  - Line manager
  - Obstetricians and/or GPs
  - Paediatricians
  - Other midwives in the maternity service
  - Child and Family Health services
- How the midwives and doctors will collaborate
- Escalation processes
- Management of conflict
- Clear articulation of clinical responsibility/accountability for inpatient care by MCoC midwives
- How education, case and peer referral will be undertaken within the model
- How evaluation will be undertaken

(Please note: this is not an exhaustive list).

Remember: these documents may be drafted simultaneously as one may inform the other. For example, identifying equipment needs in the operational plan will assist in calculating the operational costs in the business plan.

Communication Strategy & Publicity

The development of a communication and consultation strategy will ensure senior management, clinical staff (both within the service and external) and the community are kept informed at all stages of development and implementation. It is important to start this at the beginning of the development of the MCoC and to continue with it throughout the implementation phases of the model.

Examples of strategies to utilise in the communication plan are:

- Regular dissemination of information and provision of updates at staff meetings
- Use of hospital and/or LHD websites
- Display of posters within the hospital and in the local community, such as ultrasound departments and GP surgeries and Child and Family Health services
- Distribution of flyers within the local community
- Having the MCoC model added as an agenda items at key stakeholder meetings
- Promotion of community discussion via local radio and newspapers
- Gaining invitation to local consumer groups to discuss the model

A few points to remember about effective communication:

- Vary the methods – face to face (formal meetings as well as corridor chats) posters, information bulletins,
  - Don't forget the back of the toilet door!
- Be transparent; tell as much as possible. Try not to have secrets. Start communicating early and update people frequently
- Take every opportunity to talk up the message
- Don't be afraid of dissent (it will always be there) allow it to be aired, clarify issues wherever possible, challenge thinking when needed
- Work with "early adopters", allowing the "late adopters" to watch on the sidelines, coming on board when they are ready. However, don't forget to keep them in the loop with regular updates
- Be clear about the message and stick to it (over and over and over and …..) e.g. "Midwifery Continuity of Carer models are about access and choice for women. Women want these models ….and so do lots of midwives"
- Try not to respond in haste, "think twice, speak once" is a useful adage
- Don't assume people understand what is being talked about – the message need to reconfigured for different audiences
- Take the necessary time with people to talk through the issues. Some will need more time than others: it's worth the investment.

Recruitment

A key step to the development of the MCoC model is recruitment and long-term the retention of the midwives. When developing the implementation plan timeline recruitment of the midwives needs to be included. The amount of time to enable successful recruitment must be taken into consideration early in the implementation phase. Good recruitment processes underpin a strong workforce. Specific time dependent factors are:

- Drafting a thoughtful, well written position description is the first step to successful recruitment.
  - Clearly describe the work to be undertaken by the midwives, the expected scope of practice as well as the expectations and obligations of both the service and the midwife. This process will assist in determining the essential criteria and interview questions
  - Define the essential criteria needed to work in the new MCoC model
  - What are the expectations of ongoing Continuing Professional Development for the MCoC model? For example continuing professional development is a

requirement of all midwives and is included in every position description. However, midwives working in a stand-alone or publicly-funded homebirth model may be required to undertake additional advanced life support training.
  - A willingness to work in a team and good communication skills are essential for all midwives, but a keen and detailed understanding of this would be expected from midwives applying to work in a midwifery group practice
- Executive approval of job description
- Management of applications
- Short listing and interviewing of applicants
- Appointment of successful applicants
  - Orientation
  - Provision of any specific additional education if required, e.g. perineal suturing or cannulation skills.

As with any employment in NSW Health, recruitment of midwives to a MCoC model is undertaken in accordance with NSW Health policy. Please read the following Recruitment and Selection of Staff in NSW Health Services Policy Directive from NSW Health. For more details visit:

http://www.health.nsw.gov.au/policies/pd/2011/PD2011_012.html

It may be considered that only experienced midwives are suitably skilled to work in MCoC models. However, less experienced midwives should be considered equally for recruitment into continuity models recognising that they may need additional support as they transition into this model of care - an important strategy for succession planning. The support can be provided internally from other midwives in the model, as well as externally from other staff in the maternity service, and should be individualised, planned and documented. These needs can be identified through the recruitment process, so that both the service and the midwife clearly understand their expectations and responsibilities at the commencement of employment.

Managing long-term sick leave, maternity leave and long service leave can be challenging in this kind of model. It's a good idea to think about how this will be managed when the model is being designed and the issue of sustainable staffing is being considered. For example, some midwives may like to move in and out of the model over set periods (perhaps 6 – 12 months). Facilitating this kind of rotation will ensure the model can continue to be adequately staffed at short notice. An acknowledgement by the maternity service at the outset that creative solutions are sometimes required at short notice will facilitate a smoother transition when it is needed.

Education & Professional Development

An important factor in regard to sustainability of the model is education and professional development.

The midwives who are to work in the MCoC model are required to be competent and skilled across the continuum of pregnancy, labour and birth and postnatal care. If the maternity service has relied on midwives being skilled in one aspect of care, such as labour and birth or postnatal care it will be important to support their attainment of the appropriate knowledge and skills to care for women and babies from antenatal booking to postnatal discharge (in hospital or at home).

Many different avenues of education and professional development support are readily accessible at a LHD level and via the CIAP (Clinical Information Access Portal). CIAP is available on all NSW Health intranet sites. Other resources are available through national organisations such as the Nursing & Midwifery Board of Australia (NMBA), and the Australian College of Midwives (ACM).

NMBA

Resources include:

- National Competency Standards for the Midwife
- Codes of Ethics and Professional Conduct
- A midwife's guide to Professional Boundaries
- National framework for the development of decision-making tools for nursing and midwifery practice
- Registration standards e.g. Recency of practice

For more details visit: http://www.nursingmidwiferyboard.gov.au/

ACM

Resources include:

- MPR (Midwifery Practice Referral)
- MidPlus
- Skills assessment / inventory

- National Midwifery Guidelines for Consultation and Referral 2008
- Professional development workshops and on-line resources

For more details visit: http://www.midwives.org.au/

Peer Review

Midwives who work in MCoC models will need midwifery and obstetric peer referral to support their clinical practice and to enable them to be reflective practitioners. Often maternity services provide meetings that provide this support for obstetric staff and managers, but not for the midwives. It is important the midwives either become involved in the current peer referral forums, or they are supported to undertake their own with support from their manager and an obstetrician.

Advanced Life Support Training

Additional training may be beneficial for midwives working in more isolated models, e.g. stand-alone maternity services, or public homebirth models. An example of such training is the ALSO (Advanced Life Support in Obstetrics) Course which is a theoretical and practical course designed to assist health professionals develop and maintain the knowledge and practical skills to manage emergencies that may arise in maternity care. This course is facilitated by a not-for-profit organisation and a cost is associated with registration and the provision of the manual. For more details visit:

http://www.also.net.au/

Similar courses are available such as PROMPT (Practical Obstetric Multi Professional Training). For more details visit: http://www.aimsi.org.au Individual LHDs may also have maternity emergency training programs in place.

Model sustainability

One of the key factors in the success of any model is sustainability. When designing the model, it's essential to be mindful of strategies to promote and enhance sustainability. The following sections may assist.

Clinical Supervision

> *'Clinical supervision is a support mechanism for health professionals within which they can share clinical, organizational, developmental and emotional experiences with another professional (or group of professionals) in a secure, confidential environment in order to enhance knowledge, skills and reflective practice"*
>
> (Maternal and Child Health Primary Health Care Policy PD2010_016)

Midwives working in a MCoC model are an identified priority group for clinical supervision as part of their work is to perform the psychosocial screening for women booking to the model.

In addition to this, there are specific aspects of working in MCoC models that can increase stress and tension in their work life and where clinical supervision can become a proactive strategy for sustainability within the model. These aspects include on-call working hours, being a highly visible group within the greater team and the relationship development with the women which can create anxiety, tensions, possible co-dependence or possible strained relations if the relationship is difficult. The relationship can also create anxiety when there is an adverse outcome and the group and the woman share the circumstances

Clinical supervision should be an integral component of MCoC models and has been demonstrated to have positive results as a reflective approach to practice, as a recruitment and retention strategy and as a means to enhanced quality of clinical care through increased awareness and empathy amongst clinicians.

This supervision should be available regularly, can be very effective in a group arrangement for the midwives working together through issues and should be facilitated by someone formerly trained who is not a line manager to the midwives. Supervision should also be conducted in a space that ensures privacy and all participants need to be reassured of the confidentiality of information shared to enable free and open disclosure.

Succession planning

Succession planning is essential to the sustainability of any MCoC model. One of the best ways to achieve this is by providing experiences for student and newly registered midwives to practice within these models in a supported environment. MCoC models provide the perfect learning environment for all student midwives.

For the Bachelor of Midwifery students, their supernumerary status facilitates their placement within these models for a portion of their clinical midwifery education. Challenges exist in providing adequate opportunities for the students being educated through postgraduate programs. Flexibility is key to ensuring

that they have the opportunity to experience continuity of care firsthand. Some facilities may wish to utilise the supernumerary time allocated to each employed student, built in to Birthrate Plus®, for this purpose. The MCoC models provide a perfect vehicle through which Graduate Diploma and Masters (pre-registration) students can recruit their follow-through experiences.

For the newly registered midwife the opportunity to work within a MCoC model in the transition to practice period has many benefits. It allows the new midwife to integrate and embed the new knowledge and skills into her practice in a holistic way, whilst being supported by experienced midwives.

Regular meetings

A significant difference for midwives who work in MCoC models to current mainstream practices is that they are often working in isolation due to their irregular work patterns. This is due to the ad-hoc nature of the job and that often only two midwives will be working together in a MGP of eight midwives on any given day. This isolation can be from their MCoC peers and other colleagues in the hospital or community. The importance of regular meetings is therefore paramount to ensure that they maintain links with each other and the organisation as a whole. Weekly meetings are the most effective and need to be included in the midwives' roster. These meetings need to have a clear management structure and include an agenda and minute taking.

These regular MGP meetings can provide the midwives with a forum to:

- Meet with their manager for general service updates
- Management of any issues (including conflict resolution)
- Provide each other with peer support
- Manage the day-to-day workings of the model
- Organise back-up and annual leave
- Referral clinical cases
- Undertake mandatory education sessions
- Provide opportunity for clinical supervision

Evaluation

Evaluation of the MCoC model is an essential aspect of the implementation and the ongoing sustainability of the model. Without evaluation it is impossible to assess if the model has been successful and is meeting the stated aims and objectives. It is also important to include the midwives in this process. It will enable them to take ownership of the model and understand firsthand how well the model is performing. The weekly meetings are a great time to discuss the evaluation methods and coordinate responsibilities for these ongoing evaluation requirements.

The design of the evaluation will be guided by the outcomes defined in the project plan and/or business case. Most services focus on three areas for their evaluation: the clinical outcomes of mother and baby, the woman's satisfaction with the model and the midwives satisfaction.

Clinical outcomes for mother and baby can be collected, for the most part, through ObstetriX or local maternity data system. Outcomes could include:

Mother

- Gravida and parity
- Gestation at booking
- Antenatal complications/admissions
- Onset of labour
- Mode of birth
- Intrapartum complications
- Pain relief used
- Perineal trauma
- Blood loss
- Postnatal complications

Baby

- Apgars
- Birth weight
- Admission to nursery or NICU
- Breastfeeding on discharge

Outcomes not available via ObstetriX or maternity data system include:

- Continuity of antenatal care (number of midwives seen)
- Primary midwife during labour
- Primary midwife at birth
- Backup midwife at birth
- Length of postnatal care at home
- IIMS data to track any incidents

Women's satisfaction with the model can be ascertained via a postnatal survey or questionnaire. It may be useful to record numbers of letters and cards of thanks as well as tracking any complaints.

Midwives' satisfaction with the model can be ascertained in a variety of ways. Formal ways of ascertaining their satisfaction are via tracking retention rates, recruitment into the model, sick leave, questionnaires and feedback gained in annual performance appraisals. Informal methods include meeting with the midwives regularly to discuss their day-to-day issues working in a MCoC model. This relationship with the midwives enables the manager to monitor any changes in morale and issues which may need an urgent response.

Existing Midwifery Continuity of Carer models

A list of the operational MCoC models is provided below and is current at time of publication. Please note that there are many other models are under development.

Level 2

- Belmont Birthing Service
- Mullimbimby Birthing Service
- Murwillumbah
- Ryde
- Wyong

Level 3

- At the time of publication no models operating in Level 3 facilities

Level 4

- Campbelltown
- Canterbury
- Hornsby
- Manly
- Tamworth

Level 5

- Blacktown
- Gosford
- Lismore
- Maitland
- St George
- Wollongong

Level 6

- John Hunter
- Nepean
- Royal Hospital for Women
- Royal North Shore
- Westmead

The following services also have a publicly-funded homebirth service:

- Belmont Birthing Service
- Mullimbimby
- Royal Hospital for Women
- St. George
- Wollongong

Essential Reading

- Midwifery Continuity of Care: A Practical Guide. CSE. Homer, P. Brodie & N. Leap 2008. Churchill Livingston/Elsevier.
- Midwifery Models of Care: Implementation Guide. Queensland Health.
- The Midwife-Mother Relationship, 2nd Edition. 2010. M. Kirkham (Ed). Palgrave MacMillan.
- Sustainability, Midwifery and Birth. 2011. L. Davies, R. Daellenbach and M. Kensington (Ed). Routledge, Taylor and Francis Group.

APPENDIX 1

Caseload Roster for all FTE midwives who work in pairs and have designated days off																														Days/mth
		M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	
RM	**FTE**																													
A	1.0	O	O	O					O	O	O			**O**	**O**			O	O	O	**O**	**O**			O	O	O			16
B	1.0			O	O	O	**O**	**O**			O	O	O			O	O	O					O	O	O			**O**	**O**	16
C	1.0	O	O	O					O	O	O			**O**	**O**			O	O	O	**O**	**O**			O	O	O			16
D	1.0			O	O	O	**O**	**O**			O	O	O			O	O	O					O	O	O			**O**	**O**	16
E	1.0	O	O	O					O	O	O			**O**	**O**			O	O	O	**O**	**O**			O	O	O			16
F	1.0			O	O	O	**O**	**O**			O	O	O			O	O	O					O	O	O			**O**	**O**	16
G	1.0	O	O	O					O	O	O			**O**	**O**			O	O	O	**O**	**O**			O	O	O			16
H	1.0			O	O	O	**O**	**O**			O	O	O			O	O	O					O	O	O			**O**	**O**	16
Daily total		4	4	8	4	4	4	4	4	4	8	4	4	4	4	4	4	8	4	4	4	4	4	4	8	4	4	4	4	
O=Available for 24 hours Blank entry = not available and not working																														
Wednesdays = meeting, administration and education day It is a good day for midwives to take owed time as there are plenty of midwives to care for their caseload																														
A + B = 1 pair they have a primary load of 40 women each and will provide backup for each other as they work opposite days to each other. They will manage each other's caseload of women on days off and A/L C + D = another pair of primary and backup for a cohort of 80 women. E + F = pair. G + H = pair																														
A, C, E & G work on the same days of the week and will support each for excess workload. B, D, F & H work on the opposite days and support each other when there is excess workload.																														

A/L – it is best if only one midwife is on leave at one time. It is important to plan A/L in advance as you do not want women's EDB to be during her midwife's A/L. It is also useful to have a two week 'window' before and after A/L weeks with no women booked to give birth in that time.

Caseload roster for all FTE midwives who work in pairs and have designated days off incorporating 1 midwife's Annual Leave																													**Days/mth**
		M	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	
RM	**FTE**																												
A		O	O	O					O	O	O			**O**	**O**			O	O	O	**O**	**O**			O	O	O			16
B				O	O	O	**O**	**O**			O	O	O			O	O	O					O	O	O			**O**	**O**	16
C		O	O	O					O	O	O			**O**	**O**			O	O	O	**O**	**O**			O	O	O			16
D				O	O	O	**O**	**O**			O	O	O			O	O	O					O	O	O			**O**	**O**	16
E		O	O	O					O	O	O			**O**	**O**			O	O	O	**O**	**O**			O	O	O			16
F				O	O	O	**O**	**O**			O	O	O			O	O	O					O	O	O			**O**	**O**	16
G		O	O	O					O	O	O			**O**	**O**			O	O	O	**O**	**O**			O	O	O			16
H		Annual Leave							Annual Leave							Annual Leave							Annual Leave							
Daily total		4	4	7	3	3	3	3	4	4	8	3	3	4	4	3	3	8	4	4	4	4	3	3	8	4	4	3	3	

O = midwife is available for 24 hours & supports other midwives if they are busy or on leave
Blank entry = not available and not working

Caseload roster that includes 2 x PTE midwives who are supported by 1 x FTE midwife																														
		M	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	
RM	**FTE**																													
A	0.64	O		O			**O**	**O**	O		O					O	O						O	O						10
B	0.64				O	O						O	O					O		O	**O**	**O**			O		O			10
C	1.0		O	O	O					O	O	O		**O**	**O**		O	O	O					O	O	O		**O**	**O**	16
Daily total		1	1	2	2	1	1	1	1	1	2	2	1	1	1	1	2	2	1	1	1	1	1	2	2	1	1	1	1	
D	1.0			O	O	O	**O**	**O**			O	O	O			**O**	**O**	O					O	O	O			**O**	**O**	16
E	1.0	O	O	O					O	O	O			O	O			O	O	O	**O**	**O**			O	O	O			16
F	1.0			O	O	O	**O**	**O**			O	O	O			**O**	**O**	O					O	O	O			**O**	**O**	16
G	1.0	O	O	O					O	O	O			O	O			O	O	O	**O**	**O**			O	O	O			16
H	1.0	Annual Leave							Annual Leave							Annual Leave							Annual Leave							
Daily total		3	3	6	4	3	3	3	3	3	6	4	3	3	3	3	4	6	3	3	3	3	3	4	6	3	3	3	3	
1 x PTE (0.64) will have a caseload of 20 women. Therefore A + B can share a caseload of 40 women and back up midwife C who is the FTE.																														
Wednesdays are also good days for midwives who are owed time to take it as a meeting day but no Available.																														

Midwifery Group Practice that includes 4 x FTE midwives (Included are 3 months of roster)																															
		M	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T MTM**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**Days /mth**
RM	**FTE**																														
A	1.0	W	W				OC	OC	W	N	N	W				W		W	N	W			NB	N		W	N			16
B	1.0	NB	N	N		W			NB			N	N	OC	OC	W	W	N					Annual Leave							10
C	1.0	W	W	W	W	W			W			W	W			N	N			N			W	W	W			OC	OC	16
D	1.0	W		W	N	N				W	W	W	W			B	W				OC	OC	W		N	N	W			16
Daily Total		4	3	3	2	3	1	1	3	2	2	4	3	1	1	4	3	2	1	2	1	1	3	2	2	2	2	1	1	
		M	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T MTM**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**Days/mth**
A	1.0	N	N	W		N			NB	N				OC	OC	W	W	N	N	W			W	W			N			16
B	1.0				W	W	OC	OC	W		W	W	W			W		W	W	N			NB	N	W	W				16
C	1.0	W	W	N					W		W	W	N			NB	N				OC	OC	W	W	N	N				16
D	1.0		W	W	N				Annual Leave																W	W	W	OC	OC	8
Daily		2	3	3	2	2	1	1	3	1	2	2	2	1	1	2	2	2	2	2	1	1	3	3	3	3	2	1	1	
		M	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T MTM**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**Days/mth**
A	1.0	W				W	OC	OC	W	W		N	W			N	N		W	W			N	N	W	W	N			17
B	1.0	NB	N	N					W	W	W	W	N			st	st			W			W			N	W	OC	OC	16
C	1.0	W	W	W	N	N				N	N	W				NB	W	W	W		OC	OC	W	W						16
D	1.0		W	W	W				NB			W	W	OC	OC	W	W	N	N	N			W	W	N					16
Daily		3	3	3	2	2	1	1	3	3	2	4	3	1	1	2	3	2	3	3	1	1	4	3	2	2	2	1	1	

PTO for instructions

Midwifery Group Practice that includes 4 x FTE midwives (Included are 3 months of roster) con't

This group has 1 x on call person for each weekend and they each work one weekend a month.

'W' = rostered to work and will be available for antenatal, intrapartum and postnatal care, but will not take the telephone calls overnight.

'B' = rostered to come in for weekly meeting only.

Blank entry = not available and not working.

'MTM' = monthly 'meet the midwife' meeting

'st' = Study leave

'N' = triages the telephone calls overnight (2000 – 0800) for all the midwives and is available for her own women if they need her to come into the hospital overnight. If a woman needs to come into the hospital overnight the triage midwife will call in the primary or backup midwife for this woman to come in and care for her.

Midwifery Group Practice that includes 3 x FTE midwives and 1 x 0.8 (PTE) midwife (Included is one month of roster)

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T MT M	F	S	S	Days/ mth
A (0.8)	W	W	W	N	W	OC	OC	W			W	W						W	N			N B	N	N	W				14
B			W	W	N			N B	N	N			OC	OC	W	W	W	N	W					W	W	W			16
C	Annual Leave								W	W	W				N B	N	N			OC	OC	W	W	W	N	N			13
D	N B	N	N	W	W			W	W		N	N			W			W				W			W	W	OC	OC	16
RM/ DAY	2	2	3	3	3	1	1	3	3	2	3	2	1	1	3	2	2	3	2	1	1	3	2	4	4	3	1	1	

Caseload roster for all 3 FTE midwives with a midwife who provides A/L relief																														
		M	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**
Name	**FTE**																													
A	1.0	X	2	P	P	P	**2**	**X**	P	P	W	X	X	**P**	**P**	2	2	2	2	2	**X**	**X**								
B	1.0	P	P	W	X	X	**P**	**P**	2	2	2	2	2	**X**	**X**	X	2	P	P	P	**2**	**X**								
C	1.0	2	2	2	2	2	**X**	**X**	X	2	P	P	P	**2**	**X**	P	P	W	X	X	**P**	**P**								
D		Annual Leave relief who will work for approximately 21 week/yr in the caseload (depend on the A/L taken by the other midwives)																												
Daily total		2	3	3	2	2	2	1	2	3	3	2	2	2	1	2	3	3	2	2	2	1								
	P = Primary on call, 2nd = second on call, W= workday, X = not on call & not working 4th midwife provides A/L relief and will take on the roster of the midwife who is on A/L 3 week roster period instead of a 4 week roster period and rotates																													

Caseload roster for all FTE midwives with two MGP's working alongside each other and supporting each other when work load or S/L is excessive																														
		M	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**
Name	**FTE**																													
MGP with more structured roster who provide back-up for 4 midwives																														
A		2	W	W	X	X	**X**	**X**	P	2	2	2	P	**2**	**2**	X	X	P	P	2	**X**	**X**	W	P	W	X	X	**P**	**P**
B		W	P	W	X	X	**P**	**P**	2	W	W	X	X	**X**	**X**	P	2	2	2	P	**2**	**2**	X	X	P	P	2	**X**	**X**
C		X	X	P	P	2	**X**	**X**	W	P	W	X	X	**P**	**P**	2	W	W	X	X	**X**	**X**	P	2	2	2	P	**2**	**2**
D		P	2	2	2	P	**2**	**2**	X	X	P	P	2	**X**	**X**	W	P	W	X	X	**P**	**P**	2	W	W	X	X	**X**	**X**
Daily total		3	3	4	2	2	2	2	3	3	4	2	2	2	2	3	3	4	2	2	2	2	3	3	4	2	2	2	2
	P = Primary on call, 2nd = second on call, W= workday, X = not on call & not working																													
MGP with back up between pairs of midwives with each midwife responsible for her women during the week and 1st and 2nd on call over the W/E for both pairs																														
		M	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**
E		O	O	O	O	O	**P**	**2**	O	O	O	O	O	**X**	**X**	O	O	O	O	O	**2**	**P**	O	O	O	O	O	**X**	**X**
F		O	O	O	O	O	**X**	**X**	O	O	O	O	O	**P**	**2**	O	O	O	O	O	**X**	**X**	O	O	O	O	O	**2**	**P**
G		O	O	O	O	O	**2**	**P**	O	O	O	O	O	**X**	**X**	O	O	O	O	O	**P**	**2**	O	O	O	O	O	**X**	**X**
H		O	O	O	O	O	**X**	**X**	O	O	O	O	O	**2**	**P**	O	O	O	O	O	**X**	**X**	O	O	O	O	O	**P**	**2**
Daily total		4	4	4	4	4	2	2	4	4	4	4	4	2	2	4	4	4	4	4	2	2	4	4	4	4	4	2	2
	A/L is organised in each of the small MGP's, but they would not plan to have more than one midwife on A/L from each MGP at one time																													

	Large MGP who share triage of calls for whole group																												
		S	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**	**S**	**M**	**T**	**W**	**T**	**F**	**S**
Name	**FTE**																												
A / B	2 X PTE	O	N	O	X	O	O	X	**O**	O	O	X	X	N	**O**	O	X	O	**O**	O	O	X	X	O	**O**	O	O	N	X
C		A/L							X	O	O	**O**	O	X	O	X	N	O	O	**O**	O	X	O	O	N	X	O	O	X
D		X	O	O	**O**	N	X	**O**	O	O	**O**	O	O	X	X	O	**O**	O	O	X	N	X	X	O	O	**O**	N	X	**O**
E		O	N	X	X	**O**	O	O	O	N	X	O	O	O	X	X	O	O	N	X	O	O	**O**	O	X	X	O	O	O
F		X	N	X	SD	SD	SD	O	O	N	X	O	**O**	O	X	O	O	X	X	O	**O**	O	O	N	X	O	**O**	O	X
G		O	**O**	O	N	X	X	X	X	**O**	O	X	N	X	O	O	**O**	X	O	X	X	X	X	**O**	O	O	X	X	X
H		X	O	**O**	O	O	N	X	A/L																				
I		X	X	X	O	N	**O**	O	X	X	X	N	O	**O**	O	X	X	X	X	O	O	O	X	X	O	X	X	**O**	O
J/K	2 X PTE	**O**	O	X	X	X	O	N	X	X	O	O	X	O	X	X	X	**O**	O	N	X	O	O	X	O	X	X	X	**O**
Daily total		4	4	4	4	4	5	4	4	4	5	5	5	4	4	4	4	5	5	4	5	4	4	5	5	4	4	4	4
		X = Rostered Off O = Rostered On O = triage 0800-0800. Take calls for all midwives and contacts primary/back up midwife for that woman if care needed N = work day, but not on call SD = Study Day A/L = Annual Leave																											

APPENDIX 2

Template for Terms of Reference

Terms of Reference

Name of Steering Group/Working Party
Date:

Background

Purpose:
The purpose of this group is to …

Responsibilities and activities:
The Steering Group/Working Party Group will:

Membership:

Business rules:

Chair –
Secretariat –
Meeting frequency -

Communication program – e.g. 'Agenda will be distributed two weeks prior to the next meeting and minutes will be distributed 1 week following the meeting'
Membership is representational
Quorum is half of the membership plus one.

Reporting
The Steering Group/Working Party reports to…

Referral
The role and function of the Steering Group/Working Party will be referraled...

APPENDIX 3

Risk Assessment(AS/NZS ISO31000:2009)

How to undertake gap analysis and assess the risks associated with changes to clinical work processes in maternity services

Risk Assessment

The following guide outlines the process used to identify and assess the risks associated with changes to a clinical work process within a hospital or LHD. This is intended to be a guide only and further information and assistance is available and should be sought prior to undertaking a risk assessment. Many CMCs have received additional training in this area and NSW Health provides detailed support for clinical redesign via its website.

The risk assessment process has already been utilised by a number of facilities where service delivery change has been proposed to meet the changing needs of women, midwives and LHDs.

The process has proven to be valuable in not only assessing risk but also in providing a forum in which facilitated, open communication between clinicians can occur and issues raised can be constructively addressed. The process encourages collaboration of clinicians to ensure the design of new models of care is efficient and safe

The risk assessment process allows the team to:

1. Describe how the proposed changes affect existing services in relation to who does what, where, when and how.

2. Assess the risks associated with those changes

3. Make recommendations for systems and procedures that need to be in place to support the changes to ensure that the project is successful.

What is Risk Assessment?

Risk assessment is a systematic process that assists in the identification of risks to a process and prioritises risk in relation to its consequence and likelihood. A risk assessment is proactive in its approach, attempting to predict the impact of risk before it takes place.

How to conduct a Risk Assessment?

A risk assessment is best conducted within a team environment. This ensures there are multiple viewpoints available for consideration of the risk in its context. The team dynamic ensures participation of stakeholders, encourages open communication and ensures that workload is shared. Team members also bring different experiences of working within the same process to the Risk assessment which facilitates risk identification. All of these factors encourage ownership of the process.

Establishing context

Establishing the context is often the most difficult part. The context needs to be established in order to set the boundaries of the risk assessment. In facilitating a risk assessment it is ***essential*** that you are clear on what it is that you are assessing. For

example, when considering the risks associated with changing a maternity service the context is the entire process, starting with the referral of woman to a service and concluding at its end point – discharge of mother and child. Along the way there will be points where the service interacts with external agencies – the impact of your service change on these agencies needs to be included in the risk assessment process. ie ambulance, tertiary facilities, NETS.

All of the above needs to be documented and distributed to the team prior to your first meeting. In addition you will want to provide an overview to key stakeholders such as hospital executive, clinical directors and the hospitals risk manager.

In addition, as facilitator of the process it would be beneficial to provide the team with a list outlining the proposed changes to the service. These become the basis of the risk assessment. The best way to identify the proposed changes is to use a process map.

Step 1: Process Map the work flow.

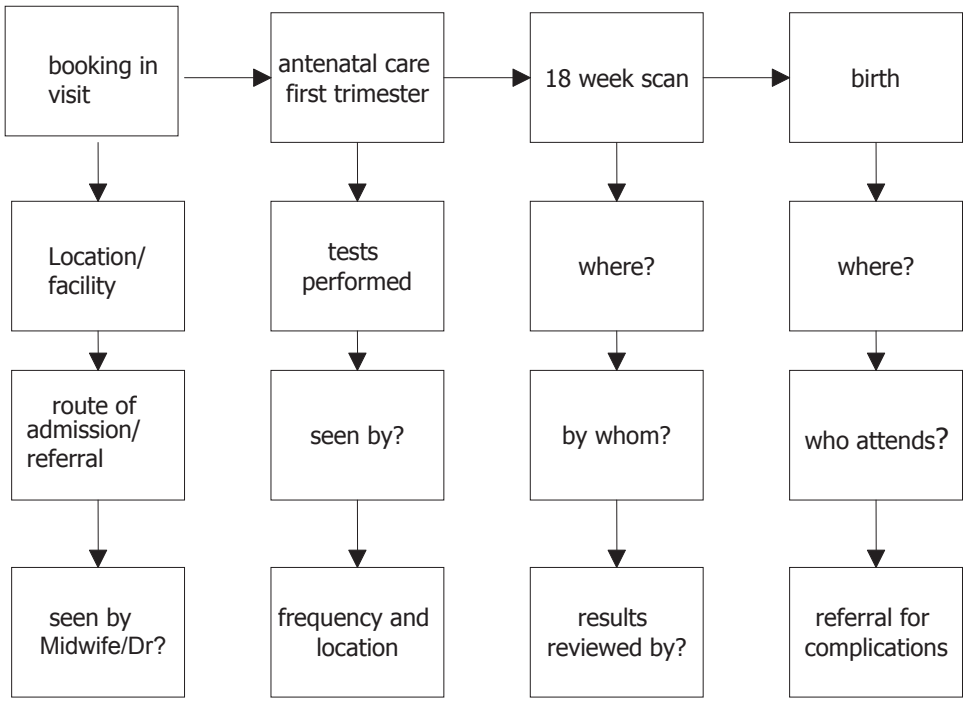
Before you can understand the risks associated with the way a service is delivered you must first understand how the service will actually change. One method to do this is to process map the existing service (how things are currently done) and then to process map the new service (how it will change).

The difference between the two processes is the "gap" and it is this that will be risk assessed. The intent of the gap analysis is to identify what processes are changing and the potential impact upon service continuity and patient safety. By changing a service there is an opportunity to design out current problems in the system however, in doing so you may inadvertently design some new problems into the system. For example, in a low risk model there will be a need to consider, transfer of women who develop complications in labour to a tertiary hospital. This change will impact upon both the ambulance service and the tertiary hospital which introduces additional risk factors that may not have previously been considered.

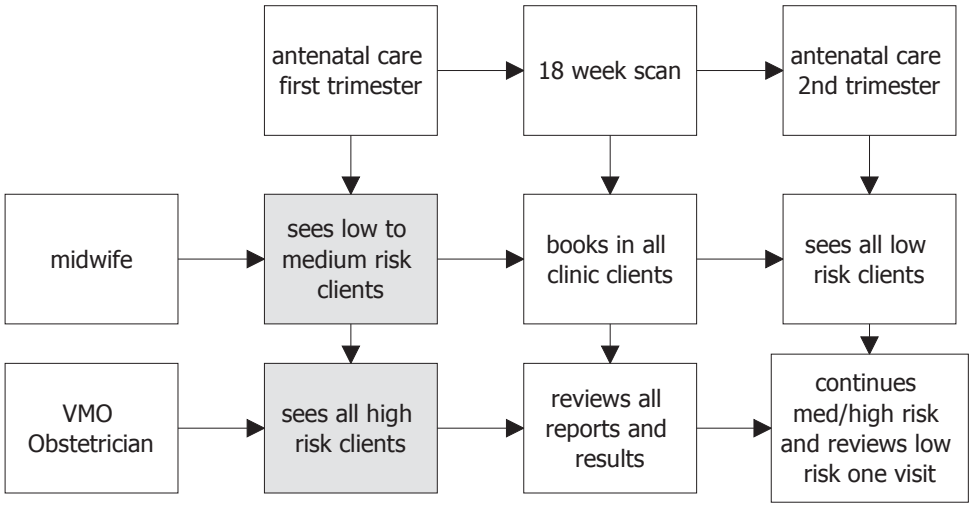
How to construct a Process Map:

There are many models to map work processes. Below is a simple version which looks at the macro steps and then records the sub processes or conditions of the step.

Another version is to create a 2 dimensional matrix that assigns responsibility for each step of the process:



You can then track and highlight the changes:



TIP: Use post it notes or systems cards to put the process charts together

Record the Changes

Once the changes have been identified enter them into the risk assessment template. Eg:

Process Step	Proposed change in service
Antenatal Care 1st trimester	Midwives will be responsible for midwifery care for women with medium risk pregnancies

Step 2: Identifying Risks

Once you have identified and documented the changes you can then begin to analyse the potential threats associated with that change.

Process Step	Proposed change in service	Threat					
Antenatal Care 1st trimester	Midwives will be responsible for midwifery care for women with medium risk pregnancies	Midwives may misdiagnose complications					

Step 3: Risk Rank the threat using the SAC coding (see pg. 34)

Determine the maximum reasonable consequence of the threat. Then determine the likelihood of that occurring. Then use the matrix to assign the threat a risk rank. This version asks you to record consequence (C) and likelihood (L) as well as the risk (R) rank. To facilitate this you can amend the SAC matrix to label the consequences A through to E and the likelihood 1 through to 5. (see below)

Process Step	Proposed change in service	Threat	C	L	R		
Antenatal Care 1st trimester	Midwives will be responsible for midwifery care for women with medium risk pregnancies	Midwives may misdiagnose complications	A	2	1		

Step 4: Identify Current Controls and Possible Additional Controls

This needs to be considered in relation to the severity of the risk and the adequacy of current controls.

- Consider existing policy/procedure currently in place that control or limit the impact of the threat
- Could these controls be improved?
- Should controls be referraled?
- What new policy or guidelines are required?
- Does DoH play a role in developing the additional control?

Process Step	Proposed change in service	Threat	C	L	R	Current Controls	Possible Current Controls
Antenatal Care 1st trimester	Midwives will be responsible for midwifery care for women with medium risk pregnancies	Midwives may misdiagnose complications	A	2	1	Weekly referral of all tests results by VMO Obstetrician	Guidelines for medical consultation to be developed Clinic meetings to referral these cases on a weekly basis Clients to be given clear guidelines on when to self-refer

Step 5: Identify Priority Risks and Priority Controls

- After identifying all threats they can be sorted into priority order based on the risk rank.
- Next list all the possible additional controls that have been assigned to high risks (SAC 1 & 2).
- Use this table to create the summary of critical controls in the executive summary.

Risk Priority	Process Step	Possible additional Controls	Responsible	Due Date	Status
1 Extreme Risk	Antenatal care 1st trimester	Guidelines for medical consultation to be developed	O&G Management	01/01/01	Draft
		Clinic meetings to referral these cases on a weekly basis	MUM Maternity Services	01/04/01	Not started
		Clients to be given clear guidelines on when to self-refer	O&G Management	01/04/01	Not started

The information captured in the risk assessment is then used to inform:

- The approval process on whether or not the proposed change will proceed
- The implementation project plan and budget
- The audit or quality processes which monitor performance and outcomes.

Severity Assessment Code (SAC) November 2005

This matrix should be used in conjunction with the NSW Health Incident Management Policy Directive

STEP 1 Consequences Table (For notification, consider the actual consequence or outcome using this table as a guide. The examples listed here are not exhaustive.)

		Serious	Major	Moderate	Minor	Minimum
CLINICAL CONSEQUENCE	Patient	Patients with **Death** unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management or: ■ **Suspected suicide**[1] ■ **Suspected homicide**[2] or any of the following: **The National Sentinel Events** ■ Procedures involving the wrong patient or body part ■ Suspected suicide in hospital ■ Retained instruments ■ Unintended material requiring surgical removal ■ Medication error involving the death of a patient ■ Intravascular gas embolism ■ Haemolytic blood transfusion ■ Maternal death associated with labour and delivery ■ Infant discharged to the wrong family	Patients suffering a **Major permanent loss of function (sensory, motor, physiologic or psychologic)** unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: ■ Suffering significant disfigurement as a result of the incident ■ Patient at significant risk due to being absent against medical advice ■ Threatened or actual physical or verbal assault of patient requiring external or police intervention	Patients with **Permanent reduction in bodily functioning (sensory, motor, physiologic, or psychologic)** unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: ■ Increased length of stay as a result of the incident ■ Surgical intervention required as a result of the incident	Patients requiring **Increased level of care including:** ■ **Review and evaluation** ■ **Additional investigations** ■ **Referral to another clinician**	Patients with **No injury or increased level of care or length of stay**
CORPORATE CONSEQUENCE	Staff	Death of staff member related to work incident or suicide, or hospitalisation of 3 or more staff	Permanent injury to staff member, hospitalisation of 2 staff, or lost time or restricted duty or illness for 2 or more staff or pending or actual WorkCover prosecution, or threatened or actual physical or verbal assault of staff requiring external or police intervention	Medical expenses, lost time or restricted duties or injury / illness for 1 or more staff	First aid treatment only with no lost time or restricted duties	No injury or review required
	Visitors	Death of visitor or hospitalisation of 3 or more visitors	Hospitalisation of up to 2 visitors related to the incident / injury or pending or actual WorkCover prosecution	Medical expenses incurred or treatment of up to 2 visitors not requiring hospitalisation	Evaluation and treatment with no expenses	No treatment required or refused treatment
	Services	Complete loss of service or output	Major loss of agency / service to users	Disruption to users due to agency problems	Reduced efficiency or disruption to agency working	Services: No loss of service
	Financial	**Loss of assets** replacement value due to damage, fire etc > $1M, **loss of cash/investments/assets** due to fraud, overpayment or theft >$100K or **WorkCover claims** > $100K	**Loss of assets** replacement value due to damage, fire etc $100K-$1M, **loss of cash/investments/assets** due to fraud, overpayment or theft $10K-$100K or **WorkCover claims** $50K-$100K	**Loss of assets** replacement value due to damage, fire etc $50K to $100K **or loss of cash/investments/assets** due to fraud, overpayment or theft to $10K	**Loss of assets** replacement value due to damage, fire etc to $50K	No financial loss
	Environmental	Toxic release off-site with detrimental effect. Fire requiring evacuation	Off-site release with no detrimental effects or fire that grows larger than an incipient stage	Off-site release contained with outside assistance or fire incipient stage or less	Off-site release contained without outside assistance	Nuisance releases

[1] **Suspected suicide** of a person (including a patient or community patient) who has received care or treatment for a mental illness from an Area Health Service or other PHO where the death occurs within 7 days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation;

[2] **Suspected homicide** committed by a person who has received care or treatment for mental illness from an Area Health Service or other PHO within 6 months of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation.

STEP 2 Likelihood Table

Probability Categories	Definition
Frequent	Is expected to occur again either immediately or within a short period of time (likely to occur most weeks or months)
Likely	Will probably occur in most circumstances (several times a year)
Possible	Possibly will recur – might occur at some time (may happen every 1 to 2 years)
Unlikely	Possibly will recur – could occur at some time in 2 to 5 years
Rare	Unlikely to recur – may occur only in exceptional circumstances (may happen every 5 to 30 years)

STEP 4 Action Required Table

	Action Required
1	**Extreme** risk – immediate action required – Reportable Incident Brief (RIB) for all SAC 1 incidents must be forwarded to the DoH within 24 hours. A Privileged Root Cause Analysis (RCA) investigation must be undertaken for all Clinical SAC 1 incidents with a report being submitted to the DoH.
2	**High** risk – need to notify senior management. Detailed investigation required. Ongoing monitoring of trended aggregated incident data may also identify and prioritise issues requiring a practice improvement project.
3	**Medium** risk – management responsibility must be specified – Aggregate data then undertake a practice improvement project. **Exception** – all financial losses must be reported to senior management.
4	**Low** risk – manage by routine procedures – Aggregate data then undertake a practice improvement project.

NB – An incident that rates a SAC 2, 3 or 4 should only be reported to the DoH if there is the potential for media interest or requires direct notification under existing DoH legislative reporting requirements or NSW DoH Policy Directive.

STEP 3 SAC Matrix

LIKELIHOOD	CONSEQUENCE: Serious	Major	Moderate	Minor	Minimum
Frequent	1	1	2	3	3
Likely	1	1	2	3	4
Possible	1	2	2	3	4
Unlikely	1	2	3	4	4
Rare	2	3	3	4	4

Every incident assessed against the Severity Assessment Code Matrix should be scored separately for both their actual and potential consequence or outcome

NSW HEALTH

APPENDIX 4

Template for Business Case

Business Case for
(Project Title)

Presented to
(name, position)

Presented by
(name, position)
(Date)

Insert name of Local Health District and or Facility

1. Executive Summary

Include a clear and concise outline of the whole proposal, including the purpose and rationale for proceeding.

Provides a useful 'big picture' overview

Should be brief (one to two pages maximum) and include:

- Short account of current position, issues / problems and the need for change
- Broad scope of the proposal
- A brief outline of the method of analysis used to identify and assess options for addressing the issues / problems
- A short description of the recommended approach or solution, including expected benefits and any known drawbacks
- A cost summary

2. Project Definition
Problem / Opportunity being addressed

Describe the current situation, outline strategic issues, give rationale (your business case could be addressing a problem that needs solving or an opportunity which has arisen)

Project Objectives / outcomes

How will the proposal support the Local Health District's core interests and priorities? (ie provide better service to clients, assist by providing better supporting systems etc). What strategies will be employed to achieve the objectives? What training and post implementation support will be needed?

Demonstrate that discussion and consultation with affected parties has taken place. Provide views of all key stakeholders ie community, clients, staff etc in brief in this section – provide full information of studies, meetings held etc in Appendices.

Include SWOT analysis

- Strengths
- Weaknesses
- Opportunities
- Threats

3. Implementation plan

Set out the proposed timeframe and milestones.

Set out the project management framework and other strategies. Include management plan – ie who is responsible and accountable for what area of the project etc, key stakeholders and their roles, training required, staffing issues, change management required, procurement strategies etc.

4. External funding arrangements (if applicable)

If part or all of the funding will be sourced from the private sector, must include an acquisition and financing plan for the project

5. Assessment of Options

List and describe options considered for addressing the problem outlined in Section 2, Project Definition.

What will differentiate this service from alternatives (if applicable).

List any existing projects or services (internal or external) that can be significantly affected by this project and a contact officer for the other processes.

6. Conformity with legislation, policies and strategies

Relate the feasible options for the project back to relevant agency and government legislation, policies, standards and strategies (ie individual service plans, Asset Strategic Plan, LHD Strategic Plan)

Consideration must be given to the changes to the work environment which will result from the model change. It is a requirement of the Work, Health and Safety (WHS) Act that staff are consulted if changes occur to their working environment including premises where staff work, systems or methods of work or the plant or substances used for work. If this applies to your business case, these issues must be addressed.

7. Financial Analysis

a. Cost Benefit & Cost Effectiveness Analysis

Assess the impact and net benefits of the chosen option in comparison with other possible approaches. It may be helpful to seek input from the hospital finance department to assist with the financial aspects of the business case.

Include resources required for the project and their source including who is responsible for what and who are the beneficiaries and what staff impacts may occur. Show benefits gained as realisable (cash), quantifiable (resources) and tangible (improved quality)

A finance profile should be included to cover items such as:-

- Staffing – salary base rates, leave, workers comp, superannuation, overtime & other on costs
- Motor vehicle purchase (preferable) or lease rates and other travel costs
- Equipment required e.g. computer, printer, phone/s desks, stationery & consumables, advertising, postage, uniforms / clothing
- Support services costs – cleaning, maintenance and servicing, security, Human Resources, Payroll, Finance other support services
- Rental / leasing of floor space (capital charging for LHD floor space)
- Fuel, light and power costs

b. Asset Purchases – Leasing versus Buying

Cost Centre Managers should undertake a cost of leasing versus outright purchase, when ordering assets of significant value to determine if the Health Service is getting value for money. (If applicable see attached Addendum)

8. Risk analysis and risk management

Compare the risks and impacts of implementing a particular feasible option with the risks and impacts of not implementing it. What are the flow-on effects of not proceeding?

9. Critical Success Factors

Include a brief summary of factors, which are critical to the success of the project, and therefore of which LHD needs to be aware of.

10. Quality and Evaluation Mechanisms

Include any quality issues or mechanisms that need to be associated with the project. Also describe evaluation strategies that will apply to the project.

Appendices (if required)

This is the place to include any feasibility studies, details of any research, detailed economic and financial analyses, explanatory notes etc.

APPENDIX 5:

Example of Operational Plan

XXX Maternity Service
Midwifery Group Practice (MGP)

Operational Plan

This operational plan aims to provide all staff within XX (Hospital, Local Health District (LHD)) information that will assist in the understanding of the new midwifery continuity of carer model – Midwifery Group Practice (MGP) at XX. The model will offer midwifery care for women with normal risk, through the continuum of care i.e. antenatal, intrapartum and postnatal care. The model will be an additional option of care for women and will operate parallel to the existing care offered to women at XX. This plan describes the services and the implications within the LHD.

This document addresses the most commonly asked questions. Should there be any further questions, please contact XX (MUM Maternity Services XX Hospital) tel. XX

Contents

Overview of MGP

Use this section to outline the overarching concepts of your new model. For example:

MGP is a primary health, midwifery continuity of care model that offers normal risk women an option of continuity of midwifery care. MGP midwives will be responsible for a caseload of 40 women per year based on 1.0 FTE (i.e. 4 women per month over/for 10 months with no caseload during planned leave) and part-time midwives on a pro-rata basis.

The MGP will aim to provide 24 hour continuity of clinical care across the continuum. A known midwife within the MGP will provide the majority of antenatal care and education, care during labour and birth and post-partum home support and care (for at least 14 days) to all women within their caseload.

The midwives will be rostered to 24hr on-call shifts with a second designated midwife on-call each day for back up and support. The MGP midwife will work a maximum of 12 consecutive hours (can be combination of antenatal and postnatal visit, and intrapartum care). Each MGP midwife will have a dedicated work mobile phone and an MGP woman will directly contact her midwife as needed. The midwives working within this model will be required to have a minimum of 9 designated days off a month. The NSWNA pilot annualised salary agreement has been negotiated at 29% in addition to base rate

Women receiving MGP care will still be able to access all other services offered to women booked at Hospital XX e.g. Social Work, Diabetes Clinics. All midwives providing MGP care will continue to utilise the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (as per NSW Health Policy Directive 2010_22).[1,2] The ACM Guidelines describe the parameters for identifying normal risk pregnancy and supports midwives to make appropriate consultation and referral to other clinicians and allied health staff if risk factors arise in pregnancy, labour and the postnatal period. Acceptance into the model will be based on normal risk criteria. Midwifery care may continue even when referral to care by a secondary or tertiary level health care provider is necessary i.e. the midwife continues to provide midwifery care and support to the woman in collaboration with other health care providers.

At all times the MGP midwives will be practicing under the policy and procedure guidelines set out in the Unit Policy, Procedure & Guideline Manuals and on the XX LHD, Procedure and Guideline intranet site. The systems and processes established within the unit will be utilised by all carers including the MGP midwives.

Proposed changes from current Maternity Service

Outline what the key changes are from your current service. For example:

- Offer midwifery continuity of care model
- Changed work conditions including annualised salary, flexible work arrangements, on-call
- Transition from hospital to home 4 to 6 hours after birth if mother and baby well
- When risk is identified and the woman is referred to a medical practitioner the individual situation of the woman will be evaluated and documented agreement will be made about the responsibility for the provision of continuing maternity care

MGP Objectives

What are the objectives of your MGP. For example:

- To provide care and facilities that are aligned with each woman's needs to ensure the right care is delivered to women by the right health professionals in the right setting and in a timely fashion.
- To provide a philosophy of care that focuses on pregnancy, labour and birth, and postnatal as a normal life event.
- To provide a safe service with quality maternal and neonatal outcomes based on best practice
- To promote women's satisfaction during pregnancy and childbirth by enabling their participation in decision making relating to their care.
- To provide evidence based midwifery care
- To provide continuity of care by a known midwife within a designated group
- To implement an affordable and sustainable model of maternity care within the current budget.

Evaluation

You may want to add in here any specific data items as outlined in the project plan. Include details in the appendix along with copies of any questionnaires, surveys or audit tools.

There will be a process evaluation of the model including specific outcomes for the women at six months after implementation and then ongoing. Predetermined MGP Key Performance Indicators will be monitored on an annual basis and more frequently where there are identified adverse outcomes or identified concerns about outcomes or processes (Appendix 1, 2).

Antenatal Period

Booking-in

Need to detail here the local arrangements for co-ordination of booking appointment and how this will interact with the MGP.

Women access Maternity Services by GP referral via xxxxxx. (Detail process steps…)

1.

2.

Booking-in 1st visit

Outline booking process including any specific processes of the Hospital or LHD.

Notes Referral

Outline any processes for the referral of clinical notes including the booking history.

Midwifery Triage

Detail how will women be allocated into the MGP, ideally this should be prior to the first booking appointment. For example:

A MGP allocation meeting will be conducted weekly. Women who are eligible for the model will be allocated to a midwife based on parity, and EDB month - to the MGP midwife/s who has a vacancy for the month. The allocation process should ensure an equal distribution of workload amongst the midwives. The midwife will contact the woman allocated to her caseload and make a booking appointment date suitable to the woman and the midwife.

The yellow antenatal card and antenatal record (in a purple folder) will be identified with the MGP midwives name and work mobile telephone number. The card will also have relevant Birthing Unit and Maternity Unit contact numbers attached (as per all women birthing at NBHS).

Subsequent antenatal visits: will be discussed by the MGP midwife with the woman. The regime of visits will be as per the NICE Guidelines3 (multigravida - 7 visits, primiparous - 10 visits = normal risk only). It is anticipated that one antenatal home visit will be undertaken at 34- 36weeks gestation.

MGP Database: (It is useful for the MGP to have a data base on which they can record women accessing the model

and other relevant data for audit and evaluation processes.) MGP midwife will enter woman's information on MGP database (ie woman's name, MRN, parity, EDB, suburb and MGP midwife's name.) This database will be maintained by the MGP midwives and will facilitate tracking of the women and will provide data to contribute to the process evaluation of the model.

Antenatal Consultation and Referral (as per the National ACM Guidelines for Consultation and Referral)

Outline processes for midwives to consult and refer with medical staff. For example:

When risk factors are identified, and depending on the risk factor and severity (Code B or C of the National Midwifery Guidelines for Consultation and Referral), ongoing care with MGP will be decided on an individual basis with the woman, MGP midwife and Staff Specialist. The possible outcomes would be either transfer care to Obstetric, collaborative care or tertiary centre care. Collaborative care will be between the woman, the MGP midwife and the Staff Specialist with a documented management care plan that also outlines lines of responsibility for care.

Senior obstetric consultation/discussion will occur between 40+7 and 40+10 weeks gestation regarding the assessment for induction of labour, management and birth.

Should the MGP woman require assessment during pregnancy outside her scheduled antenatal visit, she is to contact her MGP midwife. The MGP midwife may arrange for the woman to be assessed in the Birthing Unit (BU). The MGP midwife will usually meet the woman in BU for assessment, MGP midwife will organise a consultation with senior obstetric medical officer/Obstetric Staff Specialist for MGP women if medical management is required. Any antenatal care episode provided in BU will be recorded in the woman's medical record and entered into the MGP database to contribute to the process evaluation of the model.

Phone consultation is to be done in accordance with Maternity Services "Telephone Consultation" guideline and the MGP midwife will document discussion on the phone call sheet. The midwife will ensure that she/he has the phone call sheet available at all times (kept in diary/home) which will be filed in women's notes at the earliest convenience.

There may be occasions where the MGP midwives will need to reschedule planned antenatal visits. This may be if she has worked for 12 consecutive hours or has been called in for intrapartum care. If the MGP midwife can't reschedule visits, she/ he will need to contact the MGP partner/ 2nd on-call midwife to see the women or reschedule the women visits.

The MGP midwife will make arrangements to facilitate the woman meeting the other MGP midwives in the group. A monthly meeting and information session will be held to provide an opportunity for the women to meet the other midwives in the MGP as well as meet other women and their partners who are due around the same time.

Antenatal Admissions

Outline the arrangements for a woman's care should she need to be admitted antenatally. For example:

If the woman requires admission during her pregnancy the ward staff will be responsible for the provision of daily care. However, there will be ongoing communication between the ward staff and the MGP midwife to ensure the MGP midwife is informed about the woman's progress and ongoing management plan.

For women who have had an antenatal admission the discharge documentation is to include a management plan indicating handover to the ongoing lead carer, the next planned antenatal visit and future schedule of visits. If the woman on the MGP program is discharged prior to the date/time planned, the ward midwife is to contact the MGP midwife to inform her of this change. Ongoing collaborative care will be between the woman, the MGP midwife and the Obstetric Staff Specialist/Registrar with a clear, documented management care plan.

If the woman commences labour during her in-patient stay, the ward midwife is to contact the MGP midwife and advise her/him.

Preparation for labour and birth, and parenthood

Outline provision for antenatal education for women within the MGP. For example:

All women participating in MGP models will be able to access Preparation for Parenthood programs. Other external courses may be offered as appropriate.

Supporting families early Safe Start strategic policy

Detail process of referral for vulnerable women. For example:

In line with NSW Health Safe Start strategic policy PD2010_0164 midwives will conduct the usual psychosocial screening process at booking – in. Women with identified vulnerabilities, where families may be at risk, where the woman has mental health issues or substance use she will be referred to the XXX (Safe Start/psychosocial/perinatal mental health intake etc) meeting. The MGP Midwives will have the ongoing responsibility to monitor identified issues or initiate referral for newly identified issues to the Safe Start/psychosocial/perinatal mental health intake etc meeting.

Post-dates Pregnancies

Detail the agreed management plan for women over 41 weeks gestation. For example:

From 41 weeks gestation, MGP women will receive collaborative care with the MGP midwives and senior medical officer/Staff Specialist. A clear management plan will be developed and documented. The MGP midwife is to attend to the usual care of women at this gestation.

Induction of labour (IOL) for post-dates pregnancy

Detail the arrangements for care of a woman requiring a post-dates induction of labour. For example:

The MGP midwife will conduct antenatal outpatient induction of labour (IOL) assessment and consult senior medical staff for the development and documentation of a management plan. The MGP midwife will retain the primary carer role unless induction is complicated by a "B''or"C" category risk. Where a consultation occurs for these categories it should be clear whether primary care and responsibility continues with the midwife or is transferred to the medical practitioner. The midwife maintains overall responsibility for midwifery care within her scope of practice in collaboration with the medical practitioner and remains responsible for this discrete area of the woman's care.

Cervidil / Prostin IOL

The MGP midwife will conduct the pre-induction admission and final pre-induction assessment, including CTG. She will perform the vaginal assessment, cervidil /prostin insertion and post-induction CTG in accordance with guidelines. The MGP midwife will hand over care to the BU midwife until notified that she is in established labour. The clinical handover from MGP to the BU midwife will include a documented plan, negotiated between the midwives, which outlines the indications for the MGP midwife to be notified to return.

ARM/Syntocinon IOL

The MGP midwife will attend the BU at 0700 to attend the induction assessment and the induction in collaboration with the relevant obstetric medical officer.

Elective Lower Segment Caesarean Section (LSCS) Operation

Detail the arrangements for care of a woman requiring an elective LSCS operation. For example:

The MGP will be available for the woman's care on the day of the LSCS operation. If the woman comes in the night before, the ward staff will be responsible for the woman's admission unless the MGP has negotiated otherwise. There is to be ongoing communication between the MGP midwife and ward staff.

Intrapartum Care

Detail the process and arrangements for care of a labouring woman. For example:

When the woman commences labour the woman will contact her MGP midwife (via work phone).

Close consultation between the woman and the MGP midwife will be maintained by phone until arrangements have been made to meet in the Birthing Unit (BU). The MGP midwife will document all discussions on the phone inquiry sheet. The midwife will also inform the BU of the pending arrival time for the woman and self. The MGP midwife will conduct the woman's assessment unless her condition warrants earlier assessment by BU staff.

Should an MGP woman arrive at the hospital requiring assistance and has not contacted her MGP midwife, the BU staff is to contact the MGP midwife and inform her of the woman's presentation. If the primary MGP midwife is unavailable/not contactable the second on call midwife will be contacted.

A list of MGP midwives and work mobile and home phone numbers will be kept in the BU.

The BU and MGP midwives will work as a team assisting each other as required. Ongoing communication will occur between the MGP midwife and team leader as indicated.

The MGP midwife can provide care for a maximum of 12 consecutive working hours. After which she will hand over the lead carer role to the next midwife on-call. If birth is expected within a reasonable timeframe, the primary MGP midwife may choose to remain, in a support role only. If the primary MGP midwife has already worked most of her 12 consecutive hours when called to attend a woman in the Birthing Unit she may negotiate with the second on call to undertake care immediately. The Birthing Unit will routinely provide the second midwife for birth.

The MGP midwife will be responsible for ensuring she/he takes meal breaks and liaises with the team leader / MUM or midwifery colleagues when assistance is required.

If the primary midwife's 12 consecutive hours is complete soon after birth and the woman requires minimal postnatal care and transfer to the ward, it is reasonable to expect the primary midwife to negotiate the postnatal care from Birthing Unit, if activity allows, rather than calling the 2nd on call midwife.

All midwives providing MGP care will continue to utilise the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (as per NSW Health Policy Directive 2010_22).[1,2] When a variance from normal arises during labour it is the midwife's responsibility to communicate promptly with midwifery and / or obstetric colleagues and document the management and review plan.

Postnatal Care

Detail the process and arrangements for a woman's postnatal care. For example:

Discussion regarding the expected postnatal pathway begins when the woman "books – in" to the MGP. The expectation is that a women will transfer home within 4-6 hours provided her condition remains uncomplicated and her baby is well. Midwives should provide appropriate support to women at home, especially within the first 24 hours. This may include a postnatal visit on the day of birth to monitor maternal and infant well-being, allay anxiety for the woman and her family and support feeding.

Discharge planning will be undertaken by the MGP midwife with the woman. MGP postnatal home support and/or phone visiting is available for at least 14 days.

Beyond 4-6 hours: Transfer to Ward

Postnatal ward midwives will assume the lead midwife role during the MGP woman's in-patient period. However it is expected that the MGP midwife will visit and provide care whenever possible. The MGP midwife will seek out the woman's allocated carer when visiting/phoning the woman to discuss any outstanding support, information or care she/he can provide for the woman. When a MGP midwife visits and provides care, she will document the outcome of visit and communicate this verbally to allocated carer.

Babies requiring admission to the Special Care Nursery (SCN) will be cared for by nursery staff. The MGP midwife and nursery staff will communicate regularly regarding the baby's progress.

Transfers to a non- XXXX Maternity Services facility

Detail processes for when a woman and/or baby requires transfer from the hospital. For example:

Maternal

If a MGP woman requires transfer to a tertiary centre, escort if required will be negotiated between the MGP midwife and the relevant inpatient area and will be based upon MGP availability and workload. The tertiary referral centre will assume full responsibility for ongoing care.

Neonate

Transfer of neonates to a tertiary centre will be as per local policy. Escort if required will be negotiated between the MGP midwife and the relevant inpatient area and will be based upon MGP availability and workload.

Readmissions

Neonatal

Babies requiring readmission to the Special Care Nursery (SCN) will be cared for by nursery staff. The MGP midwife and nursery staff will communicate regularly regarding the baby's progress.

Maternal

Women requiring re-admission to the postnatal ward will be cared for by ward staff. The MGP midwife and ward staff will communicate regularly on the woman's progress.

Referral to Child and Family Health (C&FH)

Referral to C&FH, and/or Parenting Support Program will be attended by MGP midwives for MGP women. This will also include where a high priority referral is required.

When discharging the woman from MGP, the MGP midwife will complete ObstetriX and MGP database.

Management Structure

Detail the management structure that the MGP will work within. Outline reporting pathways and line management responsibilities. For example:

The MGP model promotes an autonomous way of working for the midwives. They are responsible for the organisation of their individual workload to meet the needs of the women through the continuum. They also need to develop effective relationships within the MGP to ensure adequate communication between one another and commitment to shared responsibility for on-call arrangements.

The MGP midwives have a reporting line through the management structure of the XX Maternity Service as is usual for all midwives in the Maternity Unit. The usual process of request for leave, notification of sick / FACS leave will apply. If there are professional / performance issues identified these will also be addressed by the maternity services manager in the first instance.

The maternity services manager will also be responsible for monitoring the education requirements of the midwives, the hours worked by each midwife and the mobile phone accounts.

Clinical Referral

Detail the processes for formal and informal clinical referral and reflection. For example:

MGP will conduct a regular meeting every week with the expectation that all MGP midwives attend unless on annual leave, with a woman in labour or has been working on the night preceding. The day consists of case referral and reflection, peer referral, group meeting, allocation of women and midwives for care and an education session. The meeting/s will be supported by the maternity services manager and/or CMC as required.

Each midwife will receive a copy of the Australian College of Midwives National Midwifery Guidelines for Consultation and Referral for reference when allocating risk categories. Adverse outcomes are subject to the usual reporting and referral mechanisms.

Each MGP midwife will undertake her own yearly referral and reflection on practice as part of the performance referral process. As part of this process each midwife will access her own personal practice statistics through the LHD ObstetriX data manager and subject them to critical self-analysis.

Professional Development

Detail how the midwives will access education and training and other opportunities for professional development. For example:

As per the National Registration and Accreditation Scheme each midwife will maintain an up-to-date midwifery professional portfolio. All midwives are encouraged and supported to continue their professional development by developing a professional development plan based on the ACM Self-assessment tool. Midwives working in this model are mandated to attain the Australian College of Midwives- Midwifery Practice Referral- 'MPR' within 12 months of commencing in the model.

As with all midwives opportunities to attain and maintain clinical skills will be provided to ensure MGP midwives maintain competency. Essential education requirements such as Fetal welfare, Obstetric emergency, Neonatal resuscitation Training (FONT) will continue for all staff. MGP midwives will participate in education programs as required by the organisation.

Clinical Supervision

Detail opportunities for the midwives to access clinical supervision. For example:

The MGP midwives will be provided with Clinical Supervision for one hour every month. This will occur at one of the scheduled meetings and there will be a commitment made by each midwife to attend. A supervisor will be allocated to MGP who will provide this supervision each month.

Workforce Processes

Detail any specific workforce process in your LHD that may impact or influence the development and day-to-day running of the MGP.

Introduction of the MGP model will be subject to NSW Health Workforce Policy Directives

Annualised Salary

Detail how the midwives will work within the NSW Annualised Salary Agreement. For example:

The MGP midwives will be employed under the Model Pilot Agreement for Midwifery Caseload Practice Annualised Salary Agreement IB 2008_002.[6] In return for this salary and flexible working arrangements the midwives will provide the service of continuity of care to 40 women / FTE / year.

Each MGP midwife will receive and sign off on a copy of the NSWNA pilot salary agreement and the latest Position Description.

Each MGP midwife will keep a log sheet of hours worked. While short term in-balance in hours may be anticipated, the expectation inherent in the pilot salary agreement is that balance of hours will be maintained over the longer term. Long term in-balance in hours will be subject to referral and management by the maternity services manager

On-call

Detail the on-call arrangements for the MGP. For example:

The MGP midwife will be on 24 hour call, during their rostered 'days on', for their own caseload of women. When not on duty or on-call, the MGP midwife will divert her mobile phone to the next MGP midwife on-call for that group practice.

During 'days on', the MGP midwife will attend booking-in, antenatal and intrapartum care and postnatal visits as required for her caseload of women.

In accordance with the pilot salary agreement MGP midwives will work a maximum of 12 consecutive hours. If and when it becomes clear that intrapartum care and/or pre-arranged visits are likely to exceed this 12 hour limit, the midwife will arrange hand over of intrapartum care as indicated to the MGP midwife on-call and where possible re-organise scheduled visits. Scheduled visits that cannot be rearranged for another time will be provided by the next available MGP midwife on call.

If for any reason the MGP midwife cannot be contacted on her mobile phone (eg flat battery or switched off, non-reception area) the MGP's midwife's home number can be used by staff but is not to be given to women.

Rosters

Detail arrangements and processes for the MGP roster. For example:

MGP midwives work flexible work arrangements to meet the needs of the women. Therefore, they are not rostered to shifts but provide care when required by the women. However, there will be a roster plan developed to ensure that all full time midwives are allocated to nine days off each month and there is an even distribution of midwives responsible for weekend on-call. This roster process will be developed by the MGP midwives and submitted to the maternity services manager.

A master roster will be issued including rotating weekends to Salaries office. The roster is updated with annual and long service leave.

Annual Leave

Detail how the MGP will manage their annual leave. For example:

Annual leave

In accordance with clause 30 of the award and as per the NSW Annualised Salary Agreement pilot salary agreement.6 The MGP midwife will be required to book annual leave with the maternity services manager at least 6 months in advance. The midwife will not allocate or accept women into her caseload whose EDB falls within her approved holiday period (+ 7 days either side if taking more than 2 weeks). She will need to re-distribute her antenatal and postnatal visits between the other group midwives prior to commencing leave.

Should an MGP woman birth while the primary MGP is on annual leave, the partner and/or on-call MGP midwife will attend the birth and report back to the primary midwife upon her return.

Sick Leave

Detail how the MGP will manage their short term and long term sick leave. For example:

Short term

In the event of short term illness the MGP midwife may where possible re-schedule her appointments and visits and arrange phone diversion to on-call MGP midwife to provide cover for intrapartum care. A sick leave form is only required where any part of the unwell midwife's workload is undertaken by another.

Long term

The usual arrangements for formalising long term sick leave will apply. Care for the caseload of women affected by their primary midwife's leave will be re-distributed amongst the remaining group midwives. Re-distribution needs to consider each midwife's current caseload to minimise risk of excessive work load.

If necessary and where it does not compromise safe staffing in the maternity unit, it may be possible to allocate suitably skilled midwives to provide interim leave relief. If this is not possible the women may need to re-allocated to traditional care. The decision needs to be based on reasonable workload for midwives and safety for women. This process will be coordinated by the maternity services manager.

MGP Office / Telephone number

Detail arrangements for MGP office space, IT and telephone. For example:

MGP will be provided with office space (desk/computer/phone) at XX Hospital. The office contact number for MGP will be xxxx the message bank on this phone will be cleared by MGP daily.

Voicemail will advise the caller that no urgent matters are to be left on this line and advise of alternate number provided.

Clinic Rooms

Detail arrangements for where the midwives can carry out antenatal clinics, antenatal education and any other clinical care. For example:

MGP will utilise clinic rooms in the Antenatal Clinic or established outreach clinics in the community.

Home Visiting

Detail arrangements for antenatal, early labour and postnatal home visiting. For example:

Home visiting will be undertaken using the LHD Child and Family Health Nursing - Universal Health Home Visiting –guideline. The MGP midwife will conduct an OH&S risk assessment (Home Safety Checklist) with the woman prior to the first home visit.

Mobile Phones

Detail arrangements for the midwives to have access to mobile telephones. For example:

Each MGP midwife will be provided with a work mobile phone for direct communication between the midwife and the women and between the midwife and the hospital. The work mobile phone will be with the MGP midwives at all times when on-call. The MGP midwife will need to comply with the LHD guideline Mobile Communications Devices (including Mobile Phones) Allocation and Use–. Midwives residing in areas without mobile reception will need to divert the mobile phone to their home number for the necessary period of time. The midwives will also be responsible for ensuring that each woman has an alternate number to contact and this would usually be the Hospital XX's Birth Unit number.

Motor Vehicles

Detail the arrangements and processes for midwives to either access hospital pool/fleet cars or use their own. For example:

As the MGP midwives will be continuing the care in the community after discharge from hospital there will be considerations for vehicle use. The MGP midwife will use the cars allocated to Maternity when available or an alternate hospital fleet car. Where neither of these options are possible or practicable the MGP midwife will use her own car.

All work use of the midwife's private car will be recorded in LHD log form with reasons for using own car. All personal car usage documented on the LHD form will be signed off monthly by the maternity services manager and reimbursed according to business rates as per NSW Health Policy Directive Travel- Official PD2009_016.7 The MGP midwife will need to demonstrate the comprehensive insurance status of her/his private vehicle and a valid driver's licence.

Medical Records

Detail the type of medical record that the midwives will use, for example woman held records, electronic records, hospital medical record etc. Will need to outline processes for filing, handling and storage of information.

Medical records will be maintained in accordance with NSW Health Policy Directive PD2009_057 Records Management - Department of Health.8

Equipment

Detail the equipment that the midwives will be provided and where they can access stock for example blood bottles, needles, syringes and paper. This may include but not be limited to: hand held fetal dopplers, sphygmomanometers, stethoscopes, O2 cylinders and neonatal resuscitation equipment. For example:

The MGP will be provided with, or have available, all the required equipment to ensure that antenatal care can be provided in community locations and postnatal care in the home. It is anticipated that the MGP will require some additional equipment to achieve this.

MGP will be provided with a standardised "kit" with all equipment required for community based postnatal care. As most of the equipment is the same as current stock items used within the unit this should be a cost neutral exercise. Additional equipment such as portable baby weighing scales and kit bags will be required. The MGP midwives will be responsible for the maintenance and restocking of this equipment.

All MGP midwives will be issued with a diary to facilitate management of antenatal appointments and postnatal care visits.

MGP Midwives will use all the usual stationery / stock items that are available in the Maternity Unit.

Commonly Asked Questions

Q: What will I do if the woman is in labour and the MGP midwife is not in the Birth Unit?

A: The core midwives can provide the care the woman requires immediately and make efforts to contact the MGP midwife or second on call. We all have a duty of care to the women in our care and therefore cannot put them at risk by not providing the care required.

Q: Will I need to assist the MGP in the Birth Unit?

A: Yes, as the MGP midwives will also assist the core midwives. Both groups will provide assistance as in receiving the baby at birth, assisting for meal breaks, emergency assistance etc.

Q: Who cleans up after the birth?

A: The midwife caring for the woman cleans up after the birth where possible. Remembering that we are working in a team and we can all offer assistance where possible with whatever possible. If the MGP midwife has just completed 12 hrs the core midwife may offer to assist with cleaning, likewise the MGP midwife may offer to assist with cleaning and other care to facilitate the core midwives workload.

Q: Who does the postnatal check?

A: MGP midwives will provide immediate postnatal care in Birth Unit. Ward midwives will assume the lead midwife role during the MGP woman's in-patient period. The MGP midwife will seek out the woman's allocated carer when visiting the woman to discuss any outstanding support, or care she can provide for the woman. This may sometimes include the postnatal check. The MGP midwife will document the outcome of visit and any care attended and will communicate this verbally to the woman's allocated carer before leaving the ward.

Q: Will the MGP midwives be using the usual stationery and forms?

A: Yes, the MGP midwives will use all the usual stationery, forms; adhere to the same protocols, policies and guidelines that the rest of the unit use.

Q: What if an MGP woman phones the Birth Unit in the middle of the night, and can't get on to her midwife?

A: Check whether it is an emergency situation. If it is, respond as per protocol. If it is not an emergency the Birth Unit will attempt to contact the MGP Midwife on her mobile and her home landline number. If unsuccessful the Birth Unit will take the woman's phone number and reassure her that a second midwife will shortly make contact. The second MGP midwife on call is to be contacted and will make early contact with the woman.

Q: What if the woman telephones in the middle of the night during the pregnancy complaining of pregnancy related issue. Do I call the MGP midwife?

A: If the issue can be addressed over the phone and the woman does not require assessment the core midwife can deal with it over the phone. If during the discussion you decide the woman requires assessment in Birth Unit during the night the MGP midwife should then be contacted. If the assessment can wait until the morning a call could be made to the MGP midwife in the morning advising her of the woman's needs.

Q: If a woman telephones in the middle of the night with a breastfeeding issue should I call her MGP midwife?

A: In this case it is appropriate that the core midwife addresses the issues that the woman has over the phone.

Q: Can a MGP midwife choose to practice differently to the core midwives?

A: The MGP midwives will be working in a different manner in that the organisation of their hours and their activities will be different. However, they will work under the same protocols, guidelines and policies of the service.

Q: What do I do if I have concerns about clinical care or any issues with MGP?

A: If you have any concerns with the model or the clinical practice/ care of the MGP midwives you can discuss this with the individual concerned. If you prefer you can speak to the MUM of the unit and/or ME/CMC. It is important to remember that the MGP midwives are still part of the team and the process that you would normally follow in such matters will still be the same. As this is a very new way for most of us to work we do invite open discussion and constructive feedback.

Q: In some models there has been an "us and them" attitude. Will this happen here?

A: In developing the MGP model, this possibility was taken into account. It is important to always remember that we are working as a team to provide care for the women and babies in our care regardless of where we work.

Q: Can any of us be MGP midwives?

A: Yes. Interested midwives will be provided with clinical support to obtain necessary skills should vacancies occur. There may be some consideration of rotation to MGP once the model is well established.

Q: What about burnout for MGP midwives?

A: Some midwives working in similar models have experienced burnout. In developing the MGP model, the midwives have been encouraged to be mindful of caring for themselves, and are required to preserve their rostered days off. The hours worked and the workload of the MGP midwives will be frequently assessed and strategies provided to minimise the possibility of burnout. The MGP midwives will be provided with Clinical Supervision for one hour every month.

Q: Will the Centering Pregnancy© model continue to be offered? (if applicable)

A: Yes. The CenteringPregnancy© model will continue to be offered to appropriate women at the time of booking in. Group antenatal care may also be possible within the MGP model.

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Appendix

1.

XX Maternity Service MGP Model Aims to ensure that:

1. Majority of Antenatal visits are provided by the primary midwife

2. 75% of women in the model will receive intrapartum care by their primary midwife

3. All women accessing midwifery continuity of carer programs receive postnatal care at home for at least 2 weeks after the baby is born

4. Evaluation of the model occurs within six months of implementation.

2.

XX Maternity Service MGP Key Performance Indicators (KPIs)

KPI 1: Number of antenatal visits: number by primary midwife / total number of visits.

KPI 2: Number of women receiving intrapartum care by their primary Midwife / total number of women in the model

KPI 3: Number of women receiving postnatal care at home for at least 2 weeks / total number of women in model

KPI 4: Evaluation of the model undertaken within six months.

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