Nursing and Midwifery Office, Queensland
Queensland Health

Delivering continuity of midwifery care to Queensland women

A guide to implementation
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Executive summary

1. Why provide continuity of midwifery care?
Midwifery continuity models are popular with women, provide improved birth and satisfaction outcomes, are cost-effective and are common overseas. For these reasons Australian governments are committed to increasing women’s access to these models as outlined in the National Maternity Services Plan and actioned by the Queensland Government with the commitment to provide public birth care in these models. Continuity models also have advantages in the development and retention of a skilled workforce which is responsive to day-to-day demand.

2. Midwifery continuity models
These models provide each woman with care from a known midwife/midwives, usually to six weeks postpartum. To meet the needs of women and be sustainable for midwives, continuity models are innovative and flexible in relation to place of care and in midwives’ working arrangements.

Women with any level of complexity of care benefit from continuity of midwifery care, and midwives consult with and refer to doctors and other caregivers according to guidelines and clinical need.

3. Steps in implementing a new model
New models are initiated by senior management, who set a capacity target, identify funding, secure a sponsor, notify staff and other relevant stakeholders and appoint a project officer with the required abilities.

The project officer develops a project plan, assembles a project steering committee including appropriate internal and external stakeholders, informs staff and ensures compliance with departmental requirements. In consultation with the steering committee and in consideration of local needs and projections, project documents are developed, including a philosophy, model of care, business plan and risk register.

Once the project is approved, discussions occur with partner health service providers (including major referral hospitals and community-based services) and emergency transport services. A local agreement is negotiated with the union and local midwives. Midwifery position descriptions, upskilling requirements and communication and referral pathways are developed. Clinical governance systems are defined including key performance indicators (KPIs).

Transition to the new model must be carefully managed and monitored, with a clear understanding of how midwifery continuity models work and with commitment and practical support from management for midwives to innovate. Good communication within the service, multidisciplinary case reviews, frequent team meetings and networking relationships beyond the service enable a collaborative culture to develop.

4. Key elements to successfully implementing a midwifery continuity of care model
Five key elements to successful implementation have been identified:

- Leadership is the most critical element, requiring adaptation to the different needs, philosophy and midwifery autonomy characteristic of these models.
- A clear vision for the model, shared by the key people who will develop and deliver it, is required for success in achieving it.
- A woman-centred philosophy of care ensures the model delivers what women need and clarifies the roles of caregivers.
- Communication within and beyond the service builds collaboration and understanding.
- Engagement of stakeholders helps align expectations and manage divergent motivations.
5. Cultural change—building a supportive cultural environment
Implementing midwifery models involves significant cultural changes within services and with partner services, largely relating to the very different practice and more autonomous working arrangements of midwives in continuity models. Medical staff need to be engaged to understand the model and how collaboration will work.

6. Clinical governance
As midwife models are relatively new in Australia, they have specific clinical governance requirements including a specific set of Key Performance Indicators (KPIs). Processes for risk management, monitoring and review and clinical audit should be included.
Processes for consumer participation and informed choice should be built into models from the outset. Use of Queensland’s Maternity and Neonatal Clinical Guidelines are recommended.

7. Costing and revenue for caseload models
Midwifery continuity models (inclusive of one-to-one labour care and home visiting) show cost savings when compared with standard care. However, a project investment will usually be required to establish the model. Analysis of Australian models shows that savings are mainly due to reduced antenatal and neonatal admissions and reduced medical interventions.

8. Industrial issues
Midwives working in caseload models in Queensland Health services are covered by special provisions within the Award. They do not work shifts, they organise their work time according to the needs of their women and as negotiated within their MGP and with their line manager.
Each model requires the negotiation of a detailed Local Agreement, developed by a working party with appropriate representation from management staff, midwifery staff and the Queensland Nurses Union (QNU).

9. Professional development and capacity building
Midwives moving into a continuity model of care have particular professional development needs, largely relating to the requirements to work across the full scope of practice. A range of resources is available to support midwives preparing for work in continuity models, including the Australian College of Midwives Midwifery Practice Review.

10. Midwifery practice in continuity models
Midwives working in these models must take a high degree of responsibility for the care of their clients and for their work arrangements. This requires a different philosophy and skill set. Relationships with women are close, continuous (sometimes for more than one baby), responsive to women’s needs and very effective in supporting women’s ability to birth and mother.
Working arrangements are flexible and involve negotiation amongst midwives in the MGP and in practice partnerships to cover women’s care needs. Care can be provided in a range of settings, including women’s homes, community-based clinics and in hospitals.
Midwives working in midwifery models should be active in developing and refining their model of care and planning long-term and day-to-day working arrangements. When well supported by management, this results in sustainable, reliable service.

11. Collaborative maternity care
Midwifery continuity models involve a high level of collaboration amongst practitioners, improving quality of care and workplace experience. Communication pathways, clinical guidelines and protocols and multidisciplinary education and review processes enable collaborative practice. Many models will depend on collaboration with practitioners from other facilities when care requires escalation.
Robust consumer representation is helpful to encourage practitioners to work collaboratively when delivering the choices and needs of women and families.

12. Sustaining and evaluating

Midwifery models show high rates of staff satisfaction and retention when operated sustainably. Strong communication culture and processes, supportive and flexible management and good understanding of the midwifery model and women’s needs all contribute to sustainability.

13. Eligible midwives

Eligible midwives have been notated by the Nursing and Midwifery Board of Australia, after demonstrating their experience and competence across the scope of practice. They are able to provide Medicare rebatable services, subject to certain conditions including 'collaborative arrangements' with a medical practitioner. State and Territory governments have committed, in the National Maternity Services Plan, to developing credentialing processes and enabling eligible midwives to access and collaborate with public maternity facilities.

Over time, eligible midwives are likely to make a significant contribution to deliver to women a continuity of community-based primary maternity care and reducing the burden on public facilities.
Section 1
Why provide continuity of midwifery care?

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

The Queensland Government has made a commitment to the community to provide access to continuity of midwifery care for women using public maternity services. Consequently many services are now facing the challenge of developing new midwifery skills and capacity and establishing new models or expanding existing models.

In delivering on this commitment, Queensland Health is committed to supporting women’s choice of other models such as GP shared care and access to specialist obstetric care as needed. Queensland Health is also committed, under the National Maternity Services Plan, to facilitating women’s access to private midwifery care in collaboration with public facilities.

There is an impressive array of books and other resources on continuity of midwifery care written by Australian and overseas experts which are referred to in this guide and which we hope will be well used. This guide is intended to provide information specific to the needs of Queensland Health facilities and lead readers to these other resources.

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

Why provide midwifery continuity of care?

Improving the sustainability of rural maternity services
Midwifery continuity models have significant potential to improve the quality and sustainability of services for women in Queensland’s rural and remote areas. Established models such as those at Goondiwindi and Mareeba have already improved the care for women and the professional role of midwives.

Queensland has a large number of small rural maternity services where birth numbers are low. In some communities maternity services are provided during the antenatal and postnatal period, but women must travel away from home for birth. Government recognises the importance of retaining rural maternity services to communities.

Queensland Health has recognised that current workforce shortages in rural maternity services threaten the sustainability of rural services. Some rural services have identified that having midwives providing nursing care for sick non-maternity patients in a shiftwork model, and providing occasional birth care, undermines job satisfaction and skill levels. Additionally this model requires rostering midwives on all shifts and is highly dependent on local GPs to provide shared care, sometimes in areas where GPs are overloaded. In these ways traditional rural models of midwifery practice may contribute to workforce problems (Yates, Usher, & Kelly 2011).

In contrast, continuity models mean that midwives are available for women when they need maternity care. Midwives increase their skills and experience and are able to take higher levels of responsibility for care. Birthing numbers may increase as women, who may previously have travelled to regional centres for birth, choose to stay and use the continuity model (Scherman, Smith & Davidson 2008). Successful models use innovative strategies to provide inpatient postnatal care by nursing staff in collaboration with caseload midwives. Implementing these models requires whole-of-service changes, significant professional development for midwives and adaptation to new ways of working for many staff.
The challenge for rural units is recognised in this guide and resources are recommended throughout which demonstrate how services can successfully make these changes. Staff involved in the development of rural models are strongly recommended to study existing rural midwifery continuity models. Goondiwindi and Beaudesert have published reports available from the Nursing and Midwifery Office of Queensland (NMOQ) website.

International models

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

In New Zealand over 80 per cent of women have a named midwife responsible for their primary maternity care. New Zealand women choose a Lead Maternity Carer (LMC), who can be a midwife, GP or obstetrician (Guililliland, Tracy & Thorogood 2010). LMC midwives work as caseload midwives providing continuity of care. They frequently work from community-based private practices, often called “group practices”, in which several midwives work together. These midwives provide antenatal and postnatal care mostly in the community and birth care in urban hospitals, rural primary birthing units or at home, sometimes in remote and inaccessible locations. “Core” midwives based in hospitals, usually working shifts, support the primary midwives when women are admitted. Introduction of this model started in 1990 after reform of New Zealand’s health legislation allowed midwives access to maternity funding. As well as delivering greater continuity of carer to New Zealand women, these reforms have delivered cost savings through reducing interventions and resources and cost shifting more expensive secondary services to primary and community services (Guililliland, et al. 2010).

The National Health Service (NHS), covering health services across the United Kingdom (UK), provides community-based midwifery care to a high proportion of women. It is expected that women can directly and easily access a midwife from early pregnancy for maternity care. Services are expected to provide women with the support of a named midwife throughout pregnancy and for women to be able to contact a midwife day or night at any stage in pregnancy if they have concerns (Department of Health 2004).

The Netherlands is often used as an example of achievable primary community-based midwifery care, as a significant proportion of births occur within the woman’s home under midwifery care. Low risk women in the Netherlands have out of pocket charges for using hospital facilities; however this charge expires if the woman has a medical condition (Hendrix, Evers, Basten, Nijhuis & Severens 2009). Midwives have remained primary carers for the vast majority of Dutch women and home birth is seen as a normal part of life (Mackay 1993).

In Canada, midwifery is a relatively newly recognised profession and midwifery is not regulated in all provinces. However where the options for midwifery care exists many women are able to access publicly-funded midwifery care including for birth in hospital, birth centre and at home (O’Brien, et al. 2010). Canada is also the site for exemplary perinatal outcomes in extremely remote locations with Inuit women birthing in midwifery care in their home communities in far northern Canada (Van Wagner, Epoo, Nastapoka & Harney 2007).

Australia-wide moves to improve access to midwifery continuity

The consensus document Primary Maternity Services In Australia - A Framework For Implementation (Australian Health Ministers’ Advisory Council (AHMAC) 2008) commits all jurisdictions to offering women continuity of carer whenever possible and supports enabling midwives to provide care across the continuum and applying the full scope of their skills.

Australia has seen steady progress toward increasing women’s access to midwifery continuity models over the last 20 years. Birth centres and midwifery group practices are in place in all states and territories and have been increasing in numbers. Demand for these models is also increasing. Several states have models that include publicly funded homebirth.

The Commonwealth’s 2009 Maternity Services Review recommended improving women’s access to choices in birth care and an expanded role for midwives (Department of Health and Ageing 2009). In response to this review, the Commonwealth has created a range of Medicare Benefits Schedule (MBS) items and Pharmaceutical Benefits Scheme (PBS) rebates, payable to women using the services of private midwives notated as ‘eligible’ midwives by the Nursing and Midwifery Board of Australia (NMBA). These developments are relevant to all maternity services and are explained in greater detail in Section 13.
These reforms can be seen as part of a national policy drive to strengthen primary, preventative health care, with the goal of improving community health and managing the stresses on acute services. From this perspective, continuity of midwifery care can be recognised as being community-based, primary health care with a strong preventative focus.

The Queensland context

Historically women in Queensland have had limited access to continuity of midwifery care. Birth centres have operated at Mackay since 1994 and at the Royal Brisbane and Women’s Hospital since 1995. A birth centre operated in Bundaberg from 1992 to 1995, closing after Commonwealth funding finished. A small number of women birth at home with the care of private midwives.

The first statewide review of maternity care in Queensland was Re-Birthing - Report of the Review of Maternity Services in Queensland, 2005, by independent reviewer Dr Cherrell Hirst (Hirst 2005). A range of reforms were recommended including locally-based maternity services and providing pregnancy, birth and post-birth care with a known carer. The Queensland Government’s positive response to Re-Birthing (Queensland Health 2005 ) was the State’s first policy statement on maternity care and has led, along with other initiatives in health policy, to significant progress in maternity care policy in Queensland.

The Re-Birthing report found that less than one per cent of Queensland women had access to continuity of midwifery care. Since then the number of women accessing continuity models has increased. The government expanded women’s access to continuity of midwifery care by funding new birth centres at the Gold Coast (2006), Townsville (2008) and Toowoomba (2010). Additionally, midwifery group practices in a number of public facilities and at the Mater Mother’s Hospital in Brisbane have brought continuity of midwifery care to more women in other locations.

An important stage in delivering on the Government’s Re-Birthing response was the announcement of continuity of carer targets in late 2010. The Government committed to providing continuity of midwifery carer to 10 per cent of women using public maternity services. Services were expected to double the size of existing continuity models. In addition services facilitating less than 200 births per year are required to move their entire service to a continuity model. Structural, policy and cultural reforms made since the Forster Review (Forster 2005) and the Re-Birthing report (Hirst 2005) and improved capability amongst clinicians and managers in Queensland Health facilities (Queensland Health 2011) make these targets achievable. A list of services and targets can be found at Appendix 1.01.

Outcomes of midwifery continuity

The safety and quality of midwife-led models are well established in the scientific literature. Appendix 1.02 provides a summary of documents providing evidence of midwifery continuity of care outcomes. Appendix 1.03 presents some evidence, in particular outcomes from the Gold Coast Hospital Birth Centre, in a powerpoint format.

The 2008 Cochrane Review Midwife-led versus other models of care for childbearing women is the authoritative source. It concluded that ‘all women should be offered midwife-led models of care and women should be encouraged to ask for this option’. When midwife-led models were compared with other models of care the reviewers cited a range of improved outcomes for women, with associated positive implications for facilities. Benefits of midwife-led care included reduced antenatal hospitalisation, reduced use of regional analgesia, reduced episiotomy, reduced instrumental delivery, significantly reduced length of hospital stay and increased initiation of breastfeeding.

The Cochrane Review found no statistically significant difference in caesarean section rates between midwife-led and other models of care. However some studies and audits find significant reductions in caesarean section in caseload midwifery models, when risk factors are controlled for, without compromising outcomes (Hatem, Sandall, Devane, Soltani & Gates 2008). The 2009 study of the Gold Coast Birth Centre found that caseload approximately halved the caesarean rate in women (six per cent compared to 14 per cent) (Toohill, Turkstra, Gamble & Scuffham 2011). Similar outcomes have been found in models providing care to all risk women such as the MGPs at Women’s and Children’s Hospital in Adelaide (Tumbull, et al. 2009).
A recent Cochrane Review also identified alternative maternity settings such as birth centres alongside standard hospitals offered improved outcomes for women receiving midwifery care without increasing perinatal mortality (Hodnett, Downe, Walsh & Weston 2010).

Cost-effectiveness of midwifery continuity models

Maternity service managers are understandably very interested in the cost of running midwifery continuity models, given their responsibilities for budgets and expenditure. After the initial cost invested in the transition, these models are cheaper to run than standard care.

In 2001 Caroline Homer found that the cost per birth of the St George Hospital’s community-based team midwifery service was about 74 per cent that of standard care while caring for women of all risk levels. Savings included reduced antenatal midwifery care costs, reduced antenatal admissions, a major reduction in admissions to special care and reduced caesarean section rate. The community midwifery model had extra costs in on-call and postnatal home care, but these were much smaller than the savings in other areas (Homer, Matha, Jordan, Wills & Davis 2001).

Savings mostly arise from reduced demand on services other than primary midwifery care and are largely due to the preventative and early intervention characteristics of care. A whole of service perspective is needed to recognise these benefits. Several international and Australian studies over several years document the direct cost savings of midwifery continuity models. However the indirect savings, from improved outcomes such as breastfeeding, are also potentially significant.

A 2008 research project compared the cost of care for women receiving MGP care at Gold Coast Hospital’s Birth Centre to the cost of providing standard care to women with the same risk profile. From a hospital cost perspective, caseload care in the birth centre saved $825 per birth, at $4 696 per birth compared to $5 521 per birth in standard care. MGP caseload postnatal care is inclusive of home visits to six weeks compared to home visits to one week in standard care. Therefore postnatal costs were higher in MGP care, but intrapartum and newborn care costs were low enough to realise overall savings (Toohill, Turkstra, Gamble & Scuffham 2011).

It is relevant to note that costs of standard maternity care are likely to rise, with new requirements such as universal postnatal contact for all women which is already in-built to MGP models. Further savings can be realised in Australia through the evidence of reduction in sick leave, retention of workforce and midwives’ improved satisfaction levels from working in MGP (Collins, Fereday, Pincombe, Oster & Turnbull 2010; Toohill, 2008).

A more detailed analysis of costing issues is offered in Section 7.

Consumer Demand

Women have been the biggest driver of midwifery continuity models in recent years. Birth centres and other continuity models are very popular with women and families who experience their care. Many birth centres have associated consumer groups established by users, which focus on supporting the service and ensuring other women have access. Urban birth centres offering continuity of midwifery care tend not to be able to meet demand, despite often having locally defined “low risk” entry criteria.

We also met our first midwife, who we liked immediately. She read our birth plan which detailed our desire for an active labour. She read it carefully and respectfully and declared that she felt very comfortable in supporting us in the way that we had identified. We felt comfortable and reassured. This midwife was wonderful. She provided considered support and advice, whilst allowing my husband and I to have our own space and ‘do our own thing’. We felt strong and capable and excited about the imminent birth of our baby.  

(submission, Review of Maternity Services in Queensland)
The emotional and social benefits women experience from having a known carer are not captured in outcome statistics, but are very real to women and are revealed by research. Women’s satisfaction has been reported to be high where MGP care has been available (Fereday, Collins, Turnbull, Pincombe & Oster 2009; Toohill 2008). Most women consider it very important to know the person providing their care, especially in labour. Women also want to be able to make choices about their care, which are more easily negotiated with a known individual carer than with an organisation or within team models where it has been reported women are still exposed to up to 30 different carers across the continuum (Homer 2006).

Primarily, the political push for increasing access to midwifery care has come from consumer demand. Women have persistently advocated at a political level for more choice and specifically for continuity of one-to-one midwifery care and governments are listening to them. It can be hard for services to adapt to having expectations set politically but this is likely to become an increasing part of the health care environment.

Consumer representation and engagement in health service delivery has increased in Queensland and around Australia. Government policy supports this and communities and consumers increasingly expect to have meaningful input into the health services they use. While this may be an unfamiliar process for services, effective consumer engagement is useful in facilitating needed culture changes and can be rewarding for clinicians and managers.

Consumer engagement and representation is discussed in Appendix 1.04.

References


www2.cochrane.org/reviews/en/ab000012.html


Section 2
Midwifery continuity models
—what do they look like?

It is easy to tell if a service is offering continuity of midwifery care. The litmus test is to ask the woman "who is your midwife and what is her contact number?" If the woman is able to tell you, then the service is offering continuity of care. In situations where the woman does not know, or isn't sure, the service obviously is not providing continuity of care.

This section provides an introduction to midwifery continuity models. The ways midwives actually provide care, including on-call and off-call arrangements and day-to-day clinical care, are outlined in Section 10 Midwifery practice in continuity models.

Definitions

The following definitions are intended to assist discussion with commonly understood meanings. In practice, models may not fit precisely into a definition, but it is essential for those establishing new models to focus on individual women’s experience of continuity and their relationships with caregivers.

Caseload midwifery

In caseload midwifery each woman has a primary midwife providing the majority of her pregnancy, birth and postbirth care (Homer, Brodie & Leap 2008). This model is also referred to as a “continuity of carer model” or “one to one” midwifery care. Caseload midwives provide care to a number of women per year, organise their time flexibly around their women’s care needs (Homer, et al. 2008) and don’t work rostered shifts. Private practice midwives frequently provide care in a caseload model (see Section 13 for further discussion about eligible midwives).

Case load

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

Midwifery Group Practice

A Midwifery Group Practice (MGP) is the organisational or management unit in which caseload midwives usually work (Homer, et al. 2008). The purpose of the MGP is to support the practice of the caseload midwives within it and to facilitate communication within the MGP and with management.

Within Queensland Health most caseload midwives work in a Midwifery Group Practice. There may be more than one MGP within a facility.

Maternity Care Co-ordinator

This person is nominated by the woman to coordinate her maternity care (National Health and Medical Research Council 2010). This is usually a primary maternity care provider such as a midwife or GP. In the private hospital sector this may also be the woman’s private obstetrician.

In a Midwifery Group Practice the woman’s primary midwife would also be her maternity care coordinator. An important part of the role is to coordinate the woman’s access to services and care from other clinicians according to her needs.
**Primary midwife**

Each woman receiving caseload midwifery care will have a “primary midwife” who provides the majority of her midwifery care and is her maternity care coordinator. ‘Known midwife’ and ‘named midwife’ have the same meaning as ‘primary midwife’.

The woman will probably describe her primary midwife as ‘my midwife’.

**Team midwifery**

A model of maternity care in which a woman receives all of her midwifery care from a team of midwives (six to eight midwives, sometimes more, sometimes less), but does not have a nominated, known, primary midwife. Meeting a number of the team midwives antenatally may provide some continuity for intrapartum care.

Team midwives usually work in shifts across the 24 hour day, and rotate across the antenatal, intrapartum and postnatal stages of care for their group of women (Homer, et al. 2008). In effect, the whole team carries a case load collectively. In general, team midwives do not work on-call and are not paid an annualised salary. There may be more than one team operating within the same facility.

Examples of several midwifery models in Queensland are described in appendices 2.1 to 2.5.

**Basic characteristics of a midwifery continuity of care model**

The key characteristics outlined in Homer et al. (2008) are fundamentally based on woman-centred care:

- The main aim of the model is to provide the woman with access to a known midwife at all times during pregnancy, labour and birth and the postnatal period.
- Antenatal care is provided in a range of venues: community, hospital, home.
- Midwives facilitate information sharing and antenatal support.
- There is planning, involving the whole family, around birth and postnatal care.
- The woman knows her midwife for birth care.
- Birth care is provided in whichever setting is appropriate for the individual needs and wishes of the woman and depends on what is available locally.
- Postnatal and newborn care is provided in the community with much of it taking place in the woman’s home.
- Where necessary, midwives will consult and refer to medical practitioners using their clinical judgement and the ACM National Midwifery Guidelines for Consultation and Referral (2008).

**What is a midwifery continuity model?**

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

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

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

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

Some other models broaden midwives’ clinical experience across the full scope of midwifery practice. Team midwifery care, for example, is provided by a group of midwives who work...
shifts, but also rotate across antenatal, intrapartum and postnatal stages of care. This builds midwives’ skills and may deliver increased continuity of care, but generally delivers a low level of continuity of carer to women and may also contribute to fragmentation of care (McCourt, Stevens, Sandall, & Brodie 2006).

Midwifery group practice

A Midwifery Group Practice (MGP) is the organisational unit of caseload midwives. The MGP is organised to maximise continuity of carer for individual women, while supporting and sustaining midwives in their work. An MGP may be large or small and there may be more than one MGP in a service with a large number of caseload midwives. The key to effective delivery of care by an MGP is to ensure partnership and backup arrangements within the MGP provide care to each woman from only two or three midwives.

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

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

Small MGP models may include only two to four midwives. Each midwife will be the named midwife for a number of women. They will also have another group of women for whom they are the back-up midwife. In small MGPs the woman’s access to a known care provider for intrapartum care is relatively straightforward, as the pool of possible caregivers is small.

In larger MGPs (≥4), women’s access to continuity of carer, particularly for intrapartum care, must be tightly monitored. Broadly distributed backup arrangements (e.g. whole group providing back up) in large MGPs will tend to provide only a small proportion of women with care from their named midwife in labour and birth.

Who receives midwifery continuity of care?

Continuity of carer is beneficial to all health care consumers. It has been shown to improve outcomes and consumer satisfaction across areas of health care and across degrees of complexity of care (Fereday, et al. 2009; Toohill 2008; Tumbull, et al. 2009).

Midwifery continuity of care has traditionally been embedded in ‘low risk’ models. However there is no evidence to support excluding women from midwifery continuity models because of their risk status or the complexity of their needs (Sandall, Hatem, Devane, Soltani, & Gates 2009). For example, women receiving intensive obstetric care benefit from a primary midwife coordinating their care, facilitating their access to obstetric care and providing their primary care needs during antenatal, intrapartum and postnatal periods. An example occurs in Adelaide at the Women’s and Children’s Hospital where a maternal and fetal medicine midwife coordinates care in collaboration with the MGP midwives (Homer, et al. 2008).

Some midwifery continuity models in Queensland provide care to all women in a defined geographical area, including those with complex pregnancy or health needs. These models mainly occur in rural areas (e.g. Goondiwindi and Mareeba) but they could also function effectively in urban areas.

Other continuity models focus on women with specific needs, such as socially disadvantaged and vulnerable women and do not exclude women due to risk status (e.g. Logan MGP). Birth centres tend to have low-risk-focussed exclusion criteria (e.g. Toowoomba Birth Centre, Gold Coast Birth Centre), with some models (e.g. Gold Coast Birth Centre) retaining women within the continuity of carer model, supported by collaborative obstetric care, if complications develop after a set gestational period.

Regardless of the target client group all models will use the Australian College of Midwives’ (ACM) National Midwifery Guidelines for Consultation and Referral (2008) and maintain a culture of collaborative care.
Queensland women are being encouraged to explore their options for maternity care. The Queensland Centre for Mothers & Babies (www.havingababy.org.au) has developed a range of decision aids to encourage exploring the models of care available.

There is no need for facilities to examine whether local demand exists for midwifery continuity models. Wherever midwifery continuity models are available they are very popular with women. International evidence clearly demonstrates women’s preferences for continuity and satisfaction with continuity models. Local experience also demonstrates that where models exist, demand usually significantly exceeds capacity. Queensland maternity facilities need to incorporate midwifery continuity of care models into their local, geographical and workforce context.

Place of care

Overview

As women progress through pregnancy the midwife meets their continuity needs by working in various environments, particularly the woman’s own home. This brings benefits to the woman as well as to the midwife and the institution. Cost benefits of providing care in the community rather than in hospitals or health centres are difficult to measure but there are proven overall savings for the midwifery continuity of care model (Homer, et al. 2001; Toohill, et al. 2011). Government policy supports the decentralisation of maternity services, so that ‘care is local or feels local’ (Queensland Health 2005).

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

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

Antenatal care – including home, hospital clinics, community centres

I alternated between Karen and Meredyth, Karen was lovely and Meredyth was the warmest, kindest person I had ever met. I got to know them both throughout the pregnancy as did Michael and my children. They both prepared me well for all aspects of the pregnancy, labour and birth.

(submission, Review of Maternity Services in Queensland)

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

The benefit for the midwife in seeing a woman in her home is that it may provide an insight into the woman’s home environment, her social support network and the other external factors that may be impacting her pregnancy.

Labour and birth care

Labour and birth care may be provided in a hospital birth suite, a birth centre or potentially in the woman’s home. At the time of writing this document Queensland had no publicly funded home birth services, so this option will not be discussed in depth. Information on publicly funded home birth models is available at www.nmh.uts.edu.au/cmcfh/research/homebirth.html.
For well women, evidence supports the use of specific, low-risk-focussed birth environments (Davis, et al. 2011). Care provided in birth centres compared to conventional labour wards/delivery suites increases normal birth rates, reduces obstetric interventions and women are more satisfied with their experience (Gottvall, Waldenström, Tingstig, & Grunewald 2011; Hodnett, et al. 2010).

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

It is entirely appropriate for continuity models to admit women regardless of risk status and to provide intrapartum care in the environment suitable to the woman’s needs (refer to Clinical Services Capability Framework and ACM Guidelines). This already occurs in rural models such as Mareeba and Goondiwindi, where all women are accepted into the model and the choice between birthing in the primary unit or the obstetric (secondary) unit is made collaboratively.

Early presentation to hospital is associated with a 10–30 per cent increase in unnecessary admissions increasing bed occupancy and costs (Ball 1996). It is also associated with increased intrapartum intervention rates (Lauzon & Hodnett 2001). In continuity models, intrapartum care usually starts with phone contact between the woman and her midwife (or group practice partner on-call). The midwife’s familiarity with her client helps her to make decisions about early labour care and when to travel to hospital. Early labour care may be provided in the woman’s home. This may avoid early admission to hospital as an essential aspect to improving outcomes.

### Early labour care at home

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

### Complex care in labour and birth

In situations of increasing complexity, the woman’s named midwife—her maternity care coordinator—continues to provide primary care and continuity. Women may be transferred to secondary care providers such as obstetricians, or tertiary care facilities. When practical it is highly desirable that the midwife continue to provide midwifery care to the woman. This maintains continuity of care, supports the woman’s plans and choices, is very reassuring to the woman and improves maternal and neonatal morbidity and mortality (Homer, et al. 2008). Continuity in these situations also maintains midwives’ skills in complex care.

### Midwifery continuity during and after transfer

When women need to transfer from Mareeba to Cairns they will be accompanied by their MGP midwife, who may then provide ongoing primary midwifery intrapartum care during obstetric-led care. In other rural settings women will have the midwife organise their transfer but, dependent on workloads at the primary hospital, they may not provide ongoing care at the transfer site.

Midwives in most birth centres (e.g. Gold Coast, Mackay and Royal Brisbane and Women’s Hospital), continue to provide care to women following transfer to hospital birth suites.

Midwives in MGPs without designated birth centres, such as Mater Mothers and Logan hospitals, also continue to provide care by the primary midwife should the woman’s care be transferred to obstetric care.
**Postnatal care**

*Each day, the midwife continued her diligent attention to all of us, making sure the baby was drinking properly and I was recovering well. Her care was wonderful and holistic and most of all genuinely caring. When the difficult times and tiredness came, as inevitably they do even with the best of babies and births, the continuity of my home environment and the care from my husband and the midwife was an enormous comfort.*  

*(Review of Maternity Services in Queensland)*

In most continuity models initial postnatal care is provided for a period of a few hours (usually four to six) in hospital with the potential for longer hospital stays if clinically required by mother or baby. After this time most postnatal care is provided in the woman’s home. Some women may attend hospital, community facilities or clinics for particular needs.

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

Breastfeeding support is a key part of postnatal care and is greatly enhanced by continuity of midwifery care. Women benefit from receiving advice from one midwife (instead of contradictory advice from multiple caregivers) who can work through challenges with them. Ongoing access to midwifery care by phone and home visiting enables early intervention in breastfeeding crises when women are at risk of losing confidence and giving up. Queensland Health strongly supports increased breastfeeding rates in the first six months (see [www.health.qld.gov.au/breastfeeding/](http://www.health.qld.gov.au/breastfeeding/)).

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

Postnatal care is most effective if it continues for six weeks. There may be times late in the postnatal period where the woman may prefer to come to the midwife. The midwife may also provide postnatal care at a community base or clinic, possibly in conjunction with group education. Both of these situations may provide an opportunity for the woman to start to develop or extend social networks with women in the community.

**Transition to child health care**

Ideally midwives provide care to around six weeks after birth. Prior to the midwife concluding her care with the woman, the woman is linked to community and child health services. This ensures a seamless transition of care.

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

**References**


Section 3
How to implement a new model

This section outlines the steps in planning, preparing and implementing a new midwifery continuity model. Brief explanations are provided, with more detail available on some issues in other sections and appendices available from the NMOQ website.

Dependent upon existing resources and community links, planning and preparing for implementation may take 8 to 12 months. Carefully approaching the planning process will avoid significant difficulties later on in the implementation phase. Please refer to Homer, Brodie and Leap (2008) as an overarching guide to planning and establishing models.

Implementation tasks have been listed below under four headings:

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

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

**Phase 1—Preparation**

- The CEO of the Hospital and Health Service identifies the minimum continuity of maternity care target for their service. There is no upper limit to the target a service may choose to achieve.
- The CEO secures a senior executive sponsor or sponsors for the project (in most cases the Director of Nursing and Midwifery (DONM) or the Executive Director of Nursing and Midwifery (EDNM)).
- Senior executive notifies staff of intent to investigate and develop a model.
- Senior executive staff engages with Queensland Nurses Union (QNU) and consumers.
- Senior executive staff will identify funding for a project officer from current establishment or alternative funding source (e.g. Patient Safety and Quality Improvement Service).
- Senior executive staff will develop a role description for a project officer/change agent capable of developing the model and recruiting (e.g. Midwifery Unit Manager or senior clinical midwife). The project officer is appointed.

**Phase 2—Commencing the project**

The project officer referred to in this section will be the person specifically charged by the senior executive with developing and implementing the midwifery model of care.

- The executive sponsor ensures the project officer has project and change management skills or arranges training for the project officer.
- The project officer develops a project plan including objectives (see generic project plan template in Appendix 3.06, see example Gantt chart provided in Appendix 3.03).
- The project officer, in conjunction with senior executive staff, identifies internal and external stakeholders for inclusion on the steering committee or for engagement through other communication strategies.
- The project officer ensures the steering committee operates under terms of reference guided by Midwifery Models Clinical Governance (Queensland Health 2008) (see Section 6 and Appendix 3.01). It is important to schedule meetings six months in advance.
• The project officer develops sessions to inform all staff about the model in conjunction with the education unit. Special attention should be given to autonomy of the practitioners as well as the difference between shift work and ‘no fixed hours’ (annualised salary arrangements).

• The senior executive sponsor will seek participation from interested midwives within the facility.

• Opportunities to announce plans in the media can be considered by the project officer and executive staff (e.g. community forums or media events).

• With support from the CEO and senior executive, the project officer establishes the steering committee to guide implementation and ongoing monitoring for the new model. See sample terms of reference in Appendix 3.02. This should include (but is not limited to) internal and external stakeholders:
  – Aboriginal health worker/clinician/consumer (all if possible)
  – Allied health staff
  – Australian College of Midwives (ACM)
  – Child health staff
  – Maternity-specific consumer representatives
  – District management
  – Executive sponsor
  – Finance officer
  – General Practitioner/s
  – Midwives interested in working on the new model
  – Queensland Nurses Union (QNU) (note: a letter of invitation should be sent to QNU State Secretary, so that appropriate representation can be provided and supported)
  – Senior midwifery and medical staff
  – University midwifery academic representation.

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

• The demographic factors within the geographic/catchment area can be mapped, either in a working group or by the project officer, to assess past trends and future demand for maternity services. Identify where the current primary, secondary and tertiary services are provided. Assess current key outcomes which may align with the outcomes you would expect within midwifery model of care (e.g. normal birth rates and breastfeeding rates). Refer Homer et al. (2008, pp. 47-65).

• A community forum or consumer working group will assist the project officer to assess the specific maternity care needs and preferences of local women and families. This forum does not need to address whether consumers want a midwifery model. Focus on women who currently use local maternity services the least (e.g. women who travel elsewhere for care, women who attend fewest appointments).
• Develop a philosophy for the model. A stakeholder forum is a good place for this. A sample philosophy and notes from the associated workshop are provided in Appendix 3.04 of this guide.

• The project officer will develop a model of care document including pathways for care. This is informed by the steps above, including mapping, consultation and philosophy.

• The project officer will develop a business plan for implementation of the model (see Queensland Health template, Appendix 3.06), consider ongoing office space, administrative support and data collection.

• Develop a risk register based on AS/NZS Risk Management Standards 4360:2004 and the companion guide (Standards Australia and Standards New Zealand, 2004) (refer below; Queensland Health Risk Matrix in Appendix 3.05 and Homer, Brodie & Leap (2008, p. 132)).

Phase 3—Pre–implementation

• After development and approval of the business case, develop a staged implementation plan.

• Senior executive sponsor advises local staff of approval.

• Project officer organises and convenes team-building activity for multidisciplinary team, regardless of existing culture.

• The project officer and senior staff develop service agreements with non-government providers of maternity/child health care to facilitate models of care appropriate to the community. Establish service agreements with partners such as Child Health and community services including consideration of shared clinical space.

• Secure access and transfer arrangements such as emergency transport services. Ensure service agreements are in place with other services where transfers are anticipated.

• The continued involvement of the QNU is required to develop an industrial agreement for wages and conditions.

• The local industrial agreement will include case load numbers per FTE midwife. This is a maximum of 40 women per FTE per year and is reduced according to complexity of care and other demands on midwives. This is discussed in Section 8. A sample local agreement template is provided in Appendix 8.02.

• Develop midwifery roles and position descriptions:
  – in some facilities (e.g. urban) a minimum skill set may be set and midwives recruited accordingly
  – in some areas (particularly rural) existing midwives may be recruited and may require support to upskill to required level for continuity practice.

• Develop orientation plan for midwives, including:
  – responsibilities and expectations in role
  – travel arrangements and reimbursements
Delivering continuity of midwifery care to Queensland women

– on-call arrangements
– relief
– (See appendix 3.07 for sample orientation program).

• Advertise and recruit.

• Implement orientation plan.

• Project officer coordinates professional development planning and mentoring for midwives (see Section 9).

• Facilitate partnership arrangements among the caseload midwives. Support midwives to determine their practice partners, considering factors such as personality, geographical location, like strategies and practice philosophies.

• The project officer and/or midwives source and obtain equipment for the model (see Appendix 3.08).

• The project officer obtains pagers, telephones, arrangements and agreement for car usage (hospital or personal vehicles).

• In rural services, the project officer and midwives should consider if accommodation is required for midwives in the town where intrapartum care is provided.

• The project officer, Midwifery Unit Manager and midwives (referred to as the ‘project team’) will review (or develop if necessary) multidisciplinary workplace guidelines including:
  – criteria to determine who receives continuity of midwifery care (see Section 2)
  – consultation and referral pathways to be used with ACM Consultation and Referral Guidelines (2008)
  – processes that provide for informed choice (including where women make decisions outside of agreed pathways)
  – ensure case review pathway is developed and agreed
  – internal and external communication tools and pathways including regular case conferencing with obstetric staff (internal or external to service)
  – pathways to order and access pathology and diagnostic imaging.

• The project officer and Nursing/Midwifery Unit Manager will identify and resource office and meeting space for caseload/group practice midwives or for the team.

• Communication pathways with tertiary services will be developed and provided to the tertiary service.

• Communication and referral pathways with allied health staff will be developed, including hospital and community-based social workers, physiotherapists, dieticians, etc.

• The project team will develop or secure consumer-friendly information resources.

• The project team adopts the statewide KPIs for midwifery models of care.

• Senior staff will ensure that an administration officer (AO) is recruited or deployed to manage ongoing administration, information technology (IT), develop letter templates for referral, wait list process, phone enquiries, etc.

References

Resources available for Phase 3 include industrial agreements and local midwifery agreements.

The Nursing and Midwifery Board of Australia (NMBA) standards should be followed and are accessible from www.nursingmidwiferyboard.gov.au

The Australian College of Midwives (ACM) Skills inventory is the appropriate tool to identify any up-skilling requirements and is available via ACM’s MidPLUS program.

Phase 4—Implementation

- Allocate full time equivalents (FTE) to the group practice. For medium to large hospitals establishing a small midwifery continuity model, a minimum of four FTE midwives is recommended to sustain the model and cover leave. In small models, especially covering whole of service, it is beneficial to employ part-time midwives and maintain a higher number of midwives. Four midwives of proportionate FTE to the number of births is a suitable compromise. Models where there are less than four midwives will be more difficult to sustain.
- Three months lead-in is essential for midwives to build their caseload and to assist with transition to a new way of working.
- In the lead-in phase, midwives work with the project officer or an administrative staff member to develop clerical processes.
- The dates of midwifery group meetings and case reviews with medical staff are determined and booked for at a minimum of three months in advance (multidisciplinary case review is a requirement of clinical governance).
- Official launch, invite stakeholders and media.
- Midwives ensure the model is linked to quality and safety processes including service mortality and morbidity review meetings.
- The Midwifery Unit Manager or Project Officer determine midwifery portfolios for maintaining the model (e.g. data recording, maintaining CPD requirements, developing safe working hour arrangements and on-call/off-call arrangements).
- District management commit resources for auditing and reporting of industrial, clinical and consumer satisfaction outcomes.
- The midwives schedule education and professional development activities.
- The MGP or team midwives should meet at least weekly, particularly when first implemented. This time should be considered when determining workloads and facility layout.
- The midwives and Midwifery Unit Manager or Project Officer identify and develop research opportunities with academic partners.
- Midwives maintain professional and community links/partnerships.
- Milestones are celebrated.

References


Section 4
Key elements to successfully implementing a midwifery continuity of care model

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

• woman-centred philosophy of care
• vision
• leadership
• communication
• engagement of stakeholders.

*Midwifery Continuity of Care* by Homer, Brodie and Leap (2008) is referred to several times and is recommended reading.

A woman-centred philosophy of care

Most maternity care providers are familiar with the term woman-centred care. Queensland Health advocates that staff adopt a patient-centred approach towards persons accessing its services. Patient-centred care is recognised as a dimension of high quality health care providing strong evidence of quality health improvements through increasing safety, cost effectiveness and client and family satisfaction (Australian Council of Safety and Quality in Health Care 2010).

For maternity services, the concept of patient-centred care translates to woman-centred care and has application to all practitioners in providing maternity care.

Midwifery is a woman-centred primary health care discipline founded on the relationship between the woman and her midwife. These principles are mandated in regulatory documents (Australian Nursing & Midwifery Council 2006, 2008, 2009). The basis for all models must be the woman and her experience of care. The Primary Maternity Services document (Australian Health Ministers’ Advisory Council (AHMAC) 2008) and National Maternity Plan (Australian Health Ministers’ Conference 2011) identify woman-centred care provision as the foundation of service development.

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

Woman-centred care:

• is focused on the woman’s individual, unique needs, expectations and aspirations, rather than the needs of institutions or professions involved
• recognises the woman’s right to self-determination in terms of choice, control and continuity of care from a known caregiver or caregivers
• encompasses the needs of the baby, the woman’s family, her significant others and community, as identified and negotiated by the woman herself
• follows the woman across the interface between institutions and the community, through all phases of pregnancy, birth and the postnatal period, involving collaboration with other health professionals when necessary
• is holistic in terms of addressing the woman’s social, emotional, physical, psychological, spiritual and cultural needs and expectations
• recognises the woman’s expertise in decision making (Leap in Homer et al. 2008, Leap, 2009). Traditionally, maternity care has tended to focus on the fetus or baby with decision making resting with the medical practitioner (Guilliland & Pairman 1995). In woman-centred care decisions rest with the woman as the mother’s and baby’s needs are seen as synonymous, where addressing the needs of one benefits the other. Mother and baby should not be managed as having competing interests.
Bumps and blocks

A key element for success is that staff involved in the change process understand midwifery continuity of care models and woman-centred care. The pitfalls of trying to establish a model where there may be resistance to change and the temptation to circumvent a Midwifery Group Practice in favour of other models may be avoided by some study of midwifery continuity of care models. We have referred extensively to the work of Homer, Brodie and Leap (2008), which is essential reading for staff setting up new models. Chapters 1 and 2 recommend some background reading. Those with further interest may review further works suggested in the research section.

Vision

Having a clear vision for your service is vital. Staff involved in the transition of services must have belief and conviction in the model. McCourt and Page (1996) outline the following preconditions to successful organisational change:

- a genuine will to succeed
- vision for the model
- central values of the model
- sharing broadly from grass roots to executive.

The vision needs to address key aspects of the model:

- size of the model (is it the whole service or a proportion of the service to meet targets established by Queensland Health?)
- arrangements or organisation of provision of care (model of care)
- places/settings care is to be provided
- who the service relates to (e.g. specific needs groups, all risk, low risk)
- how the model interrelates to existing staff or co-exists with conventional models and other services.

Leadership

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

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

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

Homer, Brodie and Leap in their book *Midwifery Continuity of Care* (2008) provide additional perspectives for managers on page 11 and in Chapter 8. In this Guide, Section 5 Cultural Change and Section 9 Professional Capacity Building have additional information for leaders.

The British NHS Midwifery Leadership Competency Model describes a set of key competencies for midwifery leaders and is available from:

www.rcm.org.uk/EasysiteWeb/getresource.axd?AssetID=9950&type
Key issues for leaders in midwifery models:

- Leaders need to understand woman-centred care and informed choice. They must understand the philosophy for the model is the rudder that keeps it on course.
- Leaders accept, support and articulate to others that primary care midwives are essentially self-managing and require support and access to ongoing professional growth and development opportunities.
- Leaders will inspire and ensure development of policy and processes that support the autonomy of midwives as highly skilled professionals.
- Leaders must clarify and model respectful communication and collaborative interdisciplinary relationships as is expected in the provision of contemporary woman-centred care.
- Leaders guide and monitor development of and agreement to, robust maternity clinical governance providing for safety and sustainability.

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

A key requirement for leaders in midwifery continuity of care models is that they not only understand the value of midwifery continuity of care but also embrace the model. The commitment and drive required to transform traditional models to midwifery continuity of care requires leaders to research and understand the importance of continuity of care for women.

Key attributes of midwifery leaders:

- Open to learn
- Flexible
- Self-informed and share knowledge easily
- Persistent
- Inclusive
- Focused
- Listen and are responsive
- Maintain commitment and dedication
- Have the ability to lead and influence others

(J. Toohill, personal communication, February 14, 2011).

Communication

Planning for the model within your service

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

Homer, Brodie and Leap (2008) describe commencing a new continuity midwifery model at St George Hospital in Sydney during the 1990’s. The project was given impetus by an external regional review that recommended reform of maternity services. Change was driven by a motivated and committed small multidisciplinary group (midwives, obstetricians, researchers) built on trust. They advised that establishing effective communication and collaborative processes evolved over time and were ongoing; likening the process to ingredients for a successful marriage—it takes time, requires work and attention, predicated on commitment and needs mutual understanding and respect (Brodie, Davis, & Homer 2008).
Paramount to the success of the model is development of values and vision that is shared within the entire maternity unit. A short, clear mission statement ensures a consistent message is provided for communication both within the unit and to external stakeholders.

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

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

**Effective communication relies on ensuring everyone has:**
- been identified for inclusion in the steering committee for the model (see Engaging Stakeholders below)
- access to information: proposal shared, minutes of meetings are available and displayed, information sessions provided, newsletters distributed
- opportunities to contribute: genuine representation within planning or management groups
- processes for clarification: consultation has occurred at a number of levels and times (J. Toohill personal communication, February 14, 2011).

**Expectations**

Based on the philosophy and model developed, staff working in these models will need to have a clear picture of what they can expect.
- What is the arrangement for handing over care, by what means and with whom?
- When and where are clinical outcomes recorded and audited?
- Who and how can collaborating staff be contacted regarding variations in a woman’s health?
- How will staff respond when women choose to take a different path to that which is recommended?

Communication of these expectations leaves staff with clarity about their roles. It is important to document role delineation so that if situations arise where staff members act outside of the parameters expected of them, there are opportunities for early resolution of difficulties.

**Bumps and blocks**

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

A range of communication strategies are outlined in Section 10 and Section 11.
At the Gold Coast Hospital Birth Centre the manager would meet with the midwives for the first part of their weekly meeting to discuss workloads, annual or study leave and any issues needing consideration. After this the midwives would continue their meeting (usually without the manager), and would practice emergency drills, share outcome data, solve problems and talk about elements of the care they are providing for shared learning and peer review of practice (J. Toohill, personal communication, February 14, 2011).

Networking and communication beyond your service

It is critical to network and identify external stakeholders. Section 3 outlines requirements for communication in the project planning phase. Communicating to a wide group including those suggested below in Engagement of stakeholders is paramount.

Section 11 discusses collaboration both within and external to your service. External stakeholders may be critical to the service (e.g. GPs in rural areas) and therefore it is crucial to review Section 11 before engaging in any element of planning around the model.

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

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

Engagement of stakeholders

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

Consumers

A woman-centred model of care requires consumer engagement in development and ongoing management. Consumer input raises issues possibly not considered by the service providers. Consumer representation also facilitates focus on consumer needs by clinicians and management at the table as consumers are ultimately the reason for the existence of the service. See Appendix 1.04 for more information on consumer engagement in Queensland.

Management

Early engagement of senior administrative and management staff is required for development of new models. See a brief outline in Section 3 about steps in this process:

- The Executive Director of Nursing and Midwifery, the Chief Executive Officer of the service, the Director of Nursing and Midwifery and the Director of Obstetrics for the service should be involved from the very early planning stages as staff who have overall responsibility for the service.
- The business manager should participate actively to advise on expenditure for equipment, facilities and redirection of funds from mainstream maternity services. The business manager will be involved in developing the project plan and business case and should participate in the steering committee.
- Senior staff providing support at an external site where transfers may be received or sent would be invited to participate at a steering committee level, working group or community forum level depending on their discipline and involvement.
• In situations where the service is working with the nearest tertiary hospital for birth care or other services, the tertiary service must be fully engaged as a stakeholder in the development of communication processes and pathways.

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

Medical: obstetric and neonatal (larger units)

Meaningful engagement of medical staff is essential. New models that have developed successfully have found that one or more consultants attached to a group of continuity midwives provide for improved interdisciplinary relationships and assist with continuity of care. Please see Section 11 which discusses initial engagement, communication and collaboration with medical staff.

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

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

Midwives: core and potential caseload

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

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

Union

The Queensland Nurses Union plays an advocacy and expert role in advising on the industrial processes and legal working arrangements for staff in the midwifery continuity of care model and also remaining maternity and nursing staff.

Some stages in this process:

Early engagement with the Union is essential.

• The QNU will have steering committee representation. QNU representation should be sourced via a written request to QNU State Secretary so that appropriate representation can be provided and supported.

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

The QNU has a key role in supporting midwives and midwifery models. They particularly support models that increase workforce satisfaction and facilitate differentiated career paths.

Partnerships

A range of partnerships are integral to midwifery continuity of care. These include the relationship between the midwife and the woman, midwives’ practice partners and partnerships with interconnected services. Some partnerships are consolidated through service agreements or collaborative arrangements to secure continuity of care beyond the facility. Other partnerships complement the local model, such as emergency transport services, community services or higher level maternity support services. Please see Section 2 and Section 10 for discussion about the midwifery partnership with women and Section 11 for partnership with interconnected services.
Goondiwindi

A review of Goondiwindi’s maternity service was undertaken in 2003 as many local women were dissatisfied with local maternity services and they had to be relocated for their birth. In 2008 the Know your Midwife (KYM) MGP model was established in partnership with the local GP obstetricians. In this model, women share care with the midwives and GPs across the continuum, with the GPs alerted by the woman’s midwife when labour commences. The MGP midwives provide care across the continuum with a majority of care provided in the community. There is local elective and emergency caesarean section availability.

Midwifery care is provided by the KYM midwife regardless of vaginal or caesarean birth. Post-caesarean care is supported by general nursing staff who might provide regular antibiotic treatment or assist the woman to the shower so the KYM midwife is not required to stay on site, but is available on-call should midwifery care and advice be required. This model works well with a strong sense of community and staff ownership of the model (K. Maddox, personal communication, March 3, 2011).

References


Section 5

Cultural change—shared vision: shared culture

Moving from traditional models to midwifery continuity

Why change?

Moving from conventional maternity care to a Midwifery Group Practice requires new processes, procedures and clinical skills as outlined in earlier sections. However models are unlikely to be successful without significant cultural change within maternity services. Different roles, especially for midwives, and different relationships between caregivers: midwifery, medical and management; require a different organisational culture. Staff, especially at the leadership level, need to be sensitive to cultural issues and diligent about pursuing the required changes.

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

Queensland Health’s website on change management may be viewed at: http://qheps.health.qld.gov.au/cpic/content/pflowsup_changemngt.htm. This should be referred to by all facilities undertaking projects with culture change elements.

Traditional maternity care

In conventional care, medical doctors take a lead role in providing antenatal care, with women seeing midwives and sometimes specialist obstetricians periodically at hospital-run antenatal clinics.

In labour a different group of midwives and doctors will provide hands-on intrapartum care. After birth, while in hospital, yet another group of midwives will provide postnatal care. This occurs within a shift work model. On discharge from hospital, some postnatal care may be provided by a further group of hospital midwives or by child health nurses and/or GPs. Details vary across health services.

The traditional, or ‘medical model’ has been considered normal practice since the early 20th Century. However it has significant limitations, particularly from the woman’s perspective. Care is significantly fragmented, with women frequently seeing 25 or more caregivers (Homer 2006). Consistent care is difficult for women to access when responsibility for care is distributed among so many caregivers.

Moving to continuity models

A growing body of evidence shows improving the woman’s experience and developing a partnership with a continuous carer is linked to improved health outcomes (Sandall, et al. 2009). For the greatest benefit to be achieved, research demonstrates the woman should receive care in labour and birth from a known midwife (See Appendices 1.02 and 1.03).

This level of continuity requires not only organisational change but a change in thinking and orientation for practitioners and managers who have been working in traditional models. There will be major benefits to women, community, staff and health service provision into the future, through the reorientation of care delivery to that of woman-centred continuity of midwifery care models.

Delivering care within new models requires a process of cultural change and carries significant challenges on the path to major benefits for staff and the community.
Culture of birth—current issues

Intervention

Recent years have seen dramatic increases in the rate of birth intervention. For example, in Queensland the caesarean section rate increased from 21.4 per cent in 1993 to 31.3 per cent in 2007 (Queensland Maternal and Perinatal Quality Council 2010) and increased further to 34 per cent in 2008 (Queensland Health 2009). This has significant short and long-term health consequences for women and babies.

Increasing intervention rates have highlighted the two opposing belief systems around birth: the perspective that focuses on the risks inherent in birth and the perspective that sees birth as a normal part of a woman’s life cycle. These differences are recognised in several of the government documents informing maternity reform (Department of Health and Ageing 2009; Hirst 2005; National Health and Medical Research Council 2010).

There are facilities that have a culture of collaboration which enables the perspective of both frameworks to be addressed. MGPs can function effectively alongside obstetric units with a low level of inter-professional conflict, providing women’s primary care needs effectively and ensuring timely access to medical intervention when needed. Collaboration in maternity care is discussed in greater depth in Section 11.

Adapting to changes in the midwifery profession

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

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

Midwives’ view of themselves

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

Steps in changing culture

Engagement with the profession

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

Engaging medical colleagues

It is essential to engage a range of medical practitioners in understanding and developing the midwifery continuity of care model. Medical staff are likely to understand and accept a new model of midwifery practice, if they understand how it works and are engaged and consulted early in the development process. The workforce and capacity issues in maternity care affect all professions and most doctors involved in obstetric care can see the benefits of a stronger primary care system and improved continuity of care (Masel 2009). There is also increasing recognition of consumer preference for this model, the health benefits for women and the cost
benefits for the service. Rural doctors recognise that maintaining maternity services in rural areas is critical and that these services are frequently at risk due to workforce demands.

The benefits of midwifery models in addressing these concerns may be a productive focus of engagement with doctors. It is important that communication is extensive and frank and that problem-solving is approached with goodwill on both sides.

**Cultural change for midwives providing care**

The process to review the context of a service and prepare for change has been well described (Hendry 2008). The four phases of contextual scanning are:

- describe the maternity service within its current context
- identify relevant community trends and issues
- identify relevant trends and issues in the local health service setting
- identify and prioritise key issues, internal and external relevant to the service.

These phases are ideally explored in workshops or brainstorming exercises including midwives, doctors, management staff, consumer and community representatives.

**Bumps and blocks**

Managers with a lack of understanding of Midwifery Group Practice may be tempted to remove critical elements of MGP models. There are a range of hybrid models where midwifery continuity is attempted, but significantly undermined:

- models in which midwives work as nurses as well as midwives (working shifts in other areas of the hospital whilst trying to maintain a caseload)
- models where midwives are required to work shifts and caseload in one model
- small team models in which five to six midwives work shifts and also attempt to provide some level of continuity
- large teams (10-20 midwives) where there is limited ability for women and midwives to develop relationships.

These models have been subject to a range of difficulties including industrial issues, burnout and less successful outcomes and reduced continuity of carer (Homer 2006; Sandall 1998). They are typically implemented out of concern for the midwives, but without understanding the key to a successful MGP is to give midwives flexibility to organise their time around being on-call for a cohort of named clients.

**Women’s understanding**

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

The midwifery partnership model (Pairman & McAra-Couper 2010) views the woman as the expert on herself, her body and her physical, psychological, social and cultural circumstances. Midwives in continuity of care models need to support the woman to gain confidence in this partnership. A significant amount of time may be spent supporting women to develop skills in informed decision making, requiring the midwife to be knowledgeable in evidence-based maternity care and able to share information that is non-threatening, unbiased and appropriate to the woman’s personal context.

Widely disseminated information within the community enables women to begin to understand the benefits of continuity of care and the partnership model. Growing understanding enables women in the community to more actively engage in the developing model.
A mechanism to inform and engage the community is to develop an ‘options’ booklet outlining the model of midwifery continuity of care. However this must not be used to persuade a pre-determined direction of a service but a tool to ensure open and honest communication. Another is invitation to information sessions within the community. A further mechanism is for models to support consumer organisations in holding film nights or other social functions highlighting midwifery care.

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

**Culture of collaboration**

Traditionally the role of the midwife has been to provide care under the direction of a doctor. The midwife would seek advice and ultimately the responsibility for care would rest with the doctor.

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

**Views and beliefs within the maternity unit**

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

**Ensuring medical engagement and/or co-operation**

Medical engagement and cooperation is often noted as a barrier for development of Midwifery Group Practice.

Successful implementation of Midwifery Group Practice is only possible with collaboration in maternity care across the whole team. Collaborative maternity care has been the focus of federal maternity reforms and within this framework collaboration has increased importance in health care.

> Care is best provided by qualified health professionals who work collaboratively within a high quality, tiered health service, to ensure that women receive appropriate and timely care (Australian Health Ministers’ Advisory Council (AHMAC) 2008).

Collaboration in maternity care requires defined roles and responsibilities. The National Health and Medical Research Council (2010) found that:

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

**Staff engagement**

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

Well-meaning managers often suggest rotation through MGP for all staff as a mechanism for managing antagonism or elitism. While capacity-building and opportunities for relief are important, continuity of carer is a fundamental principle for midwifery models. Any strategy which limits the time midwives spend in the model potentially means that midwives are not staffing the model for a full pregnancy. This reduces the effectiveness of the model, the satisfaction of the staff and the skills that staff develop in continuity of care. A strategy for engaging and involving staff not working in the MGP is to ask for expressions of interest to fill any periods of leave which cannot be covered within the group.

Having a specific rotational position which allows for a year in MGP will provide an opportunity for midwives wishing to develop skills in continuity of care to gain some experience. For example the Malabar MGP in Sydney (a program specifically for Aboriginal and Torres Strait Islander women) has a 12-month rotational position for an Aboriginal midwife.

References


Section 6
Clinical governance

Elements of clinical governance

- Clinical Governance
- Research and development
- Risk management
- Continuous professional development
- Clinical audit
- Evidence based practice
- Clinical practice guidelines
- Consumer participation and informed choice
- Credentialling

Overview

Clinical governance is defined as ‘the system through which health services are accountable for continuously improving the quality of services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish’ (Forster 2005).

An appropriate clinical governance structure is essential to the success and safety of any model of care, including continuity models. A state-wide clinical governance policy (Queensland Health 2007) was implemented for all health areas following a review of Queensland’s public health system (Forster 2005). The National Health Service (NHS) in the United Kingdom uses a very similar version of this framework for the entire service (Department of Health 1998; Scally & Donaldson 1998; Starey 2001).

A significant emphasis within the NHS and this guide is the engagement of consumers in the governance of care. Levels of consumer engagement range from the system level, where consumer representatives contribute to the development of the model, to the woman who is engaged at an individual level in a partnership with the midwife providing her care.

Risk management

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

Queensland Health (Queensland Health 2008c) adopted a generic risk management framework (Standards Australia and Standards New Zealand 2004 AS/NZS 4360) that indicates the process of risk management is:

- communication and consultation
- establishing the context
- identifying the risk
- analysing the risk
- evaluating the risk
- treating the risk
- monitoring and review (Homer, et al. 2008).

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

The process of establishing the context of risk within the midwifery continuity of care model is a part of the preliminary stage of development. The context could include which risks are being assessed (e.g. human resource risks, risks to women using the service, risks to the organisation). In new midwifery models of care the context of risk can also be the actual newness of the model within the health facility (Raymond, Hartz, & Nicholl 2008).

Identifying and analysing the risk

During initial planning for the model, a process of mapping the risks in relation to care has been suggested. It is important that risks are analysed using the Queensland Health model of assessment provided in Appendix 3.05 and via QHEPS: http://qheps.health.qld.gov.au/policy/docs/imp/qh-imp-070-3.pdf

This is a component of the development on any model within Queensland Health.

Evaluating the risk

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

Treating the risk

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

- use of standardised documentation (e.g. Queensland Health Pregnancy Health Record, clinical pathways)
- regular case reviews including normal care and care involving major clinical interventions
- notification and review of incidents using PRIME
- multidisciplinary participation in clinical audit.

Further examples minimise risks for the service:

- active multidisciplinary forums within and across the maternity unit that include consumer representatives
- provision of adequate staffing including adequate time allowed for continuing professional development.

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

Monitoring and review

Monitoring risks is an ongoing process. Currently within Queensland Health models there is difficulty comparing and benchmarking to other services due to a lack of consistent data collection and analysis. The establishment of a risk register which is audited on an ongoing basis is one mechanism for review of risk at the local level.

The steering committee for the local model has an important role in clinical governance and should receive a report at each meeting. A sample clinical governance report template is provided in Appendix 6.01.

Existing Queensland Health processes should be used to assist with reviewing the service such as incident and complaints system within PRIME, local or regional mortality and morbidity reports, midwives’ outcome statistics, financial reports and attendance to KPIs identified in the model of care document.

NMOQ has a key role in assisting districts to maintain governance for midwifery continuity of care models. All services must have clinical governance processes. Midwifery models require appropriate clinical governance as do all health services.
Consumer participation and informed choice

For care to be truly woman-centred, the people managing and delivering care need to hear directly from women about their needs and care.

Modern clinical governance includes processes for consumer participation in care. This occurs at the system level and at the individual level and should be audited as part of routine clinical governance audit.

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

The Queensland and Commonwealth Governments have committed to clinical care processes which recognise women’s rights to participate in their own care, make informed choices, and give consent for procedures at the level of the individual woman. Research shows that too often women receive procedures they don’t understand or don’t agree to, which puts clinicians and facilities at risk of complaints or legal actions.

Processes to support women’s informed choice and consent include:

- consumer representation on local committees and in development of policies, models of care and guidelines. For more information visit www.health.qld.gov.au/hcq/default.asp
- ensuring all staff are aware of women’s rights and clinicians’ responsibilities regarding choice and consent. See the informed consent policy at www.health.qld.gov.au/informedconsent/default.asp
- maintaining current, evidence-based written information for women on common procedures and choices
- comprehensive antenatal education for women as individuals or in a group
- continuity of caregiver, especially having a known midwife for intrapartum care
- routine formal feedback surveys and processes.

Clinical audit

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria, identification, from the review, of action to improve clinical practice and the implementation of those actions. Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery (Queensland Health, 2008b). View http://qheps.health.qld.gov.au/policy/docs/imp/qh-imp-007-5.pdf

Clinical audit is defined as a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

Key elements of clinical audit include:

- processes that identify, as much as possible, ‘near misses’ occurring in care provided, so there is recognition of the possible implications these incidents have for becoming serious adverse outcomes. Discussions stimulated from these experiences are likely to produce improvements for all staff
- morbidity and mortality review that is multidisciplinary preferably represented or led by all staff involved
- analyse more serious adverse outcomes via tools such as root cause analysis
- assessment of the impact on ‘core maternity indicators’, for example; breastfeeding rates or smoking cessation advice and decreased smoking rates in pregnancy (National Health and Medical Research Council 2010)
- where available, engage with patient safety officers.
Key Performance Indicators

Clinical outcome comparison and benchmarking with other services provides the most relevant and straightforward evaluation of a model. Key Performance Indicators will be decided by the steering committee and will be relevant to the local context. See Appendix 6.02 for the list of statewide KPIs agreed by NMOQ for midwifery models.

Professional development

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

Credentialing

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

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

Credentialing of eligible midwives is discussed in Section 13.

Research and development

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

Queensland Health provides ongoing support to research through Clinical and Statewide Services: Coordination Planning and Research Unit. See: www.health.qld.gov.au/qhcss/research/info.asp

Complaints management

Processes are required for women to provide feedback about their care and for midwives to raise concerns about the model, unit or other elements of care. Several complaints processes exist in Queensland for both. Consistency across areas of Queensland Health needs to include maternity units.

Information regarding complaints management can be found at:

Evidence-based practice

Maternity care has long been criticised as an area where practice has been based on customary practices rather than research and evidence (Cochrane 1979; Freeman, Adair, Timperley, & West 2006). An example of this is the use of continuous cardiotoographic (CTG) monitoring in low risk women. Despite no evidence to support the use of CTGs in women without identified risks (National Collaborating Centre for Women’s and Children’s Health 2007), extensive use in normal labour is prevalent.

Evidence-based practice must underpin models of midwifery care and care provided by all health care professions. Midwifery Group Practice and continuity of care produces exceptional outcomes (Appendices 1.02 and 1.03). The development of policies and clinical guidelines for Midwifery Group Practice models within Queensland Health requires critical analysis of current documents and adaptation if necessary. All policies and clinical guidelines need to be living documents which require updating as new evidence becomes available.
Clinical practice guidelines

To ensure consistency of women's clinical care, evidenced-based clinical guidelines should be the same across services. Queensland Health has a program to develop statewide clinical guidelines, led by the Queensland Maternity and Neonatal Clinical Guidelines Steering Committee. Guidelines are available to download from: www.health.qld.gov.au/cpic/resources/mat_guidelines.asp

Midwives should be familiar with relevant clinical guidelines.

If local guidelines are required due to unavailability of state or national guidelines, development processes should be multidisciplinary, include continuity of care midwives and consumers and have a process for regular review and be updated as new evidence becomes available.

References


Section 7
Costing and revenue for caseload models

Evidence demonstrates caseload models of care cost less than traditional models of maternity care. This is due to:

- flexible care delivery which is responsive to demand
- increase in spontaneous labour rates with decreases in obstetric interventions and associated reductions in costs
- decreased length of stay so decreased demand on bed occupancy
- decreased readmission rates
- increased staff satisfaction in caseload with improved retention of workforce (Collins, et al. 2010; McCourt & Page 1996; Sandall 1997; Sandall 1998).

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

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

Establishment costs

Many of the current midwifery models have been established by realigning resources and reconfiguring work patterns from traditional models with little or no additional cost (for detailed examples see the Goondiwindi Midwifery Group Practice First 12 Month Review available from the NMOQ website; and chapter six of Midwifery Continuity of Care by Homer, et al. 2008). Other models have invested additional resources to set up continuity models to serve expanding birth numbers. Some areas have channelled funding for the universal postnatal contact service to continuity models rather than add an additional component to the traditional fragmented service.

Staff costs can be re-oriented without additional costs to the District over current service provisions.

In 2006 the Mater Mothers’ Hospital introduced an MGP for young mothers in an all risk model based on a caseload of 35 women annually per midwife. Savings of $577 were identified for each woman accessing this care, and used to offset costs for equipment (K. Wilson, personal communication, March 23, 2011).

Local overhead costs should be reviewed as these vary between services and have been reported to sometimes be overinflated. Where birth centres exist, this space should be reviewed in line with Queensland Health Service Planning Benchmarks (Queensland Health 2010b) and ensure capacity is maintained at 160 births per birth centre room per annum to optimise cost savings.

Input costs

The input costs listed below (Table 1) for setting up an MGP are based on six FTE midwives providing care to 240 women per year (note that this is the maximum caseload). The definitions and detail of caseload and MGP are discussed in Section 2 and the glossary of this document.
Award levels for midwives

Often midwifery continuity models have clinical midwives at NG6 level providing caseload care. NG5 midwives also need opportunities to work in these models, in an effective framework of mentoring, professional support and guidance with clinical decision making. Models with options for both NG5 and NG6 midwives to work together are more sustainable as there are embedded succession plans within the model.

The example given below is for a model that is additional to any current service. There is no redistribution of resources in this example however it is quite feasible to introduce this model of care through a redistribution of staff, clients and resources as indicated in Table 2 below.

Costs outlined may vary locally however this provides a reasonable estimate.

Table 1. Estimate example costs for initiating MGP model

<table>
<thead>
<tr>
<th>Labour costs</th>
<th>6.0 FTE Midwives Grade 6 – 04</th>
<th>$ 809 768</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annualised salary with 30% loading as per EB7. (employee exp+SSP)</td>
<td></td>
</tr>
<tr>
<td>1.0 FTE Project Office Grade 7 – 03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 mths (employee exp NG7-03 +SSP)</td>
<td>$ 60 790</td>
<td></td>
</tr>
<tr>
<td>0.5 FTE A03 – 03 (employee exp+SSP)</td>
<td>$ 35 726</td>
<td></td>
</tr>
<tr>
<td>Non labour</td>
<td>Mobile Phone / pager</td>
<td>$ 3 000</td>
</tr>
<tr>
<td>Recurrent</td>
<td>Computer costs / remote access</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Printer costs</td>
<td>$ 549</td>
</tr>
<tr>
<td></td>
<td>Stationary costs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Admin costs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Car lease /reimbursement motor vehicle</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical supplies</td>
<td></td>
</tr>
<tr>
<td>Non Labour</td>
<td>Clinical equipment (1 set per midwife):</td>
<td></td>
</tr>
<tr>
<td>Non Recurrent</td>
<td>Doppler</td>
<td>$ 1 000</td>
</tr>
<tr>
<td></td>
<td>Scales</td>
<td>$ 400</td>
</tr>
<tr>
<td></td>
<td>Ophthalmoscope</td>
<td>$ 800</td>
</tr>
<tr>
<td></td>
<td>Otoscope</td>
<td>$ 800</td>
</tr>
<tr>
<td></td>
<td>Stethoscope</td>
<td>$ 250</td>
</tr>
<tr>
<td></td>
<td>Sphygmomanometer</td>
<td>$ 200</td>
</tr>
<tr>
<td></td>
<td>Practice bag</td>
<td>$ 400</td>
</tr>
<tr>
<td></td>
<td>Emergency birth kit</td>
<td>$ 700</td>
</tr>
<tr>
<td></td>
<td>Breast pump and attachments</td>
<td>$ 500</td>
</tr>
<tr>
<td></td>
<td>Computers</td>
<td>$ 6 102</td>
</tr>
<tr>
<td></td>
<td>Office furniture and equipment</td>
<td>$ 6 220</td>
</tr>
<tr>
<td></td>
<td>Client educational equipment</td>
<td>$ 3 000</td>
</tr>
<tr>
<td></td>
<td>· AN education and class or groups information and equipment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Educational DVDs</td>
<td>$ 3 600</td>
</tr>
<tr>
<td></td>
<td>· Reference Library</td>
<td>$ 2 000</td>
</tr>
</tbody>
</table>

$ 935 805
For private motor vehicle usage refer:
- Midwives should seek individual tax advice as they may choose to claim their private motor vehicle use as a work related tax deduction on their personal tax return rather than be reimbursed through the pay system.

**Business planning**

Once the vision for the maternity service and model has been determined, the Business Planning Framework (BPF)—tool for workload Management 2008 (Queensland Health 2008a) will guide development of the relevant service business or operational plan www.health.qld.gov.au/ocno/documents/BPF.pdf It may be useful to collaborate with an established comparable midwifery model and review their BPF.

Matching supply of midwifery resources to a service is an integral part of a business plan. Developing a clear and complete outline in planning for the service and following the BPF principles will provide longevity and limit the need for repetitive business cases as the service grows. An example of a business case is in the appendix of the BPF tool. The Queensland Health BPF tool is a comprehensive reference and education resource which will assist in determining human resource requirements in the context of the demands placed on the service. This process should result in effective management of midwifery resources and workloads within a service.

This approach to workload management focuses on balancing demand and supply of resources to meet the identified demand.

**Service Demand = meeting woman’s needs by considering factors such as:**
- acuity
- activity
- targets
- layout and work environments
- supply
- service quality
- consumer and staff safety
- model of service delivery
- financial outcomes
- initiatives & policy direction and directives
- public/private interface.

Each stage of the process should not be considered in isolation or as separate from the desired outcome of developing a business/operational plan. The principles of the framework can be applied to a variety of health care services in rural, remote, tertiary, regional and community settings where midwives are employed by Queensland Health. Therefore the business plan will identify specific needs of a service and assist to determine issues such as:
- if one FTE midwife can carry a workload of 40 women per year or if the profile of the service identifies this caseload should be reduced
- upskilling requirements of midwives
- orientation period to the model.

Lobbying with partners and stakeholders for changes proposed within the business plan may be essential to gain support. Ensuring key Queensland Health target areas are being addressed and the proposal aligns to best practice quantitative and qualitative evidence makes for a strong business plan and provides measurable indicators that can be matched for evaluation of the service. For example 'one-to-one' midwifery care in labour (Queensland Health 2011).

The framework is depicted in the diagram below.
1. Develop a service profile
   - Aims
   - Objectives
   - Environmental analysis
   - SWOT analysis
   - Activity
   - Acuity/complexity

2. Resource allocation (supply)
   - Service demand
   - Activity
   - Acuity/complexity
   - Other factor

3. Evaluate performance
   - Routine monitoring performance against the plan
   - Scorecard reporting
   - Analysis of the balance of demand for services/activity with resources allocated

Costing

Examples below are based on:
- cost comparison using Business Planning Framework budget workup sheet
- a comparison of wages and on-costs between a Clinical Nurse Midwife Nursing Grade 6—04 Midwife who works full shift work; and a Clinical Nurse (Nursing Grade—04) Caseload (MGP) Midwife who carries a caseload of 40 women per year.

NB: cost variations may vary in relation to the locality of service and associated staff entitlements, and workload management practices.
Table 2. Comparison of costs: Midwifery Core Staff and Caseload Midwife

<table>
<thead>
<tr>
<th>Clinical Midwife – Core staffing arrangements  NG6-04</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary and Wages</td>
<td>$ 79 431</td>
</tr>
<tr>
<td>Overtime @ 10%</td>
<td>$ 7 943</td>
</tr>
<tr>
<td>Penalties @15%</td>
<td>$ 11 915</td>
</tr>
<tr>
<td>Clinical non lab expense</td>
<td>$ 6 233</td>
</tr>
<tr>
<td>SSP</td>
<td>$ 2 542</td>
</tr>
<tr>
<td>Allowances</td>
<td></td>
</tr>
<tr>
<td>Misc Other Allowances</td>
<td>$ 2 339</td>
</tr>
<tr>
<td>Annual Leave back filling &amp; Leave Loading</td>
<td>$ 8 813</td>
</tr>
<tr>
<td>LSL Levy</td>
<td>$ 1 847</td>
</tr>
<tr>
<td>Sick Leave Backfill</td>
<td>$ 3 050</td>
</tr>
<tr>
<td>Professional Development Days</td>
<td></td>
</tr>
<tr>
<td>Training Days</td>
<td>$ 915</td>
</tr>
<tr>
<td>Superannuation @ 12.75%</td>
<td>$ 13 748</td>
</tr>
<tr>
<td>Workcover Premium @ 1.5%</td>
<td>$ 1 892</td>
</tr>
<tr>
<td>Professional Development</td>
<td>$ 1 500</td>
</tr>
<tr>
<td>Rural Area Nursing Incentive Package (RANIP) Allowance</td>
<td>$ 2 000</td>
</tr>
<tr>
<td>Temp-Medical</td>
<td></td>
</tr>
<tr>
<td>Temp-Nursing</td>
<td></td>
</tr>
<tr>
<td>Temp-VMO</td>
<td></td>
</tr>
<tr>
<td>Temp-Health Practitioner</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>$144 168</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Midwife – Caseload NG6-04</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary and Wages (annualized salary @ 30%)</td>
<td>$103 260</td>
</tr>
<tr>
<td>Overtime @ 10%</td>
<td></td>
</tr>
<tr>
<td>Penalties @ 15%</td>
<td></td>
</tr>
<tr>
<td>Clinical non lab expense</td>
<td>$ 6 233</td>
</tr>
<tr>
<td>SSP</td>
<td>$ 2 542</td>
</tr>
<tr>
<td>Allowances</td>
<td></td>
</tr>
<tr>
<td>Misc Other Allowances</td>
<td>$ 2 339</td>
</tr>
<tr>
<td>Annual Leave back filling &amp; Leave Loading (no backfilling)</td>
<td>$ 1 406</td>
</tr>
<tr>
<td>LSL Levy</td>
<td>$ 2 188</td>
</tr>
<tr>
<td>Sick Leave Backfill</td>
<td></td>
</tr>
<tr>
<td>Professional Development Days</td>
<td></td>
</tr>
<tr>
<td>Training Days</td>
<td>$ 915</td>
</tr>
<tr>
<td>Superannuation @ 12.75%</td>
<td>$ 13 282</td>
</tr>
<tr>
<td>Workcover Premium @ 1.5%</td>
<td>$ 1 838</td>
</tr>
<tr>
<td>Professional Development</td>
<td>$ 1 500</td>
</tr>
<tr>
<td>Rural Area Nursing Incentive Package (RANIP) Allowance</td>
<td>$ 2 000</td>
</tr>
<tr>
<td>Temp-Medical</td>
<td></td>
</tr>
<tr>
<td>Temp-Nursing</td>
<td></td>
</tr>
<tr>
<td>Temp-VMO</td>
<td></td>
</tr>
<tr>
<td>Temp-Health Practitioner</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>$137 503</td>
</tr>
</tbody>
</table>
Considerations when implementing caseload (group practice) model

It is essential that if this model is under consideration it can be demonstrated:

- there is a critical mass of midwives willing (or who are able to be supported) to work within such a model of care
- the model is self-sustaining in the face of resignations and departures from the facility (succession planning is integral)
- there is support and collaboration with relevant medical colleagues such as obstetricians, general practitioners and obstetric registrars (may be off-site support)
- National Midwifery Guidelines for Consultation and Referral (ACM 2008) is understood by all practitioners
- the clinical governance structures around the model meets the best practise requirements.

Revenue for caseload (Group Practice) based on six FTE midwives—240 births per year

This generalised model was constructed using inlier payments for DRGs and clinic attendances (Queensland Health 2010a) and supports the premise that a caseload midwifery model of care can be a financially viable proposition within the existing structure of a Queensland Health maternity service.

Antenatal (AN):

The average number of antenatal appointments a woman currently attends and is supported in the Queensland Health Personal Health Record documentation is 10. The funding available per antenatal visit is $165.

\[
10 \text{ AN visits} \times 240 \text{ woman} \times \$165 = \$396 \text{ 000.00}
\]

Birth or Intrapartum (IP):

<table>
<thead>
<tr>
<th>DRG (Phase 14)</th>
<th>Peer Group</th>
<th>DRG Payment per case</th>
</tr>
</thead>
<tbody>
<tr>
<td>060Z - Vaginal Delivery</td>
<td>M1</td>
<td>$4,299.94</td>
</tr>
<tr>
<td></td>
<td>M2</td>
<td>$4,063.39</td>
</tr>
<tr>
<td></td>
<td>L3</td>
<td>$3,887.85</td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>$3,754.16</td>
</tr>
<tr>
<td></td>
<td>CSO</td>
<td>$2,946.67</td>
</tr>
</tbody>
</table>

With current activity across QH Facilities the CSO cost of $2,946.67 DRG payment per case, for women in a caseload (MGP) model.

\[
240 \text{ woman} \times \$2,946.67 \text{ per birth} = \$707 \text{ 201}
\]

Postnatal (PN)

Caseload models of care include postnatal care to six weeks postnatally. On average the woman and her baby are visited or telephoned seven to ten times during the six week period. Visits are variable due to discharge timing and in response to the woman and baby’s needs. Additionally babies will receive newborn care and physical assessments during this period.

\[
8.5 \text{ PN visits} \times 240 \text{ woman} \times \$165 \text{ per visit} = \$336 \text{ 600}
\]

\[
8.5 \text{ PN visits} \times 200 \text{ babies} \times \$165 \text{ per visit} = \$280 \text{ 500}
\]
Table 3. Revenue for caseload model for 240 women per annum

<table>
<thead>
<tr>
<th>Aspect of care</th>
<th>Activity</th>
<th>Revenue for 240 women per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td>AN CARE</td>
<td>10 visit @ $165/visit x 240 women</td>
<td>$396 000</td>
</tr>
<tr>
<td>BIRTH</td>
<td>CSO DRG cost @ $2 946.67 X 240 women</td>
<td>$707 201</td>
</tr>
<tr>
<td>PN CARE</td>
<td>8.5 Visits @ $165/visit x 240 women</td>
<td>$336 600</td>
</tr>
<tr>
<td></td>
<td>8.5 Visits @ $165/visit x 200 babies</td>
<td>$280 500</td>
</tr>
<tr>
<td><strong>Total earnable revenue</strong></td>
<td></td>
<td><strong>$1 720 301</strong></td>
</tr>
</tbody>
</table>

**Note:** costings will probably need to be adjusted under new funding arrangements.

This model of care is clearly sustainable within Queensland Health’s casemix funding model. Depending on local overhead cost, existing maternity services should be able to use casemix to convert a proportion of births into a new model of care with no additional recurrent funding.

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

**References**


Section 8
Industrial issues

The annualised salary

Midwives working in caseload models in Queensland Health services are covered by special provisions within the Award. They do not work shifts, they organise their work time according to the needs of their women and as negotiated within their MGP and their line manager.

Caseload midwives are paid an annualised salary as outlined in the current industrial award schedule 9 (Midwifery models of care) copied in Appendix 8.01. Current awards and agreements may be found at:


Key elements of the annualised salary award for caseload midwives

• Caseload midwives are paid a loading (at the time of writing this was 35 per cent) on top of award rates. The loading compensates caseload midwives for not receiving penalty allowances, holiday leave loading and other items normally paid to shift-workers listed in the award.

• Caseload midwives receive standard annual leave, family leave, maternity leave, professional development leave and all other aspects of Queensland Health awards.

• Midwives on annualised salaries work an averaged 76 hour fortnight instead of an 80 hour roster each fortnight, therefore midwives on annualised salaries do not receive a rostered day off each month.

• The 76 hour fortnight is averaged over eight weeks of work.

• Midwives can provide continuous care for up to 12 hours, after that time the current award requires the midwife to hand over care. They may hand over care at eight hours or as required due to fatigue.

• Under the award, local agreements for annualised salaries and associated working arrangements are negotiated between stakeholders.

Please note: Awards are periodically re-negotiated so it is important to check the current award.

Working groups

The award requires a working group to be established before a midwifery model of care is developed. This group includes local midwives with an interest in working in the model, local midwives who may be affected by the model, Queensland Health managers, the Queensland Nurses Union (QNU), universities and other key stakeholders to consider the appropriate midwifery model.

The development of a working group, steering committee or reference group, including consumer representatives, is required practice and is described in more detail in Sections 3 and 4.

Local agreements—process

The award requires local agreements to be developed to support the midwifery model of care. An early step in most districts would be to raise the development of a midwifery model of care at the district Nursing and Midwifery Consultative Forum. A working party would then be established to draft the agreement with appropriate representation from management staff, midwifery staff and the QNU.

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

The impact on staff should become clear through good communication and understanding of the model of care document. Mapping should be done to ensure the appropriate service and staffing levels will be achieved through the business planning framework. There must be plans for ongoing communication and staff meetings.

Once complete, local agreements are signed off by the CEO and the QNU.

A sample local agreement template is provided in Appendix 8.02.

Local agreements—content

Local agreements should specify:

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

Other issues to be considered for inclusion in local agreements:

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

Work arrangements must consider how this work will be practically undertaken, the resources that will be provided and the level of remuneration that can be expected.
Example:
A new MGP model is implemented in a rural community. The Emergency Department (ED) has previously referred clients with women’s health issues to the maternity unit or requested the assistance of the midwives on-shift to attend the women in ED. With the maternity service now operating a 24 hour on-call caseload midwifery arrangement, whose responsibility will it become to care for unbooked women who present at the hospital?

Possible solution:
• include emergency maternity admissions in on-call responsibilities of MGP midwives
• review numbers of unbooked women in previous years
• include estimates in annual case load numbers for MGP midwives.

Support needs for midwives working in continuity models must be agreed and articulated clearly for development of the local agreement and maintaining internal working relationships with colleagues.

Given no one size will fit all maternity locations or client needs, formal agreement is required to monitor and audit staff wellbeing and satisfaction. This is required for safety and sustainability, helps to inform refinement of the model and supports workforce planning.

The certified agreement stipulates that new models survey staff at six months. A survey tool has been used in a number of services to ascertain midwives’ needs in respect of industrial satisfaction.

How many women per year per FTE?

In the process of determining the local agreement it is paramount to ascertain the level of midwifery care the population will require. For example more time may be needed to accommodate the needs of Indigenous women or young women compared with the general maternity population. Within the certified agreement one FTE usually equates to a midwife caseload of up to 40 women per year. However agreement should be reached on a safe achievable case load per FTE for populations requiring more of a midwife’s time. This might include building trusting relationships with Indigenous or homeless women to encourage their access to care across the continuum for both themselves and their babies.

Rural and regional services have extra considerations in determining caseload levels:
• travel times for antenatal and postnatal appointments
• clinical capability of unit including birth services and potential times required to provide birth care
• availability and access for consultation and referral of care and time taken to transfer care
• additional time required to complete clinical tasks due to less efficient equipment or lack of equipment
• time required to support and mentor graduate colleagues into continuity of care roles, particularly if model is isolated from other midwives or support services
• services provided in addition to maternity care, including:
  – lactation consultancy services
  – pap smears
  – pathology collection and specimen examination and analysis
  – vaccination services
  – healthy hearing screening
  – longer postnatal hospital stays (e.g. post caesarean section)
• Data collection and/or analysis.
**Bumps and blocks**

The number of women per FTE midwife per year is determined by counting the number of women who book, not the number of births. If births are counted instead of bookings, the work caring for women who are transferred prior to birth or during labour, or who miscarry, is not accounted for.

This is particularly important in rural models. Women with complexities will receive their midwifery care (and often GP obstetric care) in the rural facility antenatally and postnatally, but may birth at a referral hospital (with or without their caseload midwife). Thus rural caseload midwives can be expected to provide midwifery care to a significantly higher number of women than local birthing numbers.

**Orientation and professional development**

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

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

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

The certified agreement includes provision in continuity models for a graduate midwife position and this could be provided within a mentorship program. This is discussed in Section 9 Professional Development.

**Industrial matters – what works well**

It is known that midwives working in MGP models experience satisfaction and sustainability when midwives can build meaningful relationships with women, where they have occupational autonomy and social support at work and at home (Fereday & Oster 2010; Sandall 1997). Conversely Sandall (1998) found high burnout in team midwifery models.

Service reviews of Australian MGPs have found high satisfaction for midwives working in a birth centre in a major hospital (Gold Coast) and tertiary centres without separate birthing facilities (Mater Brisbane and Adelaide Women’s and Children’s Hospitals) (Collins, et al. 2010; Moore 2009; Toohill 2008). In the Adelaide Women’s and Children’s Hospital (Collins, et al. 2010), 1000 of the 4000 birthing population were cared for within the MGP caseload arrangement (Cornwell, Donnellan-Fernandez & Nixon 2008). More study on midwives’ work satisfaction is needed, given current and predicted workforce recruitment and retention concerns.
References


Section 9
Professional development and capacity building

Overview

My midwife’s care was holistic. I received:
• nutritional advice for myself and my family
• emotional support and counseling
• evidence-based information relevant to all aspects of pregnancy, birth and post-natal care as well as information drawn from her own experience.
• standard ‘technical’ midwifery care associated with my physical wellbeing
• breastfeeding advice and support
• respect for my choices and ideas and beliefs
• a carer I respected and trusted
• physical and emotional preparation for the post-natal period and motherhood
• resources and referral for additional support or assistance if I needed it at all stages of the child-bearing ‘year’.

(submission, Review of Maternity Services in Queensland)

Midwives moving into a continuity model of care have particular professional development needs. Staff establishing new continuity models need to plan specifically for this.

Midwifery is undergoing a significant transition as a profession. At the professional level, there is a strong move to providing continuity of care. Equally significant steps include the separation of midwifery and nursing as two distinctly regulated professions and graduation of increasing numbers of midwives who are not nurses. For maternity service managers, this means that development of midwifery models, especially providing continuity of care across the full scope of practice, will be required to attract and retain their midwifery workforce.

It is important to note that continuity models require staff to maintain competence across the normal scope of practice for a midwife, which is not advanced practice. For this reason, and because philosophical orientation is so important, new graduates can be ideal recruits.

Midwives in continuity models have increased autonomy, accountability and competency requirements in their clinical practice relative to many conventional models. However there are also professional development needs that relate to the philosophy of care in continuity models and the different relationship this leads to with women. This is discussed in Section 4 in greater detail. Planning and preparation for midwifery continuity of care models must include adequate professional development and upskilling. It is not possible to simply rely on award provisions to provide this level of support.

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

All midwives

All midwives are responsible for their own ongoing professional development and competency. National registration requires all registered midwives to provide evidence of continuing professional development (CPD) and provide annual documentation of at least 20 CPD points. For more information refer to the Australian Health Practitioner Regulation Agency (AHPRA) website www.ahpra.gov.au
Each midwife working in Queensland Health has access to two elements within the award to assist them with professional development: a leave entitlement and a professional development allowance. Section 8 – Industrial issues covers the award and provides current links.

The ACM (www.midwives.org.au) has a formal continuing professional development program (MidPLUS) and a peer review process called Midwifery Practice Review (MPR) providing a good starting point for midwives and managers to plan professional development. Queensland Health supports these initiatives and encourages midwives and their line managers to incorporate the programs within their performance assessment and development (PAD) processes.

A staged approach to professional capacity-building for MGPs

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

- develop an understanding of the philosophy of midwifery continuity of care models
- examine their own beliefs
- meet with an experienced continuity of care midwife and manager to undertake a clinical skills assessment using the Australian College of Midwives skills inventory or similar document
- review non-clinical skills with the support of a mentor. The personal attributes and non-clinical skills of the midwife are listed under attributes of midwives working in continuity of care models in Section 10
- write a professional development plan using the ACM professional development plan or Queensland Health professional development proforms
- spend time with midwives already providing midwifery continuity of care prior to implementation
- arrange support by a midwifery mentor in a formal mentoring process
- undertake Midwifery Practice Review or equivalent professional review process within a time frame decided by the midwife and manager
- mentor to encourage the midwife to reflect and evaluate the clinical outcomes in the continuity of care model after a period of time.

Development of personal beliefs and philosophy

Attributes of a midwife working in this model

«The midwife began her regular visits with us, discussing everything with me from the anatomy of the pelvis to tiredness. She was never prescriptive or judgmental, just kind and respectful and experienced.»

(Review of Maternity Services in Queensland)

A range of attributes of the midwife working in continuity of care models are listed by Pelvin (2010):

- Empathy
- Commitment
- Decisiveness
- Boldness
- Generosity
- Companionship
- Integrity
- Curiosity
- Reflectiveness
- Positivity
- Honesty
- Robustness and resilience
- Practicality
- Friendliness

These attributes may come naturally to the midwife. However the midwife may, through personal development processes, strengthen some of these attributes.

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

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

I never thought I would be able to work this way, I thought it was rubbish. Now I could not go back, I couldn’t change back to fragmented care no matter what the obstacles are. I feel like my eyes have been opened in a way that I never thought possible.

(MGP midwife, Toowoomba)

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

Midwives provide care in partnership with women (Australian Nursing & Midwifery Council 2006). The word partnership is defined as having a ‘professional friend’ (Pairman 1998; Pairman & McAra-Couper 2010).

In continuity models, instead of providing health care to or for a patient or client:
The midwife and the woman work together in a particular way that integrates the notions of ‘being equal’, ‘sharing common interests’, ‘involving the family’, ‘building trust’, ‘reciprocity’, ‘taking time’ and ‘sharing power and control’.

(Leap & Pairman 2010)

The shift to working in this way requires the midwife to evaluate, and perhaps challenge, their beliefs about midwifery and the partnership with women. Potentially the most useful way to make this transition is to spend time with other midwives working this way and to speak with women who have received this care. Many midwives will benefit from reading or researching the essence of continuity of care. Vernon (2007) has a number of stories of midwives moving in to continuity of care.

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

Clinical skills assessment

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

The Australian College of Midwives Skills Inventory gives the midwife a clear picture of the clinical skills required to work across the full scope of practice. This resource is available to midwives enrolled in MidPLUS. The list of skills includes clinical skills that may fall outside the familiar scope of practice for some midwives.

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

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

The ACM Skills Inventory provides the starting point for a professional development plan, which is then used by the midwife in preparing for Midwifery Practice Review (MPR). The MPR process is discussed in detail further in this section.
Midwives working in continuity of care will need a range of skills that promote physiological birth and may not be in daily use in traditional care. These include using a variety of non-pharmacological methods of pain relief in labour including water immersion and water birth, and management of physiological third stage.

**Mareeba**

Mareeba has a population of approximately 8,000 and is 64km from the closest obstetric maternity service in Cairns, North Queensland. In 2005, Mareeba Maternity Unit set up a midwifery model when local medical availability was declining. The hospital has a Midwifery Group Practice with six caseload midwives. In addition, core midwives are rostered to the combined maternity-paediatric unit and provide in-hospital care to maternity clients.

Local GP obstetricians perform elective LSCS at Mareeba, but there is no formal on-call GP obstetric service. Intrapartum obstetric backup is provided remotely from Cairns Integrated Women’s Health Unit with most women who develop complications being transferred to Cairns Base Hospital. In addition to full continuity of care for pregnancy, labour and birth and postnatal to six weeks in the community, the MGP midwives provide pre-conception, pregnancy counselling, order pathology and ultrasound tests, and undertake well women checks including pap smears (S. Eales, personal communication, March 11, 2011).

**Communication, leadership and research**

Communication is a fundamental skill for any clinician, essential for safe practice and effective collaboration. It is important that midwives reflect and critically review their skills in communication with a mentor, trusted colleague and/or previous client. The communication skills of the midwives working in midwifery continuity of care models need to be excellent. Midwives will be assessing their communication skills as part of their professional development assessment and may include upgrading these skills in their professional development plan.

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

**Bumps and blocks**

The language we use as maternity care clinicians has a big influence on the care we provide and on the experiences of women and their families. How do women feel about being referred to as ‘patients’ or ‘ladies’, or being ‘delivered’ or ‘managed’? When performing invasive procedures, are we asking for consent in a way which recognises that the woman has a choice? What language can we model for colleagues, and use to help the woman feel in control, instead of feeling intimidated by a powerful institution and its staff? (Blyth 2005).

It is important that language and communication does not reinforce ‘opposite thinking’ (e.g. good versus bad, health versus illness, safety versus risk) (Leap & Pairman 2010). Midwives and managers working within continuity of care need to be acutely sensitive of the effect of words, the power relationships as experienced by women, and to use language which helps women to maximise their sense of power.

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

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

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

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

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

Upskilling

After assessment and professional development planning, the next stage of capacity building is the upskilling of the midwives who will provide midwifery care.

Midwives working within continuity of care models need to have had sufficient recent exposure to a wide variety of clinical situations. Multidisciplinary emergency skills activities such as MaCRM or ALSO and neonatal resuscitation programs provide the midwife with opportunities to practice skills and gain confidence.

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

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

Upskilling of midwives can also include informal processes where midwives spend time engaging with consumers and consumer organisations or time where midwives review available resources such as DVDs or other web based resources on relevant areas, such as physiological birth.

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

Managers supporting clinicians to upskill for work in midwifery group practice can also take the opportunity to consider and update their own skills. Many managers of MGPs are not midwives or they may not have practiced across the full scope of these models. It is important for managers to recognise the limitations of their skills, and be aware when it is necessary to engage support and advice from midwife managers with continuity of care experience. NMOQ or the Australian College of Midwives Queensland can provide support and advice to managers about many aspects of these models. There are also a number of successful models across Queensland where managers or previous managers can be engaged for support.

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

Mentoring

Clinicians and managers establishing and maintaining continuity of care models may benefit from mentoring by midwives and managers who have expertise in continuity of care.

Mentoring is a process that encourages reflection, support, learning and professional development in a relationship between an experienced member of staff (mentor) and a less experienced person (mentee) (Stewart 2009). The mentoring relationship is one of negotiated partnership. Key elements of a mentoring relationship are:

- to enable and develop professional confidence
- the duration and structure of the mentoring process is mutually defined and agreed by each partner
- the mentor listens, challenges, supports and guides the mentored midwife
- the mentor encourages the mentored midwife to research, explore and reflect on her practice (Stewart 2009).

Professional engagement between midwives who are working in continuity of care models and those moving into continuity of care provides a valuable opportunity for informal mentoring and support but this does not address the need for formal mentoring.

Mentoring processes are being developed to support midwives who are working in MGP in Queensland. The mentoring process will require a formal commitment from both the mentor and mentee in a six month process. At the completion of the process the midwife will participate in a review which also addresses how the midwife has addressed professional development needs. A pilot of a mentoring process will occur in early 2012 within Queensland Health (contact the Midwifery Advisor, NMOQ for information).

Midwifery Practice Review

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

Midwives undergoing MPR firstly develop a professional portfolio which documents their professional development, clinical outcomes, their reflections on their practice and a synopsis of this portfolio. The MPR process provides an opportunity for midwives to reflect on their practice in relation to the ANMC Competency Standards (2006), to develop documentation about their context of practice, to discuss their professional development and to create a plan for future ongoing professional development. The midwife registering for MPR will receive a range of documents to support this and is given a date for the review process to take place. The midwife then submits the synopsis of their portfolio to the ACM.
The professional review is a formal process where the midwife has a structured conversation with formally trained and accredited reviewers—one midwife and one consumer. The midwife’s professional development plan is discussed within the review and is considered by the reviewers relative to the information they have gathered. The MPR is formally written up and the midwife being reviewed and the reviewers all sign the documentation. MPR is conducted every three years.

For more information see the ACM website: www.midwives.org.au

Evaluation of outcomes and maintenance of skills

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

Key performance indicators will include a range of outcomes. It is important that data is collected, reviewed and evaluated so that midwives can review their own outcomes relative to their skills and the population of childbearing women they serve.

Bumps and blocks

The aims and philosophy of the unit, management, individual midwives and medical practitioners ultimately impact on the outcomes of each midwife’s care. For example inclusion and exclusion criteria that are not woman-centred, timing for the first midwife visit, on-call and working arrangements of the midwives may all significantly impact outcomes.

Summary of processes for professional development

Note: the elements below apply to midwives in any setting and many midwives will already have achieved many of them.

• **Skills assessment.** Before the midwife commences clinical care, the midwife should meet with a midwifery educator, senior clinical midwife, mentor or manager and complete a personal skills assessment tool (e.g. ACM) and an individualised organisational orientation for the role. In smaller facilities, a relationship with the regional centre may be required to assess the baseline skills of the midwives working in the new model.

• **Development of a professional development plan.** Midwives reviewing their skills will then create a plan to meet areas of need.

• **Upskilling** will then occur to meet needs.

• **Experience.** Midwives commencing practice in continuity of care models need to work alongside an experienced continuity of care midwife in an established model to gain greater understanding of continuity.

• **24/7 clinical support for midwives.** During the initial (suggested time frame six months) implementation period, identify an experienced continuity of care midwife to provide after-hours/on-call clinical support for midwives who have not worked in such a model previously. Midwives also need strong links and supportive relationships with core staff who will provide clinical support.

• **Mentoring** programs need to be provided.

• **Clinical skills training.** Midwives should attend clinical maternity skills courses such as MaCRM or ALSO and neonatal resuscitation courses. Attendance at midwifery skills courses should also be considered.

• **ACM Guidelines for consultation and referral** are used to support decision making for collaboration.

• **Queensland Health Clinical Guidelines** should be known and used by all midwives.
• **Midwifery Practice Review (MPR)**, organised by the ACM, is a formal, transparent, nationally consistent peer review mechanism that supports midwives to regularly reflect on their portfolio, their own midwifery practice and future professional development plans or identified needs. MPR is a recommended quality control tool.

• **Evaluation** of each midwife’s outcomes should occur at 12 month intervals and be used to inform their ongoing professional development plan.

**Clinician networking**

Midwives transitioning to MGP models can benefit greatly from becoming professionally engaged with colleagues working in similar models across Queensland and Australia. This brings the opportunity to informally and formally reflect and compare models and practice. Social networks and electronic communication make it possible for midwives located significant distances apart to remain professionally engaged.

The Australian College of Midwives, universities and other organisations have a variety of forums to enable midwives to engage with each other. Midwives Australia has developed a website forum to enable midwives working in continuity to speak to each other over the internet www.midwivesaustralia.com.au

**References**


Section 10
Midwifery practice in continuity models

Introduction
Understanding midwifery practice in continuity models is essential to all Queensland Health maternity services. This section gives an overview and examples of midwives’ practice in continuity models. We strongly recommend staff developing or working in midwifery continuity models read “Midwifery Continuity of Care, A Practical Guide” by Homer, Brodie and Leap (2008) for more comprehensive information.

Philosophy
Working in midwifery continuity of care practice may require a change in the way midwives think, speak and provide care. The partnership between the woman and the midwife is likely to be different from any other clinical roles the midwife has experienced. Women are considered the expert in themselves and hold the ultimate power in decisions about their birth and their care. Midwives in continuity of care models will be working in a different context and therefore need support and guidance to make this transition.

The key principles in providing continuity of care have been identified by Sandall (1997) and presented in Homer, Brodie and Leap (2008):
• an ability to develop meaningful relationships with women, meaning that midwives offer continuity of carer, rather than being on-call for women they do not know
• occupational autonomy and flexibility so that midwives are in control of, organise and prioritise their own work
• support at home and at work including midwives meeting frequently to discuss practice issues, reflect on their work, share information and to ensure that they know when individual midwives may need more support due to home issues.

Responsibility and autonomy
Midwives who provide continuity of care take a leading or coordinating role for individual women’s maternity care. Compared to standard care, this gives the midwife greatly increased responsibility for their practice and for the woman and her baby’s outcomes within the usual scope of practice of the midwife.

Autonomy means self-determination, the ability to be self-governing. The concept of autonomy in midwifery is used to provide understanding that midwifery is distinct from nursing and medicine in that it has its own distinct body of knowledge. The midwife also has her own individual knowledge making it possible to make decisions and determine actions within the midwifery context ‘in her own right’ without reference to others (Pelvin 2010).

Evidence-based practice
Understanding and being able to apply evidence to decision making is critical. Units making the transition to providing continuity of midwifery care may face opposition. Therefore it is essential the midwives must be able to back up their decisions with evidence:
• Professional engagement is essential to remaining up to date with evidence and research in maternity care.
• Skills in sourcing and analysing information about maternity care are an advantage, but may well be the role of a few individuals within the group.
• Midwives’ attendance at professional midwifery seminars, workshops and conferences will assist in seeking information to support their practice.
• Engaging with consumer organisations is another mechanism to source and reflect on evidence.
• Find a few sources of evidence (e.g. Cochrane database) that you can regularly review to support decisions.
• When faced with a decision about care where you are uncertain, seek support and guidance from a mentor or another midwife.
• If challenged on an area where you are not certain or face opposition, seek a supportive forum in which to revisit the decision, engage other clinicians and seek a range of information sources about the decision.

Most midwives on initial discussion indicate that they take full responsibility for midwifery care to the full scope of practice. Yet at times statistical analysis of transfer rates, reasons for transfer and outcomes indicate that midwives may lack confidence across the scope and respond with high rates of transfer. It is important that this risk is recognised by midwives and that they are supported by an appropriate mentor in developing their skills in communication and collaboration, and with an understanding of consultation and referral processes and guidelines.

Bumps and blocks
Midwives may feel unable to ‘stand on their own two feet’. They may find it difficult to make and own decisions when providing care. This may be exacerbated because the views and philosophy of the managers and medical staff within the unit do not support continuity of midwifery care. Smooth working of the models relies on the acceptance of the midwife as an equal member of the multidisciplinary team. The NHMRC National Guidance on Collaborative Maternity Care (2010) has been endorsed by Queensland Health and is the appropriate basis for collaboration within the unit. Engagement with consumer groups, midwifery professional organisations and NMOQ is also helpful in building a culture of respect and collaboration. It is critical that each midwife has a clear professional development plan and is supported by experienced continuity of care midwives through mentoring plans or programs.

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

Partnership between the woman and her primary midwife
The fundamental partnership in continuity of care models is between the midwife and the woman. In providing continuity of care midwives are developing a partnership with a woman that provides a different level of care to working in fragmented models of care. The partnership between a woman and her midwife is described by Pairman (Pairman & McAra-Couper 2010) as a ‘professional friendship’.

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

Those who view midwifery as a sub-speciality of nursing may be challenged by elements of the professional friendship that is a partnership. The Midwives Guide to Professional Boundaries (ANMC 2010) recognises that the context in which the care is provided has a
A guide to implementation

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

**Bumps and blocks**

Due to the close partnership midwives in caseload models form with women in their care, they usually come to know the needs and wants of women and are better able to support them. In mainstream models it is more difficult to advocate for a person you have only just met. Midwives working in continuity of care models may therefore appear or be labelled as more outspoken when in fact they are fulfilling their professional role ensuring women are understood and provided with informed choice.

Some staff (midwives, obstetricians, managers) may find this level of partnership challenging. It may pose a particular challenge where the continuity of care midwife provides care for a woman who chooses care contrary to existing policy. A clear understanding of the woman’s right to make informed choices is necessary for all staff. ‘Informed choice’ situations should be used to enable review of policy and to develop shared understanding of the needs and rights of women with unconventional preferences or needs.

**Working together**

A key element of MGP is the way in which midwives work together to provide care.

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

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

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

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

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

The needs of midwives working this way are paramount and if difficulties arise between colleagues it is important for those supporting the caseload to quickly recognise and support ways of resolving the situation.
Interactions within the whole MGP

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

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

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

Delivering continuity in midwifery models

Since the development of midwifery models, two distinct model of care types have
developed. These are caseload models and team models, which are defined in Section 2. In
addition, a range of ‘ways of working’ have evolved in each type of model.

Common ways of organising how midwives approach the provision of care are described
below:

Caseload—care for allocated women

In this way of working, caseload midwives provide care for their own women for antenatal,
intrapartum and postnatal care. Midwives take time off flexibly according to the needs of the
women in their care. The midwife will work with a backup midwife who is named and known
to the woman, but provides backup only when absolutely necessary. This model is the most
likely to provide continuity of care. Midwives who work this way, and therefore do not provide
significant back up for colleagues, report that the workload evens itself out.

I know that with four women having a baby every month, I will generally have three, four or
possibly five nights in the month where I have broken sleep. Sometimes it is less than that
with women birthing during the day. Sometimes with false alarms it is more than that, but
usually not. I find this is the best for me. I realise that my time off varies depending on the
women, but I schedule in day time relaxing to ‘fit’ and use a back up when I need to. I know
all the women well and this reduces stress both for me and for them. No one in our practice
has to provide back up for lots of women or for women they don’t know.

When midwives are only on-call for their own clients, callouts will be infrequent, however
midwives do need time off-call. The aim for midwives is to work out a method which allows
adequate time off-call, while ensuring most women receive care from their primary midwife.

• Time off in short periods (e.g. a night off-call to provide for adequate sleep and
  sustainability).
• Time off organised to fit around births. You remain on-call for your own clients for birth,
  having periods off-call for all other aspects of care. This way you may have ‘days off’ set
  down unless a birth occurs. The midwives in a partnership need to be vigilant to ensure
  required time off is taken.

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

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

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

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

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

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

Caseload—rostered on-call

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

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

It is important to consider other stressors in this model:

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

Team midwifery models—rostered shifts

The team midwifery model has not been discussed extensively throughout this guide. The ‘enthusiasm for this model has waxed and waned over the past decade’ (Homer, et al. 2008). Resources for organisation of teams include *Midwifery Teams and Caseloads* (Flint 1993) which outlines a number of different roster systems. Homer et al. (2008) also describe how rosters may work.

The significantly different factors of team models are that there is no named or primary midwife to whom the woman can refer for her care and the midwives work in a roster system across all areas. The care of the women in the team is usually shared across the whole team. This means that no one person coordinates the care for individual women.

While teams may have been seen previously as a stepping stone to caseload care, some team models have not been sustained. Enduring models include the Mackay Birth Centre. In the majority of models the smaller the team, the higher the degree of continuity experienced by women.

It is recognised that there may be other variations of team model. None of these models are described in this guide.
Measurement of continuity provided—Key Performance Indicators

The establishment of targets for continuity of care means that services must diligently monitor the way midwives are organising their work to determine the impact on the woman’s ability to have her named or primary midwife for intrapartum care. KPIs will include a measure of continuity and facilities may change their whole maternity service to a way of working that provides some element of continuity of care to ensure they meet the target. Alternatively, they may change a small amount of the service to a caseload model that provides a high level of continuity of carer to meet the target.

Bumps and blocks

Benefits for the woman and satisfaction for the midwives may be reduced where the size of the MGP disguises ways of working that do not promote continuity.

It is clear that providing a lot of back up, in addition to your own workload, will increase fatigue levels. It is not possible for midwives to predict how many hours they will work each week, as this depends on the needs of the women for whom they are providing care.

Organisation of day-to-day care

Work–life balance

Midwives moving to continuity practice need to adapt to a significantly increased level of autonomy and responsibility. Their midwifery practice is no longer constrained to clearly demarcated shifts, outside of which they carry no responsibility for care. Their midwifery practice is mixed into their life and spread throughout their time.

This change in midwives’ practice also brings a dramatic change to the work of their managers. Managers have less direct control and much of the work they oversee is out of sight. Midwives and their managers need to be very conscious of how each midwife’s needs as a mother (or father), woman (or man) and person are balanced with their responsibilities as a professional.

The day-to-day care for women in continuity of care is mostly described in stories rather than provided as tools which enable midwives to plan and provide care in an organised way. This may be due to the variety of ways of providing care.

These resources are strongly recommended:


Place of provision of care

Midwives provide care in a range of places. These include a woman’s own home, other homes, hospital antenatal clinics, community centres, community health facilities, hospital birth suites, hospital birth centres and the operating theatre.

The place for provision of care is an important consideration in effective time management. Providing some or most antenatal care in a woman’s home is desirable, but some midwives may prefer to have some visits in a central setting to connect mothers and manage travelling time for the midwife.

Community-based antenatal and postnatal care can make care much more accessible and less stressful for women and families. For this reason, local care was a key principle in the Re-Birthing recommendations. Provision of care in a community clinic or other appropriate setting can facilitate group antenatal or postnatal care. This is discussed below under scheduling of appointments.
Antenatal care in women’s homes allows the care partnership to develop in the woman’s own environment. It also helps the midwife learn more about the woman and the environment she will be in after birth. It is important however that this is geographically bound so that valuable time is not spent travelling and the midwife’s time is used cost-effectively.

**Time management for MGP midwives**

Good time management processes are essential to sustainable continuity models. Management needs to be flexible and supportive, allowing midwives to develop systems that meet their needs. Each group practice needs to negotiate mutually beneficial systems and adapt these over time. Individual midwives need to learn the time management skills that make caseload practice sustainable and enjoyable.

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

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

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

**Appointment scheduling**

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

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

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

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

Group appointments for both antenatal and postnatal care at a central location is another strategy to assist with time management and may prevent appointments being frequently moved.

**Call out and phone calls**

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

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

Group antenatal or postnatal care

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

In Queensland various services offer this type of pregnancy care. Logan Hospital group practice uses this model with young mothers.

The following list identifies some of the essential elements of group antenatal care (Homer, et al. 2008; Rising, Powell Kennedy & Klima 2004):
• health care and pregnancy assessment is provided in the group space
• women are involved in self-care activities such as opportunity for massage
• the group is not “conducted” by an expert, rather facilitated
• the group is not rigid, but is relatively stable
• the leadership is also relatively stable.

Whilst there is a plan for the sessions, the discussion is triggered by scenarios or returning group members (Homer, et al. 2008).

The benefit of this model is that it maximises effective use of education time as the midwife provides educational sessions once, rather than spending time discussing the same elements with each woman individually. The other significant benefit in using a group model for antenatal care is the relationships that are built within the group. This relationship also tends to decrease reliance on health practitioners (Homer, et al. 2008).

Diarising the next 6—12 months

Midwives providing continuity of care will benefit greatly from planning their caseload work around six months in advance. When allocating women to midwives, accepting a woman on to your caseload, or discussing with a woman whether you are available to provide their care, there are a number of considerations:
• indicate any periods where you will be away and/or require a complete day or subsequent days off
• consider professional development leave of partners
• blocking off leave in advance is extremely important
• consider the mix of primiparous and multiparous women each month
• be aware that after a particularly busy period, where there have been unexpected elements, it is important to take additional down time. Management support for this element is critical.

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

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

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

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

Non-clinical tasks

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

Managers

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

Documentation

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

A day in a caseload midwife’s life

The day starts with a 5am text from K who has had a show and is experiencing 30 minutely contractions. She feels that this is ‘it’ but recognises, as it is her third birth, that there may be some time until the contractions increase and labour establishes. I respond, look at the time and decide to get up and go for a walk, with my phone attached to my shirt.

I ready myself for the day and head in to the hospital to check on a woman who is an inpatient. I receive a call from Y who has had a slow pattern of growth for the last six weeks and is having a second serial ultrasound scan in a nearby town. The results of this scan will be reviewed by an obstetrician in the nearby town that afternoon and Y is a bit worried. I reassure her that since the first scan, the baby appears to have grown and that we will discuss the results of the ultrasound this afternoon. I have a quick catch up with my MGP partner midwife and head out for some visits.

From about 9.30am I provide an antenatal visit and two postnatal visits in the community. After seeing these women I receive a call about Y’s scan from the obstetrician. The scan result is good and after this we discuss that we are all happy with the growth of the baby since the previous scan. All is well.
At 1 pm I receive a call from K, she is in established labour and contracting really well. As it is her third baby she wants to come straight to the hospital rather than be reviewed by me at home first. So I notify the birth suite and we head in to hospital. Things are fantastic and she quickly progresses to a water birth—her first—she is ecstatic. I glance at the time, thinking about food and the afternoon ahead. I pop across the hall leaving the buzzer with K to have something to eat while K and her husband and children enjoy their new family member. My partner midwife pops in to the birth suite to tell me that she is going home and that once I finish up with K and discharge her home that she will take the on-call overnight so that I can have a rest. I tell her that these day births are nothing! And we laugh that it is unfortunate that many of the babies come overnight.

K feeds her baby and has something to eat herself while I weigh and check her baby and sort out paperwork. She showers and is ready to leave in 4 hours at 6.30 pm. I head for home switching the on-call phone to my MGP partner to have the night with the family.

Supporting midwifery continuity of care—qualities of a manager

Homer et al. (2008) outline a range of qualities that a manager needs to support the day to day practice of continuity of care:

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

Flexibility

All staff should be supported, but due to the way midwives work in continuity models, their workloads, work hours and roles are often misunderstood. Therefore managers need to develop trust in their midwives, and core staff also require education in the role of the continuity midwife.

Example

A woman comes in to labour ward, in labour, when her caseload midwife has just finished providing eight hours of antenatal and postnatal care in the community. Communication and negotiation, with consideration of the woman’s and midwife’s needs, is required. Core staff could provide some early labour care while the caseload midwife has a rest and returns later to resume care of the woman. Alternatively her caseload partner can provide early labour care until the primary midwife is ready to work or if necessary provide the whole of intrapartum care.

A day in the life of a caseload manager

My day begins when I walk in to my office and there are three notes under the door. I have made an agreement with the caseload midwives that if they have any difficulties, they need to leave a note under my door. Days where there are three notes indicate there may have been a busy night. I check and there have been a few minor disagreements with a new GP in town about a woman who had birthed overnight. He refused to ‘allow’ a physiological
third stage. I look at the situation and realise that they all need to come together to discuss the issue. I call the GP and discuss the situation, he does not appear to understand why his behaviour has caused so much difficulty. We organise to review the case at the Friday case review meeting.

The third note relates to Lily—a midwife who is working part time in caseload—who has a sick two year old, who apparently was admitted to the paediatric unit during the night. Lily is still breastfeeding and has a postnatal group visit scheduled for this afternoon. I call her group practice partner midwife and am happy to hear that they all have the situation sorted for today. I suggest that they ask the administration staff to sort out the rest of the week so that Lily has no booked visits and so that someone else can take her calls for now.

All this takes about half an hour to resolve. As there are no women actually in birth suite I take a walk to see what the rest of the staff are doing for the women who are in the postnatal unit.

After a series of meetings about staffing, budgets and a risk management review it is time for lunch. The afternoon commences with a call from one of the midwives who was involved with the GP overnight. I calm her down, speak about respectful communication but acknowledge her disappointment about the lack of recognition of the woman’s ability to make an informed decision. The administration of syntocinon by the GP in the absence of consent could pose more of a problem. I ring the GP rooms and speak to one of the GPs who has been in town since the model began. We both recognise the challenges and respectfully discuss that this is not a good start for the new GP. We come up with a few suggestions for both the midwives and the GP to start engaging on a new level. After I hang up one of the core birth suite staff comes in with the roster for the non-caseload staff and we spend the next few hours on rostering, students and discussions about leave.

As I get ready to leave, Lily’s group practice partner pops in to say the two year old has gone home with her croup under control and all should be OK. She grins at me as one of the women in her colleague’s caseload arrives saying she ‘needs it to all stop now’ as she is ushered into a birthing room with her also-grinning sister and her very concerned looking husband. By the time I lock my door I hear a crying baby and leave a post-it note saying ‘Congratulations’ on the door of the birth suite.

References


Section 11
Collaborative maternity care

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

The NHMRC Collaborative Guidance for Maternity Care (2010) provides direction to Australian clinicians providing maternity care. This guide, endorsed by Queensland Health, should be referred to by those providing maternity care and used to guide collaboration between all caregivers, both within and outside the service. The NHMRC Guidance may be found at: www.nhmrc.gov.au/guidelines/publications/cp124

In Chapter 5 of Midwifery Continuity of Care, Homer, Brodie and Leap (2008) describe and explore how midwives and obstetricians can successfully work together.

Good collaboration does not require every practitioner to be involved in every woman’s pregnancy. It is about women and their babies accessing the care they need, when needed, from caregivers who communicate and work effectively together.

Definition of maternity care collaboration

In maternity care, collaboration is a dynamic process of facilitating communication, trust and pathways that enable health professionals to provide safe, woman-centred care. Collaborative maternity care enables women to be active participants in their care. Collaboration includes clearly defined roles and responsibilities for everyone involved in the woman’s care, especially for the person the woman sees as her maternity care coordinator. (NHMRC 2010)

Communication as the first stage of collaboration

Collaborative maternity care needs to be consciously built by service leaders. There is a long process of developing pathways of communication and trust prior to collaborative maternity care working well. There are some processes to fast track this communication that can be undertaken as a part of the planning and development of midwifery models of care. Section 3 outlines the steps to commence processes of engaging stakeholders. Section 5 outlines cultural change and Section 9 outlines professional development for midwives. These are important elements of building collaboration.

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

Networking to develop communication pathways

It is extremely important that effective networking provide an opportunity for all interested parties to contribute and participate in the development of the midwifery continuity of care model. Steps to provide a path for effective networking include:

- Identifying individuals and groups who have an interest in maternity care and inviting them to participate in developing a local continuity model
- Identifying these groups may be by word of mouth, through other organisations with whom relationships exist or through social and other media
- an invitation for external stakeholders to attend an information session, a brainstorming exercise or focus groups could be the first stage
- consideration of the local context needs to be the focus for the development of partnerships (new or ongoing) that are required and suited to the local population and geography
• in the beginning linking with other professionals and community may literally mean doing some leg work and visiting local medical centres, politicians or mayors and women’s groups
• various key groups linked and integral to the operation of the service should be invited to nominate representatives to sit on steering groups and ongoing management groups at regular planned and minuted meetings. The expected representation of various entities on steering committees is outlined in Section 3 Steps in implementing a new model.

Communication within the service and developing trust
The development of clear communication pathways has been identified in Section 3 as a fundamental process within the model. Trust by other clinicians in the midwives providing primary care as autonomous practitioners is essential. Senior staff, as leaders of the respective professions, must model and set clear parameters around acceptable processes and behaviour.

Maternity care coordinator
The NHMRC identified a need for women to have a known ‘maternity care coordinator’ who is ‘the person nominated by a woman to coordinate her maternity care’ (NHMRC 2010). This is a useful mechanism to ensure communication processes are effective, as one clinician takes a leading role in ensuring communication and decision making occurs in a coordinated manner. In a Midwifery Group Practice model the woman’s caseload or named midwife would take this role. The maternity care coordinator is responsible for ensuring the woman is provided with the care required and consults, refers and transfers care when appropriate.

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

Level of service available
In Queensland the Clinical Services Capability Framework (CSCF) (Queensland Health 2011) provides the framework for determining what type of care is available in hospitals and maternity care settings across the state. The CSCF continues to provide the base decision-making tool around what is available in each hospital and setting, which then guides the need for consultation, referral and transfer of care for women. Midwifery care can be provided at all levels of Clinical Service Capability. It is possible for midwives to provide antenatal and postnatal services in non-birthing units and to travel with women to a birthing facility for intrapartum care.

The maternity section of the CSCF can be downloaded from: www.health.qld.gov.au/cscf

Consultation and referral
The location of the Midwifery Group Practice within the CSCF is the first thought when considering consultation, referral or transfer. The National Midwifery Guidelines for Consultation and Referral (ACM 2008) provides the framework for decisions regarding consultation, referral and transfer of women’s care.

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

There are also different ways of organising medical support within larger hospitals, such as allocating specific medical staff to support the midwives in continuity of care models. In services where organising care in this way is possible, communication is streamlined and the woman experiences both continuity of midwifery care and medical care. This is extremely desirable from a woman’s perspective.
Example

Mary presents to Miles Hospital (a small rural hospital) pregnant with her third baby. She has had two previous caesarean sections. Jenny is the Midwifery Group Practice midwife providing Mary’s care. Jenny considers Mary’s situation within the context of the CSCF.

- Regardless of Mary’s choices around her birth (vaginal or repeat caesarean section) there will need to be consultation with and referral to Toowoomba Hospital for birth care, as Miles will not be providing birthing services to Mary.
- Jenny explains to Mary that within the context of the CSCF there will need to be consultation with Toowoomba Hospital and referral to Toowoomba for birth care.
- Jenny then completes the necessary booking for Mary, including considering Mary’s situation in relation to any further indicators within the ACM consultation and referral guidelines. Jenny will complete the required paperwork including a referral to Toowoomba Hospital for a consultation to discuss birth care.
- Jenny explains to Mary that she will continue to provide primary maternity care to Mary locally, but that Mary will also need secondary care in Toowoomba for her birth care.

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

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

Multidisciplinary case review

A process of regular multidisciplinary case review is very helpful in developing collaborative relationships. This is covered on pages 19 and 46 of the NHMRC Guidance for Collaborative Maternity Care (2010). Obstetric support should be engaged to establish a case review process early in the development of the model. While Queensland Health does not currently have specific multidisciplinary case review templates, it is important to develop a clear process for reviewing care requirements.

Bumps and blocks

The NHMRC guidance document clearly outlines the need for development of trust. Engaging with a range of practitioners before development of the model begins is essential to commence the process of building confidence and trust. This would include medical practitioners within Queensland Health and GPs and allied health practitioners from the local area. Ongoing communication is essential to underpin the way care is provided with all practitioners being aware of their roles and responsibilities, as well as the areas for which they are not responsible. Having a known maternity care coordinator for each woman is an ideal way to ensure smooth communication.

Collaborating with other facilities

Some Midwifery Group Practices will not have on-site obstetric or medical staff or access to local obstetric care may be intermittent. In these situations processes for consultation and referral will depend on collaboration with caregivers in other facilities. Trusting relationships and effective communication pathways will need to be developed to ensure women have access to the right care at the right time.
When medical support is some distance away, decisions regarding potential place of birth need to be made in a timely fashion within the context of the CSCF (Queensland Health 2011). Planning these processes should take account of the potential for births to occur unexpectedly at any site or for women to make choices in their care that are outside recommendations.

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

**Case conferencing at Mareeba**

Face to face regular meetings occur between Mareeba MGP midwives and the consultant obstetrician from Cairns. Together the interdisciplinary team review and determine the appropriate level of care and birth place for each woman at booking and across her pregnancy, consistent with the ACM Consultation and Referral Guidelines.

Women in the town who book for maternity care are aware that their care may be shared with or transferred to Cairns, in consideration of their history or in response to indications during pregnancy or labour.

When a midwife observes deviations in the woman’s pregnancy that require attention prior to the next planned case conferencing session, or deviations occur in labour, telephone consultation occurs using the SBAR tool (see Appendix 11.01) to provide clear communication of the woman’s Situation, Background, Assessment and Recommendation so that the birth suite registrar in Cairns can provide advice or determine that liaison with the obstetric consultant is required.

Mareeba midwives are experienced in assessing timeliness and mode of transport requirements for transfer out of this rural site as no local obstetric support is rostered. However if local escalation is necessary to manage care on-site, the midwives have developed communication channels within the hospital and with local GPs.

**Collaborating with clinicians outside the service**

**Engagement with private clinicians**

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

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

Engagement with private midwives will also vary depending on the circumstances. In some communities private midwives may be valuable members of reference for management groups, bringing experience of caseload practice. Potentially, public hospitals may develop continuity models which involve eligible midwives providing some care privately. Medicare-eligible midwives collaborating with public hospitals will be explored in Section 13.

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

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

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

Other public health and community services

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

Retrieval, RFDS, ambulance

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

Representatives from both local emergency services and at the partner referral site, along with experienced clinicians from any linked sites, should discuss the various likely scenarios and how these can be managed. Local agreements should be determined. The Clinical Services Capability Framework (CSCF) should be referred to for any specific requirements for each level of maternity and neonatal service capability


References


Section 12
Sustaining and evaluating

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

Ongoing communication within the model

Communication within the model is the basis for successful implementation. It has been stated previously that in cases of poor outcomes, the great majority are found to have problems in communication as a root cause, while only a small minority result from inadequate skills.

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

Effective communication is:
- open and honest
- inclusive
- timely
- ongoing (J. Toohill, personal communication, February 14, 2011).

These factors provide impetus for building relationships and establishing trust and respect.

Issues for managers

The foundation of the model needs to include a shared understanding about meeting the needs of the woman and the midwife. Managers need a clear understanding that their role is to actively enable midwives to determine the way in which they work. Managers often report that midwives indicate they ‘don’t want to’ or ‘can’t’ work in continuity of care models. It is important that the midwives understand the model well and that they have the support of a manager who provides the flexibility that is required for midwives to adapt to the model and respond to clinical responsibilities. Issues for managers include:
- recruitment of committed midwives who will receive unquestionable management support. The midwives will need to have a balanced perspective of work-life balance, be comfortable to seek support of their manager and have or be prepared to develop clinical skills to provide care across the continuum in line with the model of care provided
- ability to trust the midwives to manage and make appropriate decisions about their practice.
- an expectation that midwives will attend the majority of the births for their own caseload women, but have the opportunity to have care provided by known back up midwives
- appropriate consultation about model-specific issues (demography of clients and geographic area to cover, determining numbers of women in each midwife’s caseload)
- support for midwives when the woman makes an informed decision that conflicts with unit policy or consultation and referral guidelines (Homer, et al. 2008)
- support and integration with core staff where these are in place
- midwifery models are challenging for managers who are used to close on-site contact with their staff, managing rostered shifts and counting hours. Continuity of care models are not driven by the needs of the service but by the needs of women and therefore may be perceived as more difficult to ‘manage’. They are not difficult but do require flexibility in management, flexibility with staffing arrangements and flexibility in how care is delivered.
How to sustain your model

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

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

Midwife managers have a responsibility to ensure midwives practice self-care. There has been a discussion about self-care in Section 10. However a further list of important elements are:

- regular scheduled days off-call
- arrangements for times where a midwife is unavailable (when not off-call)
- robust cover arrangements for unexpected leave or relief
- a system for provision of collegial advice and support
- regular supervision/mentoring/support for the midwife with a focus on self-care (Homer, et al. 2008).

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

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

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

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

Retention and managing burnout

Retention of midwives in midwifery models of care is important. Caseload models have been found to enhance midwife retention rates (Lester 2009; Sandall, Davies & Warwick 2001). Midwives tend to leave models where they feel a lack of support, receive poor communication or feel undervalued. Therefore it is important for managers to ensure enough flexibility for midwives to choose the way they work but provide enough mentoring and supervision to ensure midwives are using self-care mechanisms to support the way they work.

Burnout and midwife dissatisfaction has been identified in the literature within team models rather than in MGP models (McCourt & Page 1996; McCourt & Stevens 2009; Reed & Walton 2009; Sandall 1997; Todd, Farquhar, & Camilleri-Ferrante 1998; Walker, Moore, & Eaton
2004). However it is important that any burnout is identified and addressed. It is possible that involvement of personnel external to the unit may be required. The unit needs to have strategies in place to ensure midwives who are fatigued or demonstrate signs of burnout are managed carefully. Any management strategy which creates additional stress for remaining colleagues is unlikely to deal with this issue.

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

**Evaluating outcomes—clinical and staffing**

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

**How to benchmark**

**Private clinicians (e.g. GPs, private midwives)**

Benchmarking is an additional step in evaluating outcomes as it ensures that people who create the models are aware of the relationship between their outcomes and those of similar models. The first step in benchmarking data is to ensure collection of common data in similar ways. It is also important to compare like services. This can be extremely difficult in midwifery models as variations in fundamental elements of care provided can have a dramatic impact.

**Example**

**Model A** offers continuity of care in early labour with midwives providing labour assessment in the woman’s home. The midwives are provided with emergency birthing materials and follow appropriate safety processes for home visiting. Through this model midwives are able to ascertain whether the woman is in ‘active’ labour prior to transfer to hospital. The provision of care in this way has the impact of demonstrating to the woman that early labour is a natural part of the process, facilitates adequate rest, hydration and nutrition in early labour and reduces stress for the woman by her being in her own environment. It also has the knock-on effect of reducing the midwife’s hours as she may not remain with the woman in situations where her continuous presence is not required, when the woman is not in established labour.

**Model B** provides continuity of care only in the hospital environment in labour and the woman must come to hospital to be assessed. The midwives also must remain at the hospital with the woman if she is in labour and in birth suite or the woman must transfer to the ward where she may be in a shared room. This mechanism of providing care impacts on the woman’s level of fatigue, requires more midwifery hours and may result in other unassessed outcomes.

Obviously data collected from both models about a range of outcomes will be different, but data to be collected would be determined through the management committee and include state-wide KPIs as identified for midwifery models by NMOQ. Benchmarking between models may be challenging, but commonalities would be found to guide practice.
References

Section 13
Eligible midwives

Overview

A range of Australia-wide reforms in 2010 are intended to improve women’s access to continuity of midwifery care in the private system:

- A range of antenatal, intrapartum and postnatal MBS rebates has been enabled by the Commonwealth, for services of eligible midwives in private practice.
- The ‘eligible midwife’ notation has been created by the NMBA, enabling access to Medicare provider numbers.
- A range of medications are subject to PBS rebates when prescribed by eligible midwives.
- An ‘endorsement for scheduled medicines’ has been created by the NMBA, allowing eligible midwives to prescribe.
- Reforms of states’ and territories’ drugs and poisons legislation has occurred to legalise prescribing by endorsed midwives.
- Commonwealth-subsidised professional indemnity insurance is available to eligible midwives.

These reforms represent a major reform to Australian maternity services. However, implementation of this model has only recently commenced, significant gaps are yet to be addressed and it is unclear what models will result.

All public maternity services can expect to be collaborating with eligible midwives over the next few years. Scope also exists for facilities to establish hybrid models in which antenatal and postnatal care is provided privately by eligible midwives and for some rural or remote facilities to access Medicare rebates for antenatal and postnatal care by eligible staff midwives under Section 19.2 (see below).

Births of women receiving private care, including private births in the care of eligible midwives, are not included in Queensland Health’s continuity of carer targets.

Eligible midwives

Eligible midwives are enabled to provide MBS-rebatable services. Midwives do not have to be eligible to provide midwifery continuity of care.

An eligible midwife has completed additional requirements, as legislated by the Commonwealth Government, to receive a notation on their registration stating they are an ‘eligible’ midwife. This notation enables the midwife to apply for a Medicare provider number.

In brief, the eligible midwife has:

- three years full-time experience
- current competence across the full scope of midwifery practice
- completed a professional review process endorsed by the NMBA
- undertaken an additional 20 hours of CPD requirements annually
- met requirements for completion of a prescribing course.

More detail on eligible midwives is available in Appendix 13.01.

The benefits of eligibility apply mostly to midwives in private practice. Private practice midwives in Queensland are supported by Midwives Australia [www.midwivesaustralia.com.au](http://www.midwivesaustralia.com.au)

Medicare provider

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

**Collaborative arrangements**

At the time of writing payment of MBS rebates for services of eligible midwives is conditional on the midwife providing the service under a ‘collaborative arrangement’ with one or more ‘specified medical practitioners’. More details of what constitutes a collaborative arrangement can be found in Appendix 13.02.

The requirement for ‘collaborative arrangements’ does not give doctors responsibility for the practice of eligible midwives as they are separately regulated health practitioners. Additionally, according to statements in Parliament, the requirement for ‘collaborative arrangements’ is not intended ‘to provide a right of veto over another health professional’s practice’. The purpose of the requirement, as described in the legislation, is to provide for consultation, referral or transfer when the woman’s care requires it.

**Insurance**

All private practice (self-employed) midwives now require insurance to cover all aspects of the care they provide. The only exception is intrapartum care in the home, which is exempt from the insurance requirement until end June 2012 [www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx](http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx)


The MIGA product requires midwives to either have a ‘collaborative arrangement’ or, if this is not in place, to communicate a care plan to the woman’s booking hospital and to ensure receipt of acknowledgement of the care plan. Generally this hospital is likely to be a Queensland Health facility.

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

In addition to the government-subsidised MIGA product, insurance products are available from other providers and more products are expected over time. Currently these products do not require the midwife to meet eligibility criteria or other requirements. The current products do not cover any element of birth care. It is important to carefully consider what insurance does cover, including support in response to actions by regulators, and availability of advice when problems arise.

**Credentialing**

With ‘eligible’ private midwives providing Medicare-rebatable services, there is now a need for credentialing processes for midwives, similar to those for visiting medical officers (VMOs). Credentialing will be required as part of any visiting access agreement for privately practicing midwives providing care to women who are admitted as private hospital patients. At the time of publishing, credentialing processes for eligible midwives had commenced in Queensland and were being refined. It is likely that credentialing processes within Queensland will be consistent with those used nationally.

**Visiting access**

For women to be able to receive continuity of carer from their private midwife, mechanisms for visiting access by eligible midwives to public hospitals are necessary.

The components of a visiting access agreement include:

- A document outlining the agreement between the hospital and the eligible midwife in private practice.
- A credentialing process, including an application form, a credentialing committee, a statement of credentialing and a process to review the conduct of the credentialed midwife if a problem occurs.
- A range of other processes would need to be ensured including access to HIBCIS so the midwife is able to admit private clients; access to orientation and professional development; organisation of parking; and admission processes.
- The admission status of the woman as a private patient needs to be reviewed if a complexity develops requiring medical care. At this stage the woman may elect to change status to a public patient to receive public obstetric care or remain as a private patient if private obstetric care is available and preferred. Likewise, if the baby is admitted to special care nursery, the baby may be admitted as a public patient to avoid the cost of private care.

Models

At the time of writing this document Medicare funding is new and associated midwifery models of care are still being established. The following parameters must be considered for MBS-rebatable midwifery care:

- Midwives must be noted as eligible and have Medicare provider numbers.
- Midwives must carry professional indemnity insurance and practice within associated requirements.
- Midwives must provide services within private practice (with limited rural and remote exceptions under Section 19.2—see below).
- Care must be within a ‘collaborative arrangement’.
- Intrapartum care outside a hospital is not MBS-rebatable.
- Intrapartum care in hospital must be for a woman who is an admitted private patient.
- Midwives providing care in hospital must be credentialed by the hospital.
- Over time eligible midwives will need to maintain currency across the full scope of midwifery practice.

Within these parameters, the following models are possible:

**Private midwifery group practice models providing midwifery continuity of care**

This model is possibly the most likely to develop in a relatively short time frame and early models are operating. Midwives in private midwifery group practices will approach public hospitals seeking collaborative arrangements for antenatal and postnatal care. They will also be seeking credentialing and visiting access to provide Medicare-funded intrapartum care as a visiting practitioner.

State-wide standardised documentation and processes are currently being developed by NMOQ to support this model in Queensland. Existing relationships and documentation pathways, such as the Queensland Health Pregnancy Health Record, should be maintained as mechanisms of collaboration.

**Solo midwives with a Medicare provider number providing midwifery continuity of care**

Midwives in solo private practice will require the same arrangements and use the same documentation, processes and pathways as midwives in private group practices.

**Midwives providing an element of midwifery care**

The opportunity also exists for midwives to provide one element of care—such as only antenatal or only postnatal care. While the eligible midwife has to be current across the full scope of midwifery practice, the midwife may provide one element in private practice and maintain currency in the remaining elements in employed practice.
Hybrid private and public models

Women may be able to receive continuity of midwifery care with their midwife in private practice for antenatal and postnatal care, and with their midwife working in employed public hospital practice for intrapartum care. This model will depend on good collaboration between private midwives and public hospital management.

Rural GP-obstetricians frequently work under arrangements of this type.

Section 19.2—Rural and remote public facilities

Section 19.2 of the Health Insurance Act 1953 allows specific public facilities to be enabled by the Commonwealth minister to work under different rules. Section 19.2 allows public hospital employees to provide MBS-rebated outpatient services in declared rural and remote locations. In these locations eligible midwives might work as employees while providing MBS bulk-billed outpatient care.


Aboriginal medical services or other entities

An eligible midwife employed in an Aboriginal Medical Service (AMS), which also employs a GP-obstetrician, would meet the requirements of option 1 for ‘collaborative arrangements’ (see 5 (1) (a) in the Determination, Appendix 13.02). Such a midwife could also be employed by a public facility for provision of intrapartum care.

Midwives employed by private obstetricians or GP-obstetricians

Some private specialist obstetricians or GP-obstetricians may employ eligible midwives in their practices. These midwives could potentially provide care in private hospitals as well as doctors’ rooms.

Private hospitals

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

Possible implications for Queensland Health maternity services

It is hard to predict how the gradual introduction of eligible midwives into the maternity care system will affect public maternity services. Possible options include:

• A state-wide process and document set is being developed to support collaborative arrangements between public hospitals and eligible midwives. This will include credentialing for visiting access, in order to support intrapartum care by eligible midwives in public hospitals.

• Midwives working in public MGP models will find gaining eligibility much easier than many midwives in other models and consequently may have more options for practice.

• Women could be referred, by public hospitals or hospital clinicians, to eligible midwives for antenatal or postnatal care (if by a doctor, this may create a ‘collaborative arrangement’).

• It is conceivable that employed eligible midwives could be granted ‘right to private practice’, like doctors and create new revenue options for public facilities.

• Contractual arrangements with eligible private midwives might be used to provide services when public facilities are running at or over capacity.
Section 14
Frequently asked questions

Women birthing here are already cared for by midwives. How is continuity of midwifery care different?

Differences for women in continuity models are:
• knowing their carer(s), thus feeling safer and more confident
• having access to a known carer 24/7
• receiving responsive, personalised care
• having carers who understand and support their choices
• having carers with a more thorough understanding of their circumstances, needs and preferences, strengths and capabilities
• being more satisfied with their care
• better clinical outcomes.

Knowing their carer means knowing the midwife’s name, phone/contact number, when to call and how to call, who she works with and when she will visit.

There remains limited opportunity for most women accessing public health services to know their carer(s).

What is different for midwives working in continuity of care models that needs to be understood and supported?

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

The meaning of midwife is to be ‘with woman’. However there are barriers within mainstream care to fulfil this educationally prepared professional role. Studies report that in practice, midwives in mainstream or traditional models may spend relatively little time directly supporting or working with women (McCourt & Stevens 2009).

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

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

New models can be resourced within existing budgets with little or no additional cost. Where additional positions are required for a new service, managers can often access existing positions within their budget that have been vacant and realign these existing resources to the new model. More commonly however, proportionate resources can be redirected from antenatal, intrapartum and postnatal (including home visiting) budgets to the new model where the care will now be provided (Homer, et al. 2008). Some services have also
operationalised the universal postnatal contact funding by applying this to MGP to allow postnatal care to be extended to six weeks.

Where areas find after using the BPF that they are under-resourced for their level of activity within their mainstream maternity service, any additional secured budget can be invested in establishing or expanding a continuity of care model. Due to additional savings from reduced sick leave in continuity models, a proportion of existing budgets for on-call or agency and relief staff can also be redirected to the new continuity model. Where budgets are developed for refurbishment or for new maternity facilities, provision should be made to cost birth space and associated staffing costs for a continuity model of care. It has been found that in alternative birthing facilities, reduced unnecessary interventions occur including lowering the caesarean section and induction rates compared with care provided in a general birthing area (Hodnett, et al. 2010; Toohill, et al. 2011).

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

The managers/doctors/GPs/midwives in my area don’t want to develop a midwifery continuity of care model. What will happen?

The issues surrounding organisational resistance are addressed in Section 5 Building a Supportive Cultural Environment. It will be an inadequate response for services to actively refuse to develop models as Queensland Health has established a range of targets and timelines around model development. Resistance to change can be endemic and therefore this document offers a range of mechanisms to develop thinking and action (see Section 5). Resistance to change is often based on a lack of understanding of the model or a lack of exposure to successful, functioning examples.

A lack of knowledge and exposure to midwifery continuity of care can be addressed in a straightforward fashion. The midwifery continuity of care model is well explained throughout this document (please review Section 4.3 for a précis of woman-centred care and Section 2 and 10 for explanations of the model). Please refer to the last question in this section for further assistance.

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

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

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

Not all midwives may feel ready or able to work in continuity models. It is important to understand the source of any reluctance or apprehension and determine it is not a symptom of internal workplace pressure to resist change or due to myths surrounding what it is like to work in a caseload or continuity model. A number of midwives in Australia working in continuity models and specifically MGP models have shared their stories of how they have adapted and coordinated their professional and personal lives around family needs (Homer, et al. 2008; Vernon 2007).

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

0.5FTE caseload vs 0.5FTE shift work

A caseload midwife providing care as a 0.5FTE employee provides care for up to 20 women per annum, approximately two women per month. Allowing for the occasional on-call situation of backing up a colleague, midwives will be required to attend births in an unplanned fashion twice per month and are probably likely to have two or four more urgent call-outs per month that cannot be postponed to routine care. The remainder of the time the midwife can provide care at her convenience, scheduling visits at times that best suit other commitments such as family.

A midwife working as a 0.5FTE employee will have two eight hour shifts one week and three eight hour shifts on the second week. The midwife may have some control over timing of these shifts, depending on hospital workforce circumstances. In some rural units midwives expect to be on-call to some extent even in a shift-work model.

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

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

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

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

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

References


Glossary

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

ACM: Australian College of Midwives [www.midwives.org.au]


ALSO: Advanced Life Support in Obstetrics. [www.also.net.au]

Caseload midwifery: Refers to the model where the woman has a ‘primary’ or ‘named’ midwife, providing the majority of pregnancy, birth and post birth care (Homer et al 2008). This model is also referred to as a ‘continuity of carer model’ or ‘one to one’ midwifery care.

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

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

Clinical Services Capability Framework: The levels of clinical capability for health services in Queensland and outlines the required resources. [www.health.qld.gov.au/cscf]

Collaborating partners: Maternity care professionals who are actively collaborating (i.e. not in an employee–employer relationship). Collaborating partners refer women to each other as the need arises.

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

Collaborative agreement or arrangement: An informal or formal recognition of the terms of a collaboration.

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

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

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

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

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

CPD: Continuing Professional Development.


Doula: An unregulated health worker. A support person who assists the woman and her family to prepare for birth and parenting through emotional and physical support.

Eligible midwife: Is able to provide Medicare-rebatable services. She has a notation to her registration by the Nursing and Midwifery Board of Australia (NMBA), which is granted after application and meeting the NMBA Registration Standard for Eligible Midwives.

Family: The woman’s spouse, husband, de facto, partner, sibling, kin, parent, guardian or community.
Informed choice: When a woman has the autonomy and control to make decisions about her care after a process of information exchange that involves providing her with sufficient, evidence-based information about all options for her care, in the absence of coercion by any party and without withholding information about any options.

Informed consent: When a woman consents to a recommendation about her care after a process of information exchange that involves providing her with sufficient, evidence-based information about all options for her care so that she can make a decision, in the absence of coercion by any party that reflects self-determination, autonomy and control (NHMRC Guidance). Queensland Health policy and consent forms are available from www.health.qld.gov.au/consent

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

MaCRM: Maternity Crisis Resource Management Program, provided by the Queensland Health Skills Development Centre. www.sdc.qld.edu.au/MaCRM-000.htm

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

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

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

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

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

NMOQ: Nursing and Midwifery Office Queensland. This is the Queensland Health agency responsible for Nursing and Midwifery professional issues and includes a midwifery advisor position.

OCNO: Office of the Chief Nursing Officer. OCNO changed its name to the Queensland Nursing and Midwifery Office, Queensland (NMOQ) in 2011.

PAD: Performance assessment and development.

Primary care (or primary health care): The first level of care accessed by the consumer, without referral. Midwives and GPs provide primary maternity care.

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

QCMB: Queensland Centre for Mothers and Babies, is an independent centre based at the University of Queensland in Brisbane, funded by the Queensland Government. www.qcmb.org.au

RMI: Rural Maternity Initiative. A Queensland Health program of funding to increase rural women’s access to midwifery services, administered through NMOQ.

Strong women workers: Women who have specialised cultural knowledge related to their local community who work with Aboriginal and Torres Strait Islander health workers and other professionals in their communities in projects generally related to improving the health of pregnant women, new mothers and their babies.
Team midwifery: A model of maternity care in which a woman receives all of her midwifery care from a team of midwives (six to eight midwives, sometimes more). The team midwives work normal shifts and rotate across antenatal, intrapartum and postnatal stages of care (Homer et al. 2008). In effect, the whole team carries a case load collectively. The woman does not have a known primary midwife.

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


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Delivering continuity of midwifery care to Queensland women

A guide to implementation