NSW Health

Continuity of Care Models:

A Midwifery Toolkit

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Contents

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A welcome message

Jacqui Cross
Chief Nursing and Midwifery Officer

A very warm welcome to the *NSW Continuity of Care models: A Midwifery toolkit*.

We are pleased to present this updated toolkit, developed collaboratively with an expert working group representing NSW Health Maternity Services and partnering Child and Family Health Services. The purpose of this document is to continue supporting midwifery leaders in the design and implementation of Continuity of Care models across NSW.

We know Midwifery Continuity of Care models are desirable for women and their families, with improved outcomes for mothers and babies, as well as highly positive experiences. We also know midwives enjoy working in this way, as Midwifery Models of Care facilitate and foster ongoing nurturing relationships with the women they care for.

This toolkit aims to provide a consistent approach for implementing Midwifery Continuity of Care in NSW. It describes the different types of models currently used across the State, clarifies definitions of important terms, supports effective project management skills, and encourages Health Services to consider Midwifery Continuity as a way forward to align with community and workforce expectations.

The toolkit has been expanded to include the many important partnerships that are required when designing and implementing these models, including Child and Family Health Services, and also acknowledging the strong benefits of these models for Aboriginal and Torres Strait Islander women and babies.

As we look to the future of midwifery in NSW, it is hoped this toolkit will serve to strengthen existing models, help to initiate new models, and further enable the capacity of midwives to offer women-centred, individualised, evidence-based care in sustainable models that are truly aligned with our community's preferences.

With thanks

The Nursing and Midwifery Office would like to acknowledge the work of those who reviewed this toolkit - the state expert working group, other NSW Health agencies and organisations, as well as clinicians and managers across the Districts.

The collaborative effort to produce this practical, evidence-based resource is a testament to the goal shared across NSW of improving women's access to Midwifery Continuity of Care models.

Acknowledgement of Country

NSW Health Nursing and Midwifery Office acknowledges the Traditional Custodians of the many Countries throughout New South Wales and their connection to land, sea and community.

We pay our respects to Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today, and the continuation of cultural, spiritual and educational practices of Aboriginal and Torres Strait Islander peoples for over 60,000 years.

We acknowledge the historical disparity in health outcomes for Aboriginal mothers and babies and support Aboriginal and Torres Strait Islander women's cultural birthing practices. We reflect on the impact of past policy and practices while recognising our responsibility to work towards improved outcomes for Aboriginal and Torres Strait Islander families and communities.

The Nursing and Midwifery Office recognises the profound impact culturally safe midwifery models of care can have to strengthen physical, social, emotional, spiritual and cultural health, and the importance of growing an Aboriginal midwifery workforce as the protectors of cultural values and practices around birth.

Guided by the *NSW Blueprint for Action*, we acknowledge the right of Aboriginal and Torres Strait Islander women to access care that is women-centred, collaborative, evidence-based, respectful and above all, safeguards cultural integrity and wellbeing.

By working together to improve access to midwifery continuity of care models across NSW, we can create sustainable change for Aboriginal communities and the NSW Health workforce.

TO GROW
dturali

The word 'dturali' is from the Darug language and means 'to grow'. Yaegl woman, Jessica Birk created the artwork – the tree represents Aboriginal nurses and midwives working within NSW Health. As they care for their community, they develop personally and professionally. The growth is the community, which thrives under this care. The tree sprouts from the seed, which is the nurses and midwives' community and cultural identity. The hand holds all. It nurtures growth and provides support and strength. The Nursing and Midwifery Office has been given permission by the late Jessica's family for this artwork to be utilised.

Introduction

History of the toolkit

This toolkit was first written in 2010 to assist managers and clinicians working in NSW public health maternity services to develop and implement Midwifery Continuity of Care models. At that time, the focus of the document was Midwifery Group Practice (MGP). Since then, new **Midwifery Continuity of Care (MCoC) models** have emerged that offer options of continuity for every woman and respond to the changing landscape of the midwifery workforce.

This revised toolkit aims to:

- improve and enrich maternity care available to women and families in NSW
- support maternity services as they undertake the development and implementation of MCoC models
- increase opportunities for collaboration of care providers within the First 2000 Days Framework
- provide opportunities to attract and retain midwifery staff to maternity services
- provide necessary information to enable successful and ongoing sustainability of MCoC models

This document is intended for use by anyone within NSW Health maternity services who wishes to implement MCoC into their service.

This toolkit contains important information about the core principles of MCoC, key steps to design, implementation and sustainability, NSW-wide resources and supports, and adaptable templates to support the project lead.

NSW Ministry of Health Vision for maternity services:

All women in NSW receive respectful, evidence-based and equitable maternity care that improves their experiences and health and wellbeing outcomes.[1]

MCoC Introduction – Why Midwifery Continuity of Care?

Australia is statistically one of the safest countries in which to give birth. However, past and current reviews of maternity services have demonstrated many women's needs, including physical and holistic, are not consistently met. This is especially evident for women in rural and remote communities, and women who identify as Aboriginal and Torres Strait Islander.

Australia has a high obstetric intervention rate. There has been an international rise in caesarean section rates between 2000 and 2017 with Australia's caesarean section rate higher than the OECD average.[2] In Australia, 37% of women in 2020 gave birth by caesarean section, compared to 32% in 2010.[3] The World Health Organization (WHO) concludes that caesarean sections are effective in saving maternal and infant lives, but that caesarean section rates higher than 10% are not associated with reductions in maternal and newborn mortality rates at the population level.[4]

NSW has also demonstrated a rising LSCS rate with increases from 27.0% in 2002 to, 32% in 2009 and 36.7% in 2020, with no evident improvement in perinatal morbidity and mortality. For example, the proportion of babies born with an Apgar score of less than 7 at 5 minutes increased between 2004 and 2020, while maternal deaths remained stable between 2010 and 2019 at 5 – 8.4 per 100,000 women giving birth.[5] Such data have led to systemic reviews of Australian maternity services over the past decade. These reviews support strategies to decrease the variance between women's preferences and available services, while ensuring evolving models of maternity care are founded on best-practice evidence for clinical safety and effectiveness.

The most recent *"Strategic directions for Australian maternity care"*[6] provides national guidance for the planning and delivery of women-centred, safe, high-quality health care across the maternity continuum of care. The plan sets out a principle vision to guide the development of Australian maternity services, highlighting the value of MCoC. In both metropolitan and rural/regional settings, maternity services are responding to the recommendations within the plan, supported by international and national high-level evidence that MCoC directly addresses the identified priority areas for improvement. As such, MCoC is being utilised as an effective strategy to improve perinatal outcomes.[7]

A recent systematic review of 17,674 participants reported that women *with uncomplicated pregnancies cared for in MCoC models* experience:[8]

- more spontaneous vaginal birth
- less regional analgesia
- less instrumental vaginal birth
- less preterm birth less than 37 weeks
- less fetal loss before and after 24 weeks
- less episiotomy
- less amniotomy (artificial breaking of waters).

National guidelines state that women should have access to antenatal care close to their home.[9] The WHO also recommends midwife-led continuity of care as a health system intervention to improve the uptake and quality of antenatal care.[10] Furthermore the Australian Preterm Birth Prevention Alliance calls on jurisdictional health departments and healthcare providers to increase women's access to MCoC models, particularly for vulnerable groups, as a major public health strategy to safely reduce the rising rate of preterm birth in Australia.[11]

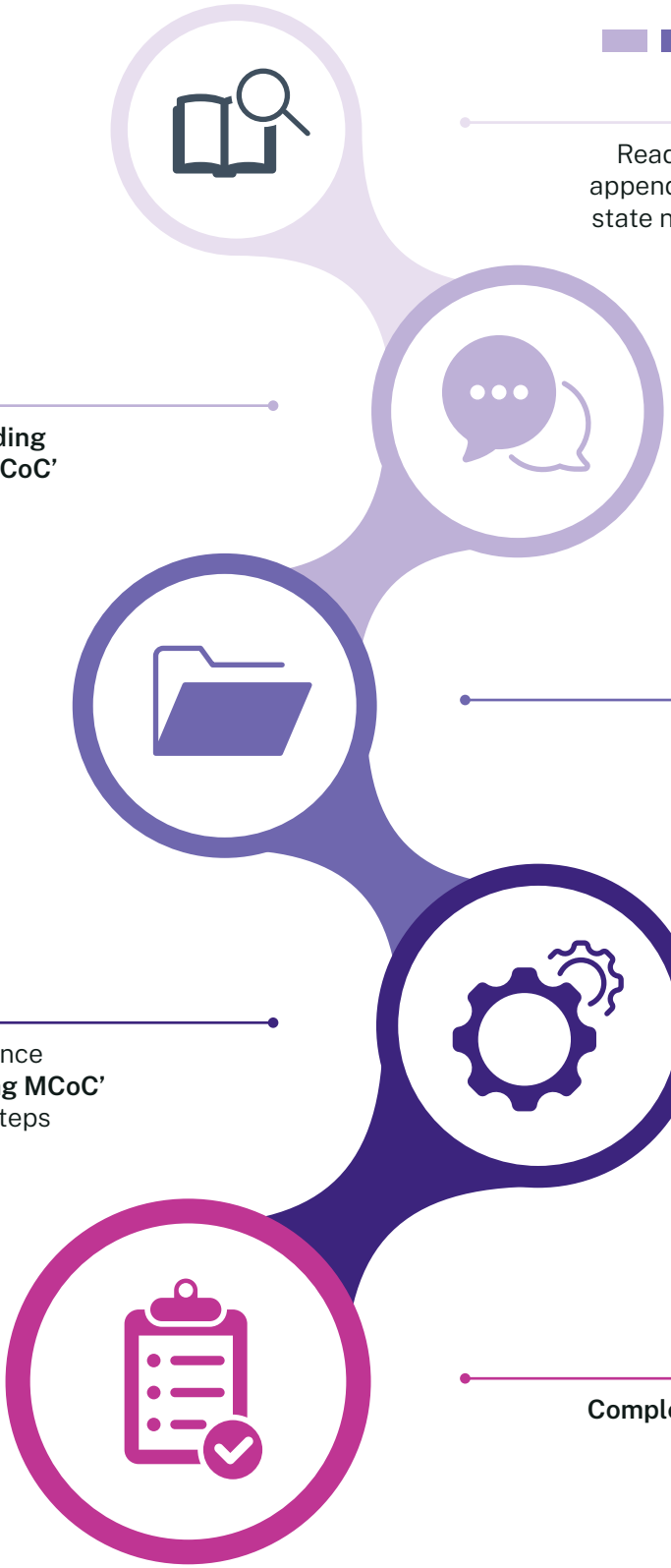
It is within this context that this toolkit has been reviewed as a key step toward achieving the NSW Ministry of Health's vision for maternity services that *"women, their partners and babies in NSW receive evidence-based maternity care that improves experiences and maternal and neonatal health outcomes."*

Toolkit links with national and state documents

This toolkit is aligned with, informed by and communicated within the context of other key national and state documents:

Woman-centred care: Strategic directions for Australian maternity care[6]	provides overarching national strategic directions to support Australia's high-quality maternity care system.
Clinical Practice Guidelines: Pregnancy Care 2020 Edition[9]	summarises available evidence on many aspects of antenatal care, with the aim of improving the experience and outcomes of pregnancy care for Australian women and their families.
Perinatal Anxiety & Depression Australia (PANDA)	is dedicated to supporting the mental health and wellbeing of expecting, new and growing families through a range of information, services and programs. PANDA helped to develop the 2017 Centre for Perinatal Excellence (COPE) 'National Perinatal Mental Health Guideline'.[12]
Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW	provides 10 goals for NSW maternity services that were developed after extensive literature review and subsequent consultation with over 17,000 submissions.
First 2000 Days Framework[13]	aims to ensure that all staff in the NSW health system understand and promote the importance of the first 2000 days of a child's life (from conception to age 5) and the best opportunities for action.
Clinical Excellence Commission Safer Baby Bundle[14]	aims to reduce the number of preventable stillbirths that occur after 28 weeks gestation, by 20% by 2023 through five evidence-based elements that emphasise the importance of best practice maternity care — health promotion and integration of the five elements of the Bundle in conjunction with continuity of care, has the potential to strengthen the Bundle's impact and reduce the rate of stillbirth.
Future Health: Guiding the next decade of care in the NSW 2022-2032[15]	builds on the foundations of the previous NSW State Health Plan and continues the work over recent years in areas such as value-based healthcare, the integration of care and improving the patient experience.
Australia's Future Health Workforce Report – Midwives 2019[16]	contains detailed modelling on midwifery workforce supply, demand and training, and projects the numbers required to 2030 for the midwifery profession.
NSW Health Women's Health Framework[17]	provides guidance to the NSW health system on delivering services and fostering environments that help women meet their physical, emotional, social and economic potential.
NSW Women's Strategy 2018-2022: Advancing economic and social equality in NSW[18]	aims to improve the economic, social and physical wellbeing of women and girls across NSW with the vision that they have full access to opportunity and choice, their diversity is recognised, they are valued for their contribution and are able to participate in all aspects of life freely and safely.
Breastfeeding in NSW promotion, protection and support[19]	provides strategies to improve breastfeeding practices by the promotion, protection and support of breastfeeding within the NSW Health system.
Healthy, safe and well: A strategic health plan for children, young people and families 2014-24[20]	provides a comprehensive planning, service and policy roadmap for NSW Health from preconception to 24 years of age, addressing the health of women and their partners during pregnancy, babies, children, young people in the context of their families and communities.
NSW Aboriginal Health Plan 2013-2023[21]	considers key issues such as how to build respectful, trusting and effective partnerships between NSW Health and the Aboriginal communities by examining the strategies about how healthcare is organised, funded and delivered.

How to use this toolkit



Step 1

Read the entire toolkit and appendices, begin to engage state networks and supports

Step 2

Complete the **'Building relationships for MCoC' section 1** activities

Step 3

Complete the **'MCoC Project Management' section 2** activities

Step 4

Review and commence **section 3 'Designing MCoC'** phase 1 and 2 key steps

Step 5

Complete section 4, 5, and **6** activities according to the project plan

There is a range of templates available at the Midwifery in NSW website that can be adapted to suit the local needs of a MCoC project for example, Steering Committee documents (Terms of reference, agenda and minutes), rosters and timesheets.

Acronyms and Abbreviations

ACI	Agency for Clinical Innovation
ACM	Australian College of Midwives
AHIS	Aboriginal Health Impact Statement
AMIHS	Aboriginal Maternal and Infant Health Service
CEC	Clinical Excellence Commission
CERS	Clinical Emergency Response System
CFHS	Child and Family Health Services
CMC	Clinical Midwifery Consultant
CME	Clinical Midwifery Educator
CMS	Clinical Midwifery Specialist
CPD	Continuing Professional Development
Districts	Local Health Districts
ED	Emergency Department
FTE	Full Time Equivalent
GP	General Practitioner
HETI	Health Education and Training Institute
LSCS	Lower Section Caesarean Section
MaCCS	Maternity Care Classification System
MAPS	Midwifery Antenatal and Postnatal Service
MCoC	Midwifery Continuity of Care
MiM	Mentoring in Midwifery
MGP	Midwifery Group Practice
MITH	Midwifery In The Home
MoH	NSW Ministry of Health
MUM	Midwifery Unit Manager
NAMO	Nursing and Midwifery Office
NGO	Non-Government Organisation
OECD	Organisation for Economic Co-operation and Development
Obs	Obstetrician
OP	Operational Plan
PPEM	Privately Practising Endorsed Midwife
WHO	World Health Organization

1

Building relationships for Midwifery Continuity of Care

1.1 MCoC relationships between women and midwives

A maternity service providing MCoC demonstrates an engagement with high-level clinical evidence and is aligned with national and state recommendations.

Fundamentally, MCoC is care based on women having the opportunity to build a nurturing and transparent relationship with a known midwife, based on equally shared responsibilities and power dynamics.

MCoC enables midwives to truly invest in the relationship with each woman to whom they provide care. This strengthens women's capacity for informed decision-making and increases the likelihood they will experience maternity services with support from a trusted care provider in an individualised way.

Women, as the consumers and partners of maternity services, have proven to be powerful allies when establishing MCoC, provided they have the opportunity to learn about the benefits of MCoC and their ability to effect change in the system itself.[22] When given the forum to do so, women will often rally with Midwives and maternity leaders during the design of MCoC. This can take the form of consumer surveys, focus groups, workshops and including strategies to engage the community in the media plan. Recruiting a consumer representative to sit on the Steering Committee is a powerful way to engage women as partners during the design of the MCoC *(see 1.3.4)*.

MCoC enables midwives to truly invest in the relationship with each woman to whom they provide care.

Core principles of Midwifery Continuity of Care

Midwives have an agreed **midwifery philosophy** of **care**, **vision for the model** and ways of **working together**.

The **majority of midwifery care** is provided by a **primary midwife**.

The **primary midwife provides care** from early in pregnancy (usually booking visit) until the woman's transition into primary health services at the conclusion of the midwifery relationship. MCoC models should **encourage seamless** and **effective integration** with other Health Services as per the **First 2000 Days Framework**.

With **planned appropriate midwifery support**, a well mother and baby are encouraged to discharge home within 4–6 hours of birth. This may include a home visit on the day of birth.

The **primary midwife provides care** between **2 weeks** and up to **6 weeks** after the baby is born.

An **interdisciplinary collaborative MCoC model** facilitates midwifery care to continue to be provided by the primary midwife even when complications arise. **MCoC manages clinical risk** when established with a core value of strong multidisciplinary relationships.

MCoC models utilise the **same clinical guidelines**, **protocols** and **decision-making frameworks** as the rest of the maternity service to **ensure consistency** and **continuity of care** and **best practice**.

MCoC models are an **effective** and **powerful way** to **grow midwifery leadership**.

MCoC is **valuable** and **safe** for women **experiencing varying levels of risk** in their pregnancy. Women experiencing obstetric and psychosocial complexities **benefit** from having a **known care provider**.[23]

MCoC models are well-placed to provide **continuity** in **collaboration** with other health professionals. A model can be specifically designed to meet the **needs of priority groups** in the local community (e.g. Aboriginal women, young women, women with increased psychosocial needs).

The conclusion of the **midwifery relationship** is **timely** and **facilitates** the **woman's transition** into **primary health services** (e.g. Child and Family Health services and GP).

Midwives have a **sound knowledge** of Child and Family Health and other community-based care services – both to **educate** families on **supports available** but also to consider if any **referrals required** for families with identified needs.

Additional core principles specific to caseload midwifery or Midwifery Group Practice caseload care (*see 1.1.1* for definitions):

One-to-one care for **labour** and **birth** is provided by the **primary or back-up midwife**.

A **back up midwife** or **team** is available whom the woman has **met on more than one occasion** during her pregnancy.

The **primary midwife provides care** from **early in pregnancy** (usually booking visit) through **labour** and **birth** and **between 2 and up to 6 weeks** after the baby is born.

The primary midwife provides care from early in pregnancy (usually booking visit) until the woman's transition into primary health services at the conclusion of the midwifery relationship.

1.1.1 Definitions of MCoC: ways of working with women

Continuity of care or carer:

There is an important distinction between continuity of *care* and continuity of *carer* models in maternity services:[24]

Definitions of continuity models

Continuity of care

A team of caregivers working within the same philosophy and framework and sharing information however there is an absence of a designated named carer

Continuity of carer

Defined as 'relational continuity' or 'one-to-one care' provided by the same named caregiver who is involved throughout the period of care even when other caregivers are required. A defining requirement of 'continuity of carer' model is that the care is provided or led over the full length of the episode of care by the same named carer

Model of care:

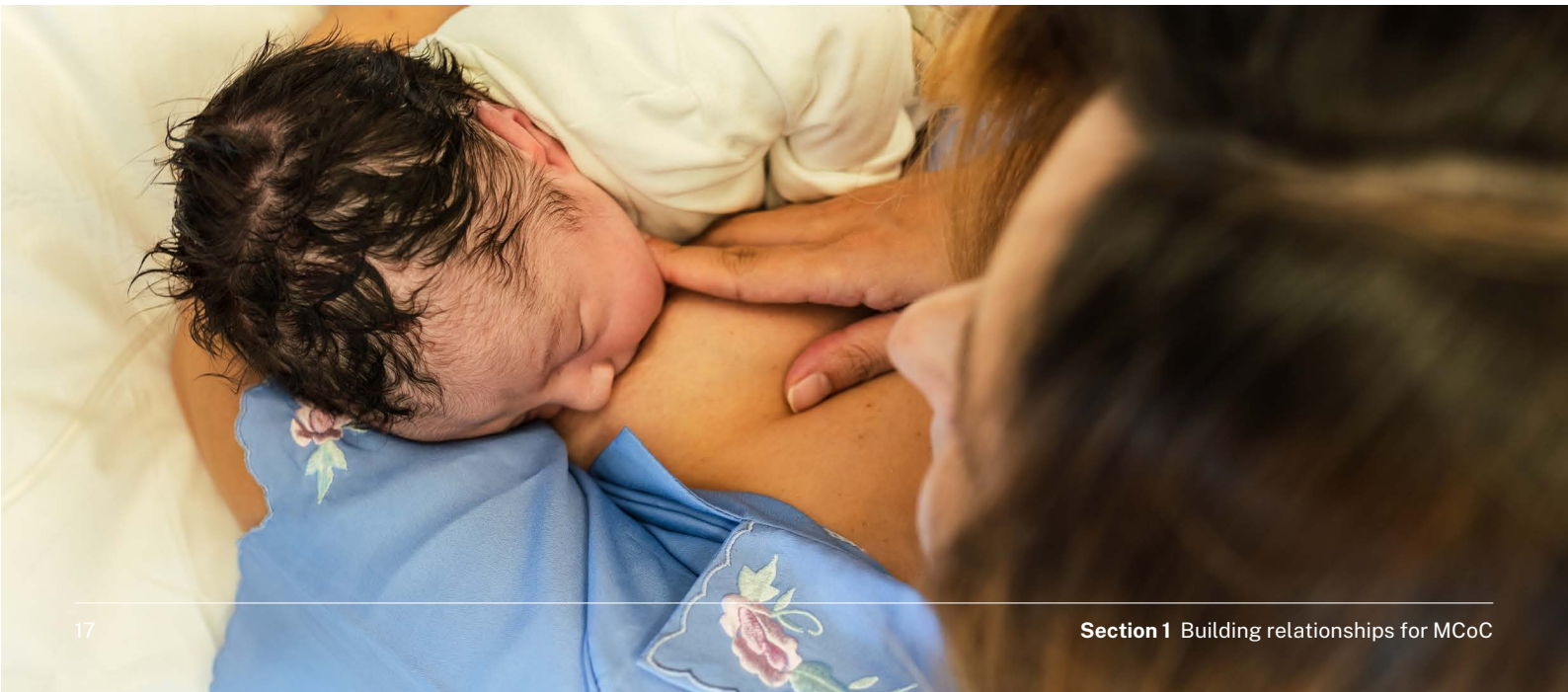
Model of care is a term that is commonly used, yet often not well defined in maternity services. A model of care is a descriptive term that outlines how specific health services are delivered to ensure care is woman-focused, safe, and innovative. This means that ideally care has localised flexibility and is provided by the right health professional, at the right time, in the right place.

Language concerning maternity models of care often needs to reflect both midwifery and obstetric care and can be highly variable due to being adapted for local context. The Australian Institute of Health and Welfare (AIHW) and the National Perinatal Epidemiology and Statistics Unit, have developed major category definitions for models of maternity care, which are recognised nationally as the Maternity Care Classification System (MaCCS).[25]

NSW Ministry of Health makes use of the MaCCS classifications, and in addition has embraced an emerging Midwifery Antenatal and Postnatal Service model of care. Definitions within models of care currently used in NSW include:

Model of care	Description	Care provider	Features	Antenatal care	Intrapartum care	Postnatal care
Midwifery Group Practice caseload care (MGP)	Antenatal, intrapartum and postnatal care is provided within a publicly-funded caseload model by a known primary midwife with secondary backup midwife/ midwives providing cover and assistance with collaboration with doctors in the event of identified risk factors.	Midwives	• women have a named, known midwife • midwives are paid with an annualised salary and work on a 24 hour on-call basis • midwives self-manage their workload outside of a traditional roster system • provides a high level of continuity of a known carer across the continuum of maternity care • in a public setting, this MCoC functions with identified obstetric/ medical support	Hospital, community or home	Hospital, birth centre or home	Hospital, community or home
Team midwifery care	Antenatal, intrapartum and postnatal care is provided by a small team of rostered midwives (no more than eight) in collaboration with doctors in the event of identified risk factors.	Midwives	• the team can vary in size, and each midwife works to support their team • midwives work shifts and are paid in accordance to what they have worked • provides continuity of care across the continuum of maternity care • in a public setting, this MCoC functions with clearly identified obstetric/medical support	Usually home or community	Usually hospital or birth centre	Home or community

Model of care	Description	Care provider	Features	Antenatal care	Intrapartum care	Postnatal care
Midwifery Antenatal and Postnatal Service (MAPS)	Women have a primary midwife allocated for the antenatal and postnatal period. Labour and birth care is provided at the birth site of a woman's choice by midwives working in the existing, standard maternity services. The MAPS model of care has a focus on outpatient services where women birth with, and receive any inpatient/ unplanned care by midwives who work within the existing standard Birthing Unit/ Maternity wards.	Midwives	• designed to link with existing services such as General Practitioner Shared Care program and the Child and Family Health Services • this MCoC is considered a sound option for sustainability • Aboriginal Maternal Infant Health Service (AMIHS) has been providing this model of care for many years to Aboriginal women who elect to use that service and can be looked to as an example of effectively functioning MAPS • in a public setting, this MCoC functions with clearly identified obstetric/medical support	Hospital, community or home	Hospital or birth centre	Hospital, community or home



Model of care	Description	Care provider	Features	Antenatal care	Intrapartum care	Postnatal care
GP/Obs shared care with a MCoC	A shared care option available for women where there is an agreed model of care between local GP/Obs and a hospital based MCoC midwives.	Midwives GP/Obs	• a shared philosophy of care and a planned sequence of visits based on the needs of the woman • antenatal care is provided by a private maternity service provider (GP/Obs) and a known hospital-based MCoC midwife • information is shared between the GP/Obs and hospital midwife • intrapartum and early postnatal care is provided in the public hospital by the known MCoC midwife • postnatal care in the home or community, provided by the GP	Usually community or hospital	Hospital	Home or community, provided by GP and/or midwife
GP/Obs shared care with a midwife clinic	Antenatal care may be shared between the GP/Obs and the midwives from the public hospital. Intrapartum and postnatal care provided by the public hospital.	Midwives GP/Obs	• a shared philosophy of care and a planned sequence of visits based on the needs of the woman • information is shared between the GP/Obs and hospital midwife clinic	Community or hospital	Hospital	Community or hospital

Model of care	Description	Care provider	Features	Antenatal care	Intrapartum care	Postnatal care
Private Midwifery Practice in NSW Public Hospitals	A Privately Practising Endorsed Midwife (PPEM) is a registered midwife in private practice who holds endorsement with the Nursing and Midwifery Board of Australia to prescribe schedule 2, 3, 4 and 8 medicines.	PPEM Midwife	• privately practising endorsed midwives seeking to provide private care in NSW public hospitals can apply for an access agreement with participating hospitals. • an Access Agreement outlines the terms and conditions under which the NSW public health organisation agrees to grant the privately practising endorsed midwife a right of access to the public hospital(s) operated by the public health organisation.	Home or community	Home or hospital	Home or community
Midwifery-led antenatal clinic	Midwives provide antenatal care predominantly and the woman births in the birth site of her choice.	Midwives	• considered an 'antenatal component' of MAPS	Hospital or community	Hospital	NA
Midwifery-in-the-Home (MITH)	Midwifery care is provided to women at home, or in some instances the woman is invited back to a hospital for postnatal care.	Midwives	• considered the 'postnatal component' of MAPS	NA	Hospital	Home, community or hospital
Private obstetrician care	Antenatal, intrapartum and postnatal care is provided by a privately practising obstetrician in private practice.	Obstetrician	• often have midwives employed to support the private practice	Community, in private practice	Public or private hospital	Hospital or home

Additional MCoC definitions and concepts used in NSW:

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

Primary midwife: the first point of contact for the woman through pregnancy, labour and birth and postnatal period. This midwife works in partnership with the woman, identifying her individual needs and ensuring that she has access to safe and supportive services. As part of this role the midwife ensures all investigations, consultations and referrals occur at an appropriate time and collaborates with other health professionals in accordance with the individual woman's circumstances and health needs. MAPS primary midwives work in a collegial way with a "core" hospital birthing team with who women birth their babies. MGP primary midwives also work in a collegial manner with a "core" hospital team who provide the role of the 'second midwife' during labour and birth.

Back-up midwife/secondary/buddy: the second point of contact for the woman when her primary midwife is not available. This may be due to a variety of reasons including when the primary midwife is not rostered to work, has worked her maximum clinical hours for that day or is on annual leave, study leave or sick leave. MAPS and MGP models may both include this 'buddy' system of back up for the primary midwife.

Annual caseload/allocations: the number of women per year for which a midwife provides primary care. Each midwife in a MCoC model is the primary midwife for women allocated to her care, and provides back up for her midwife partner's women. The annual caseload/ allocations of a midwife in a MCoC model depends on the model in which they are working. As MAPS Midwives do not provide birth care on-call, their annual caseload is higher (80-84 women per year, up to 120 women per year if women are receiving GP-shared care). MGP Midwives have a lower caseload per year as they allow hours for birth care (35-40 women per year). Regardless of the MCoC model, it is important to review caseload/allocations at least every 3 months with regards to the caseload/allocation complexity and acuity, to ensure the wellbeing of midwives and sustainability of the MCoC.

The caseload/allocations of women per year per midwife in any MCoC will be calculated using Birthrate Plus® taking into consideration:

- whether the midwife works full time or part time
- the complexity of care required by the woman and her baby (e.g. pregnancy-related, medical, psychosocial co-morbidities)
- the distance travelled by the midwife to provide this care
- provision of total or partial antenatal and/or postnatal care

1.1.2 MCoC and the effect on wider relationships within maternity services

The introduction of a MCoC model requires consideration to be given to the historical, present and potential future of a midwifery team's culture and dynamics.

MCoC impacts on the relationship between:

- women and midwives
- women and obstetric/medical staff
- midwives and obstetric/medical staff
- midwives and their MCoC colleagues
- midwives and their broader colleagues who choose not to work in the prescribed MCoC
- maternity and primary health care services, and the greater community

There are a number of strategies that can be used to evaluate and navigate these evolving relationships, and at the forefront is the project lead *(refer to section 2.1)*. This role must encompass careful consideration of how relationships will be developed, tested, pushed and eventually nurtured for the better.[26]

Evidence demonstrates it is beneficial for project leads to focus on improving the midwifery workforce's understanding of the clinical benefits for women and families of MCoC models.[22] This knowledge is then in turn communicated to women who are empowered to participate in their own advocacy for MCoC. Mobilising consumer representatives and engaging them throughout the development of MCoC validates women's experiences in maternity services and communicates that the service responds to the needs of the community.

Reviewing the existing workplace culture and creating opportunities for team building and networking throughout the MCoC project, will assist the project lead to navigate an internal resistance within the midwifery workforce.[22] Historically, dynamics can be difficult among midwives working in MCoC and those who elect not to work within the MCoC.

Ways to address this may include:

- give consideration to the "re-branding" of the 'Core team' of Midwives may prove to be a powerful tool in establishing cohesion among teams. Replacing 'core midwife/team' labels with another team name that represents the contribution this team makes to a MCoC model functioning can be symbolic of positive team culture and inclusiveness, for example, "Home team, Base team or Birthing team (in a MAPS model). One cannot function without the other, and all are valued and as pivotal as the other
- commence whole unit team building activities early before implementation
- give legitimacy to each team with identified midwife leaders and structures
- ensure equity of resources, acknowledgement and celebrations
- share challenges across the teams and continue to work as a whole unit with the shared goal of offering women access to a MCoC model

Midwives have identified key factors for achieving optimal work experiences within MCoC models. These are not only about successful relationships with the women they care for, but also the relationships they have with their peers, obstetric/medical colleagues and managers.[27] For these relationships to succeed midwives need:

- the ability to develop meaningful professional relationships with women through continuity of carer
- supportive relationships at work and at home
- positive working relationships and occupational autonomy
- being able to organise their working lives with maximum flexibility through negotiation, including:
  - positive and supportive relationships with midwifery colleagues in the MCoC model
  - collaborative relationships with obstetric/medical colleagues and midwifery peers at the hospital, and
  - midwifery leaders and managers who facilitate professional development, interpersonal confidence and skills, assistance with debriefing and reflection.

1.2 MCoC relationships within NSW Health and pillar agencies

An awareness of how NSW Health is structured can increase the capacity of a project lead to engage particular supports, pathways or networks to advance a project. This can be found at *NSW Health organisation chart – NSW Health*.

Within this structure, it is also beneficial to consider relevant strategic directions of the organisation, included in national, state and local planning documents. A strong awareness of these strategic priorities will help to inform the language use to frame the entire MCoC model and demonstrate project alignment with key targets.

1.2.1 Tiered Maternity Networks

It is critical that any potential change to a maternity service includes consideration of the Tiered Perinatal Network to assist with designing robust systems and processes for identifying and managing risk as per NSW Health Policy Directive *Tiered Networking Arrangements for Perinatal Care in NSW* (PD2020_014). The aim of effective Tiered Perinatal Networks (TPN) arrangements is to achieve the right care, in the right place, at the right time for women as close to home as possible.

The eight NSW/ACT TPNs support capability, patient flow and capacity by providing:

- a defined scope of service capability and responsibilities for each maternity and neonatal service. Service capability ranges from level 1 to level 6.[28]
- a defined pathways for consultation, referral and/or transfer when higher level pregnancy and/or birth care is required (escalation of care); referral and transfer when higher care is no longer needed (de-escalation of care and return transfer) .
- a structure for 'shared care' between maternity services of different capability levels; and 'shared care' between neonatal services of different capability levels.
- a structure for a cross-service approach to monitor and manage service demand.

A business case should consider the TPN and demonstrate how the development of a MCoC model enhances maternity care provision within the TPN.

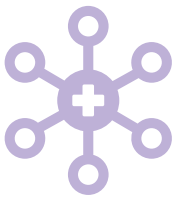
1.2.2 National Guidelines for Consultation and Referral

A NSW Health policy directive[29] mandates use of the National Midwifery Guidelines for Consultation and Referral.[30] The Guidelines provide an evidence-based framework for collaboration between midwives and doctors in the care of individual women. They are aimed at improving the quality and safety of health care. The Guidelines aim to inform decision-making by midwives on the care, consultation and referral of women with:

- clinical indications at the commencement of care
- clinical indications developed or identified during the antepartum period
- clinical indications during the intrapartum period
- clinical indications during the postpartum period

These are available from the *ACM Guidelines (midwives.org.au)*

It is useful if each midwife in a MCoC can be provided with a copy of these guidelines to build a strong sense of collaboration and referral with obstetric/medical teams.



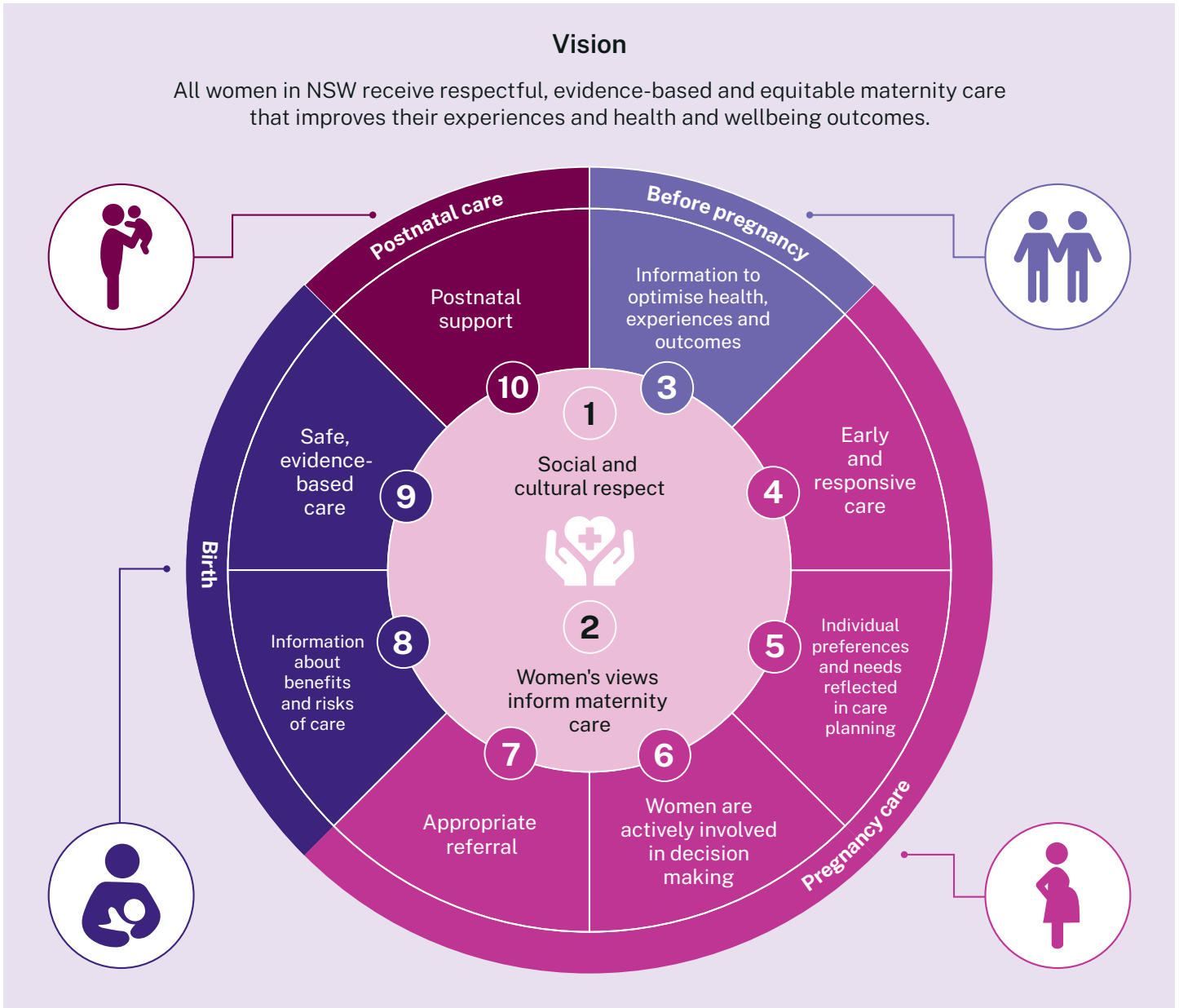
The aim of effective Tiered Perinatal Networks (TPN) arrangements is to achieve the right care, in the right place, at the right time for women as close to home as possible.

1.2.3 Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW

Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW (the Blueprint) updates the NSW Health Policy Directive *Maternity – Towards Normal Birth in NSW* (PD2010_045). The Blueprint has a holistic scope, taking a life course approach to maternity care in NSW. It aims to ensure all women in NSW receive respectful, evidence-based and equitable maternity care that improves experiences and health and wellbeing outcomes.

The Blueprint was developed in line with the *Woman-centred care: Strategic directions for Australian maternity services*, a national strategy to support the delivery of maternity services to women, from conception until 12 months after the pregnancy or birth. The Blueprint is based on the understanding that:

- pregnancy and birth are normal physiological experiences, women are experts in their lives and maternity care providers are expert in care provision
- pregnancy, birth and parenthood are life-changing in physical, emotional, social and psychological ways
- maternity care is inclusive of the diverse experiences of women, including their social circumstances (including experience of family violence), cultural and religious background, health, disability, sexual orientation and the gender with which they identify.

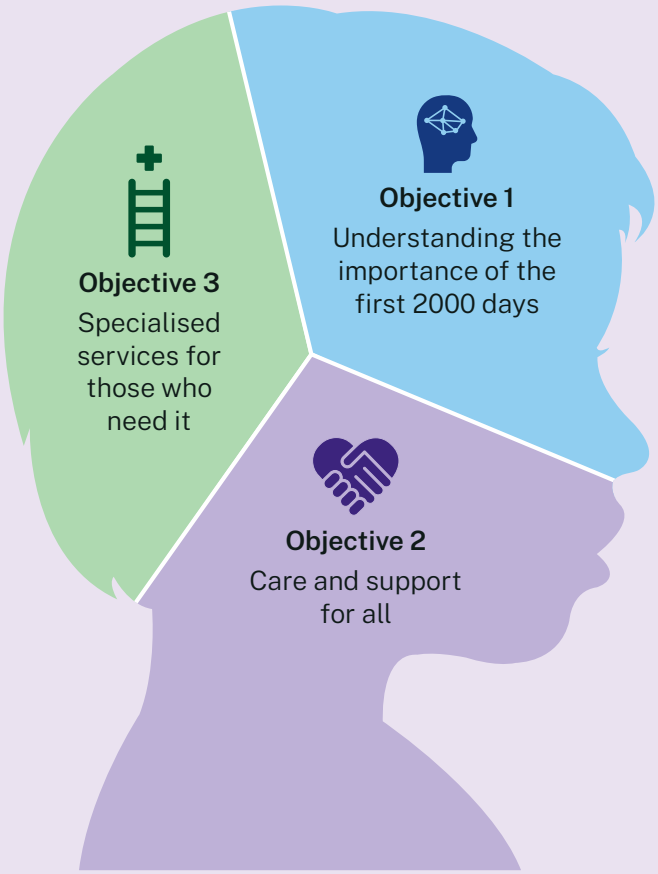


1.2.4 The First 2000 Days Framework

Evidence highlights the importance of the first 2000 days (from conception to age 5) of life for lifetime physical, social and emotional health outcomes and what parents and professionals can do to support a child's development.

The NSW Health Policy Directive *The First 2000 Days Framework* (PD2019_008)[13] is a strategic policy document which outlines what action people within the NSW health system need to take to ensure that all children have the best possible start in life.

The three objectives of the Framework are:



The framework incorporates a range of policies, programs, services and models of care to make sure that the right health services are available for everyone and at the right time.

The First 2000 Days Framework should be central to any MCoC design and consultation process as it provides a framework to improve the integration across the Health Service. A key principle of a MCoC should include the introduction of community-based services early in a pregnancy to help establish the bigger picture of child development and care for families, as well as prepare them for future supports available.

Within the First 2000 Days Framework, there are referral pathways that start in the antenatal period now for Child and Family Health Services (CFHS). This includes various sustained health home visiting programs where research indicates antenatal engagement is advantageous for improving postnatal support.

These programs support eligible families to establish positive, healthy relationships with their infants and promotes optimal social and emotional development. Individualised care in the home can help to prevent or mitigate adverse impacts during early childhood which will improve outcomes for families.

1.2.5 Supporting Aboriginal health

> "Birthing is the most powerful thing that happens to a mother and child... our generation needs to know the route and identity of where they came from; to ensure pride, passion, dignity and leadership to carry us through to the future."
>
> **Aboriginal Elder, Arnhem Land**[31]

Connection to culture is central to the health and wellbeing of Aboriginal and Torres Strait Islander peoples. Cultural identity is built on the *cultural determinants of health*:

- family, kinship, and community
- indigenous beliefs and knowledge
- cultural expression and continuity
- indigenous language
- self-determination and leadership
- connection to Country[31]

Health care that envelops these determinants strengthens Aboriginal and Torres Strait Islander families by protecting all aspects of their health and wellbeing.

Exploring and establishing a MCoC project's connection to local Aboriginal community and families can follow these first important processes:

1. Engagement with Community – consider making connections with

- Senior Directors and Managers in Aboriginal Health
- Senior Directors and Managers in Workforce
- Aboriginal Liaison Officers
- Aboriginal Maternal and Infant Health Service (AMIHS)
- NSW Aboriginal Land Council
- any local Language-based groups
- any established community groups

An effective way to start this process of engagement is by completing an *Aboriginal Health Impact Statement* (AHIS).[32] The Agency for Clinical Innovation (ACI) provides supports around supporting *the process involved for writing an AHIS*. The MCoC project lead should also seek out relevant local Aboriginal Health Policies and Frameworks, specifically the *NSW Aboriginal Health Plan 2013-2023*.[21]

Furthermore, this MCoC toolkit encompasses the wider operational elements of establishing a Continuity model, and does not address the unique and specific needs of any one particular group (e.g. Aboriginal and Torres Strait Islander women, high-risk pregnancies, young women, rural communities etc). As such if a MCoC was being designed for Aboriginal and Torres Strait Islander women, a project lead would need to be informed by specific resources for culturally safe care, such as the "Birthing on Country Model and Evaluation Framework"[33] and consider evidence-based approaches, such as the R.I.S.E. framework.[34]

2. Get to know the families

Gather and consider data that represents the current health context of local Aboriginal families, often this is also gathered in the AHIS. Sources can include:

- District statistical reports
- locally designed eMaternity reports – MatIQ and QIDS
- Ministry of Health data

The implementation of MCoC is an opportunity to improve many aspects of maternity services, and one such example is the benefits seen specifically for Aboriginal and Torres Strait Islander families. MCoC has been shown to reduce preterm birth by 50% in Aboriginal populations.[35] With preterm birth the leading cause of death and disability in children,[36] MCoC can be considered a strategy to help close the gap on the higher rates of infant death in Aboriginal compared to non-Aboriginal populations.

3. Strengthen the workforce to provide culturally safe care

MCoC project leads and Midwifery Unit Managers (MUMs) who oversee MCoC models can not only foster culturally appropriate models, but be proactively culturally responsive in their workforce by:

- engaging with Aboriginal Health Managers
- ensuring the inclusion of identified or targeted roles (for guidance refer to the *Recruitment and Selection of Staff to the NSW Health Service* Policy Directive *Appendix 1.7*)
- developing strategies for supporting Aboriginal Cadets and Registered midwife positions

Care and cultural understanding from Aboriginal midwives allow Aboriginal families to feel safe by encompassing advocacy for and protection of their connection to culture, especially when away from family and Community. There are several core values around culturally competent maternity services. These include but are not limited to:

- maternity services providing a social model of service delivery recognising that pregnancy, birth and parenting exist within the woman's social, emotional, cultural, spiritual and environmental world.
- pregnancy, childbirth and early parenting is a time of vulnerability for all women, but particularly for many Aboriginal and Torres Strait Islander women who experience inequity in health care, as well as injustice and disadvantage more broadly.
- all women require midwifery care, some women require obstetric care.
- there is wide diversity in Aboriginal and/or Torres Strait Islander cultures.[37]

Ideas for promoting cultural safety in maternity services/ MCoC:

- the inclusion of the AMIHS team at operational meetings
- a Welcome to Country letter in Language for Aboriginal families away from their community
- media items designed with Aboriginal families for the promotion and establishment of a new MCoC
- Respecting The Differences training for all staff
- encouraging NAIDOC participation from maternity services
- explore maternity unit signage in Language
- developing supportive measures for women birthing off Country
- consider the use of cot cards that celebrate local Aboriginal culture
- ensure milestones and celebrations are culturally inclusive and include the local Aboriginal community

Aboriginal families have the right to self-determination, and to accept or decline referral to any model of health care. Aboriginal families may prefer to engage with AMIHS, or a hospital based-maternity service based on where their health and cultural needs are best met.

1.2.6 Birthrate Plus

Birthrate Plus® is the workforce planning methodology used in NSW Health to calculate the midwifery staffing required in maternity services. The methodology calculates the number of midwives required to meet the needs of women for midwifery care throughout pregnancy, labour and birth and the postnatal period for the mother and her baby.

Since 2011, the Public Health System Nurses' and Midwives' (State) Award has outlined that the NSW Nurses' and Midwives' Association and the Ministry have agreed that Birthrate Plus® will be used to determine that maternity services are of sufficient size. Birthrate Plus® can be used in any maternity service regardless of its size for strategic planning and redesign purposes.

The Ministry's Workplace Relations Branch manages the centralised coordination of Birthrate Plus®. Within this branch, the Midwifery Manager for Industrial Relations and Workforce supports District Directors of Nursing and Midwifery and local Nursing and Midwifery Managers to undertake assessments.

When implementing a MCoC model, the Ministry can provide advice to the project lead concerning the possible implications for a maternity service's current staffing profile.

1.2.7 NSW Nurses and Midwives Association – Annualised Salary for MGP

A pilot agreement for a Midwifery Caseload Practice Annualised Salary Agreement (the Agreement) was first developed in 2008 between the Ministry and NSW Nurses Association. It describes the rates of pay, hours of work, on-call arrangements (including documentation of these hours), leave and travel entitlements for midwives who work in an MGP MCoC (identified as Caseload Midwifery Practice in the Agreement) model where they work on an *on-call basis*.

The current Agreement IB2014_050 can be found on the NSW Health website: *Midwifery in the workplace (nsw.gov.au)*

In accordance with the Public Health System Nurses and Midwives (State) Award, the Agreement lists clauses in the Award Clauses overridden by the Agreement. For example, clause 25 of the Award (Overtime) does not apply to midwives working under the Annualised Salary Agreement.

The Agreement requires that Districts provide rosters which describe on-call days and dedicated off-call days. Managers are required to monitor the working hours of midwives working in MGP, to ensure that their workloads are reasonable. Midwives in MGP, working with their managers, find many different ways to ensure they have appropriate leave, including dedicated days off and adequate annual leave throughout the year.

Whilst all MGPs utilise the Agreement, the way that midwives work together in these groups can look slightly different from one model to another. Agreements between all the MGP midwives and good communication are the keys to success in implementing the Annualised Salary Agreement.

When implementing MGP MCoC and an Annualised Salary Agreement, maternity services are required to gain signed approval from their District and NSW Nurses Association. Once approved and if there are already existing MGPs in the District, the new MGP MCoC will be added to the current list of existing MGP as per Schedule A of the Agreement.

The Annualised Salary Agreement is not the agreed pay conditions for any other MCoC, i.e. a midwife employed in a MAPS or team model is paid as per the State Award *NSW public health system awards and determinations – Remuneration and conditions*.

1.2.8 Nurses and Midwives Board Australia

The functions of the Nursing and Midwifery Board of Australia include:

- registering nursing and midwifery practitioners and students
- developing standards, codes and guidelines for the nursing and midwifery profession
- handling notifications, complaints, investigations and disciplinary hearings
- assessing overseas trained practitioners who wish to practise in Australia, and
- approving accreditation standards and accredited courses of study.

The project lead can access and refer to the following resources in the operational plan and Risk Assessment as a guiding description of midwifery registration:

- *Midwife standards for practice*
- *Code of conduct for midwives*
- *Registration standard: Recency of practice*
- the International Confederation of Midwives *Code of ethics for midwives*

Nursing and Midwifery Board of Australia – Home (nursingmidwiferyboard.gov.au)

1.2.9 Australian College of Midwives

Australian College of Midwives (ACM) mission statement: *To position and profile midwifery as the primary profession for quality maternity care through advocacy, CPD and support. Together we will change the face of maternity care in Australia by educating and training midwifery professionals, medical professionals, businesses, governments and mothers.*

The ACM can offer Midwives many resources including:

- MPR (Midwifery Practice Referral)
- MidPlus
- skills assessment/inventory
- National Midwifery Guidelines for Consultation and Referral (4th Edition) 2021
- professional development workshops and on-line resources

http://www.midwives.org.au/

1.2.10 Other NSW Health pillars and opportunities for support

The following NSW Health pillars have extensive resources for a MCoC project, including project management supports, education and training, networking opportunities and templates:

- Ministry's Workplace Relations Branch – for advice and support using Birthrate Plus®
- Agency for Clinical Innovation – in particular the *Maternity and Neonatal Network | Agency for Clinical Innovation (nsw.gov.au)*
- Jumpstart Project Management training (ACI)
- Advanced Implementation Methodology training (ACI)
- Clinical Excellence Commission (CEC)
- Bureau of Health Information (BHI)
- Health Education and Training Institute (HETI)
- My Health Learning Project Management courses
- NAMO supported MAPS Community of Practice

1.3 MCoC relationships within your Local Health District (District)

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

Each MCoC model will vary as it is influenced by the needs of local women, the community's expectations of the service, the role delineation of the facility, who the collaborating practitioners are and the geography of the catchment area.

There are many considerations and challenges in developing and implementing change in maternity care provision.

1.3.1 Your District organisation chart

The project lead will benefit from exploring the District intranet for the organisational chart of the Health Service to understand the difference between operational/strategic and clinical stakeholders. Having a copy of the organisational chart, along with identifying the individual who holds the role will increase a project lead's organisational literacy and capacity to connect with key stakeholders. This includes any non-government organisation or integrated services.

It is important to identify and understand the reporting and governance lines of a newly developed MCoC model. In addition, understanding any Clinical Networks or Streams within the District, will ensure a MCoC is established with appropriate governance and management structures. There are occasions in a MCoC project where maternity reporting lines may benefit from review and realignment.

It is also useful to search for any District policies specifically regarding maternity services, reviews or frameworks that are currently being implemented. These should be referenced as supporting evidence during the writing of the business case and any presentations.

1.3.2 Integrated services – Child and Family Health Services (CFHS)

Child & Family Health Services are a universal service available and offered to every family in NSW – and is therefore a consistent referral pathway in every District. With the First 2000 Days Framework as a guide, a project lead should engage with CFHS during the early designing phase. Contacting the relevant manager and identifying their role as essential to the Steering Committee will facilitate future conversations about how the services may interact and can be beneficial to groundwork and context. This will assist in establishing or improving referral pathways in both antenatal and postnatal periods, and invite greater collaboration between hospital/community services and sharing of knowledge.

While the operational plan is being written, clinicians from CFHS should be engaged to establish a working party, in particular any clinical nurse/midwife consultant that may be working within the service. This working party can then assist in reviewing existing process of referral, the development of any proposed changes to pathways and reviewing patient information systems that may not be consistent, or easily accessed across both services.

Focus groups have shown that CFHS nurses:

- appreciate being engaged early during the design phase of a MCoC project
- want the opportunity to clarify roles and scope of clinicians
- want clearer and most efficient communication, such as regular meetings
- improved discharge and referral processes

It is imperative for the project lead to have an open style of communication with CFHS management and clinicians in order to build trust and validate any past difficult experiences.

Central to this successful relationship is the commitment to ensure both Midwives and CFHS are provided with education around each other's roles, with very clear guidelines around how the clinicians navigate any overlap in services in the post-natal period. A comprehensive understanding of CFHS will allow greater collaboration between staff, and greater uptake by families.

A thorough handover to CFHS or other community services allows for timely contact from CFHS supports to meet the family needs and increases their confidence in their care plan.

The important relationship between maternity services and CFHS can be proactively fostered by:

- providing education to all staff about everyone's role and purpose
- including a standing invitation to any regular MCoC meetings
- creating a working group to review the referral process between maternity and CFHS
- developing horizontal relationships between midwifery leaders/management and their CFHS counterparts

1.3.3 People, Culture and Governance

Contacting the People, Culture and Governance (Human Resources) directorate once work on the operational plan has commenced will ensure the project is guided by local and state protocols in regards to recruitment and workforce matters. Any issues for recruitment and the workforce generally are best identified and mitigated as early as possible. People, Culture and Governance may be able to provide background on any similar projects that have occurred in the District and therefore impart useful guiding information for future decisions.

1.3.4 Your local community

Considering the local community and context is an important aspect of commencing a MCoC project.

The consumer voice is very powerful in supporting maternity service changes, and is often underestimated. Finding a means to connect the women's requests for MCoC to the Chief Executive of a District has been shown to be helpful in overcoming resistance.[22]

Building a consumer focus group to co-design the MCoC during the writing of the operational plan will ensure there is true partnership between the consumers and health service.

Other strategies may include a Quality Audit Reporting System (QARS) survey which can be easily designed and shared with a large number of consumers. The survey could be promoted via posters or direct SMS, to gather information about the baseline experience of women and their families. Collating with existing consumer data is also useful. Data from the women who use a maternity service can be included in business cases and other documents to embed a strong person-focused perspective which aligns with many NSW Health policy core beliefs.

It is also useful to consider the local community at large, demographics, growth and change, perceptions of the health service generally and any aspects that make the region or community unique and individual. This wider context can inform many aspects of the project, from the branding design to the ways the MCoC is designed.

Considering the local community and context is an important aspect of commencing a MCoC project.

1.3.5 Your MCoC obstetric/ medical Lead

Forging a strong collegial relationship between the project lead and the existing obstetric/medical service will create future opportunities for improved multidisciplinary, collaborative maternity care.

Identifying a MCoC obstetric/medical Lead who has appropriate influence to support and champion the MCoC project within the obstetric/medical community will positively impact of the capacity of the project lead to engage wider obstetric/medical staff. If this relationship can be formed very early, it will likely establish a strong core value of collaboration among midwifery and obstetric/medical services. Once a MCoC obstetric/medical Lead relationship has been formed, there are a number of ways to engage them:

- offer to attend Department meetings to share education and background about MCoC
- clearly communicate the clinical benefits of MCoC, as well as obstetric/medical continuity
- invite appropriately identified obstetric/medical staff to the Steering Committee
- clearly describe in the operational plan, governance, reporting lines and quality measures and how the obstetric/medical team operates alongside the MCoC model
- provide email updates to the obstetric/medical staff
- honestly and openly acknowledge any proposed changes to the medical service, and welcome any reservations and hesitations. These often highlight areas of the MCoC project that require more attention
- ensure there is opportunity for obstetric/medical staff to review documents like the operational plan and Risk Assessment
- invite obstetric/medical personnel to participate in the Risk Assessment process
- ensure the project lead is available to meet with obstetric/medical staff when requested to answer questions and explain the project and proposed MCoC model
- ensure paediatrics are included at the relevant time to discuss any neonatal aspects of the MCoC
- include obstetric/medical staff in the negotiations of clinical room use
- ensure the obstetric/medical staff receive adequate orientation information and support when the MCoC commences

Activities

1. Map applicable maternity services
2. Begin to brainstorm your key players
3. Locate all relevant local and state maternity services policy and frameworks
4. Map the journey of a woman seeking to use local maternity service (different from mapping the District itself)
5. For rural services, map how women are referred into the birthing service and what, if any, community based services are available to support them in their home community

2

Midwifery Continuity of Care Project Management

Project management skills and principles are the key tools required to manage and oversee change processes. These skills and principles are essential in setting up any MCoC model. There are a number of available resources for project leads wishing to develop these skills.

My Health Learning offers 'Redesign' online training programs from introductions, fundamentals and implementation of Project Management. A good place to start is the "Project Management in a nutshell (course code 40017593)."

NSW Health's Agency for Clinical Innovation (ACI) Redesign programmes also offer *learning packages* on redesigning of services and change management, as well as Advanced Implementation Methodology training (AIM).

Key steps for Project Management success

- 2.1 Recruit project lead
- 2.2 Determine an Executive sponsor
- 2.3 Write a project plan
- 2.4 Establish a Steering Committee
- 2.5 Develop a Gantt chart for time management
- 2.6 Write a media and communication plan
- 2.7 Make use of technology for effective team collaboration

2.1 Recruit a project lead

The project lead will coordinate and manage the day-to-day requirements of the project plan. It may be possible that a current employee of the District will be able to undertake this position within their current role if they are able to delegate existing responsibilities to enable them adequate time for the project. However, it is preferable to appoint a distinct project lead for a defined period of time, as evidence shows that having a financial investment in a MCoC project lead is an indicator for project success. It is very valuable for the project lead to have protected workspace and access to IT resources.

A project lead who has an identifiable team structure to work within will embed the project with multiple change agents and allow for delegation and referral when needed. This strengthens the project lead's role to engage stakeholders and capacity to effect change.[22]

Allowing the project lead to work their hours flexibly and in response to the needs of the project is a suggested recruitment strategy to increase the desirability of the work, particularly to those who work part time.

2.2 Determine an Executive Sponsor

While writing the project plan, identifying a project sponsor with appropriate executive authority is a vital step. The Sponsor is the person who has the position of authority to make strategic and resource decisions for the change process.

The project lead and Sponsor should agree upon their expected timing and method of communication, shared goals for the MCoC project and clearly demonstrated support for the project.

The Sponsor should be approached with consideration given to their capacity to advocate for the MCoC project with the Executive Team, as well as engage supports in other midwifery managers and leaders in the Service.

2.3 Write a project plan

A project plan will be one of the first documents produced, clearly describing the purpose and key steps of the MCoC project. Asking to see the project plan from other health services is useful.

The ACI has supporting templates for a project plan *Short courses, eLearning and redesign fact sheets | Agency for Clinical Innovation (nsw.gov.au)*.

Some of these elements, such as the Communication/ Media plan, are relatively brief in the project plan, and are developed further in the future with the media unit. Most Districts will have a media/communication plan template to use for this purpose.

2.4 Establish a Steering Committee

To move the project forward it is necessary to establish a multidisciplinary Steering Committee. This process ensures effective consultation, collaboration and governance for the new MCoC model.

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

Terms of Reference for the Steering Committee: The first task of the Steering Committee is to develop Terms of Reference. This will enable a clear articulation of purpose and boundaries of influence of the Committee. The Committee should aim to meet regularly (initially at least monthly).

Meeting documents – agendas, minutes and action logs: The project lead should manage the meeting documents with agendas forwarded to members prior to meetings and minutes and action logs circulated following meetings. This will promote effective communication and collaboration amongst the membership.

Suggested members of a Steering Committee:
Membership will evolve as the project progresses. Senior executives and management may decide to delegate their attendance to a team member, and then re-engage when they are required to do so.

Initial membership should include:

- senior managers responsible for maternity services (e.g. Director of Nursing and Midwifery, health service manager or divisional manager)
- midwifery Manager/s
- midwives including students and new graduates
- CMC and CMS
- GPs/Obstetrician
- paediatricians
- consumers
- Aboriginal Health Managers/AMIHS team
- Child and Family Health Managers and clinicians
- identified or targeted Aboriginal Health Professionals and/or consumer

Future membership will likely include:

- People and Culture
- NSW Nurses and Midwives Association
- Finance Managers

2.5 Gantt chart for time management

Project leads may find it useful to develop a Gantt chart to manage many tasks at one time. Templates for these can be found via an internet search and adapted easily to sit any project.

A MCoC will evolve to have multiple tasks needing completion at any one time, and there is not predetermined steps for a project lead. The role of the project lead is to respond to developments as they arise, while still be able to deliver milestone achievements to ensure project progression.

2.6 Communication and media plans

The communication plan is a vital component of project management. It enables a project lead to document the management of information throughout the project. This can be tabled with the Steering Committee and endorsed upon as the key strategy for communication throughout the project. There are a range of tools that can be used to document the communication strategy.

A communication plan should ensure it includes consideration of midwifery stakeholders, how they will be engaged and how information is shared. Utilising novel or creative tools such as a communal "Continuity Board" for posters, MCoC project updates, useful statistics, and any upcoming events will create a sense of grounding within the team if they have a place to centrally share information and start conversations.

Examples of strategies to use in the communication plan are:

- regular dissemination of information and provision of updates at staff meetings
- use of hospital and/or Districts websites
- display of posters within the hospital and in the local community, such as ultrasound departments, GP surgeries and Child and Family Health services
- use of social media as a tool to engage the community and workforce
- distribution of flyers within the local community
- having the MCoC model added as an agenda items at key stakeholder meetings
- promotion of community discussion via local radio and newspapers
- engaging local consumer groups to discuss the model, such as mothers and breastfeeding groups and playgroups

A media plan will involve the Media Units attached to Districts who are experts on PR and media issues relating to the health service. This plan will encompass the external advertising and community engagement, clearly detailing which tools will be employed to communicate important messages to key stakeholders.

Once a clear project plan has been developed, it is useful to make contact with a Media Officer. The Media Officer will guide the project lead to engage with external media outlets and ensure the correct approvals have occurred.

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

A few points to remember about effective communication:

- vary the methods – face to face (formal meetings as well as corridor chats), posters, information bulletins, email, workshops, and meetings. Consider the balance of the effectiveness vs ease of each method
- be transparent; share with stakeholders as much as possible – try not to have secrets or a 'hidden agenda'; start communicating early and update people frequently
- take every opportunity to 'talk up' the project
- don't be afraid of 'resistance', allow it to be aired, clarify issues wherever possible and challenge thinking when needed
- work with 'early adopters', allowing the 'late adopters' to watch on the sidelines, coming on board when they are ready; however, don't forget to keep them in the loop with regular updates
- be clear about the message, stick to it and be comfortable with repetition e.g. "Midwifery Continuity of Care models are about access and choice for women and improve clinical outcomes"
- try not to respond in haste to roadblocks or challenges, "think twice, speak once"
- don't assume people understand what is being talked about — the messages need to reconfigured for different audiences, be able to effectively explain MCoC to someone outside of the world of maternity. Especially when working with CFHS and obstetric/medical teams, don't assume people have background understanding
- take the necessary time with people to talk through the issues; some will need more time than others: it's worth the investment.

2.7 Technology for effective project management

When working with a team, adopting tools such as Microsoft 365 One Drive will enable the live sharing and editing of documents.

Establishing forums such as Microsoft (MS) Teams channels and chats for meetings is also beneficial, as video capacity is likely to foster more personable engagement. MS Teams can be a powerful tool to engage midwives, and increase their participation in the project.

Microsoft Forms is a platform that allows forms and quizzes to be easily created and shared.

Activities

1. Write a Project Plan, ask to see existing documents from other services
2. Establish a Steering Committee and create the supporting documents
3. Write a media and communication plan
4. Develop a Gantt chart

3

Designing Midwifery Continuity of Care

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

Phase one – Key steps of successful MCoC design

- 3.1 Identify key stakeholders
- 3.2 Map the current service
- 3.3 Collect baseline data
- 3.4 Consider the appropriate model of MCoC
- 3.5 Wide ranging consultation and engagement activities
- 3.6 Supporting midwifery students
- 3.7 Including New Graduate/Early career midwives
- 3.8 NSW Health Aboriginal Nursing and Midwifery Cadetship Program
- 3.9 Regional and rural considerations

3.1 Identify key stakeholders

With a clear project plan developed, the project lead will begin to establish the key stakeholders in the design and implementation of the MCoC project. Organising each identified stakeholder into table or chart and then brainstorming the current level of engagement and the intended future level will assist to highlight required strategies for the project lead to target and engage stakeholders.

Creating some "identifying labels" can also prove powerful, and assist these people to engage in the Steering Committee as they have a clearly identified purpose. For example:

- Consumer representative
- Midwife representative
- Obstetric/medical partner/lead
- Aboriginal Health Lead
- 'Integrations partners' – Child and Family Health Manager

3.2 Map the current service

Understanding the 'health footprint' of the service that is planning implementation will help determine other factors which will affect the MCoC model. Concepts such as distances community members travel to seek care, down to road surfaces, environmental issues impacting access to care, escalation processes and transfer options. The availability of appropriate obstetric/medical support and specialist care should also be considered.

Recruit a small team of clinicians from across the maternity service to brainstorm and 'map' a woman's journey through the service.

This task will also prove useful to reflect back upon when a MCoC is established to show a clear improvement in the woman's journey.

Mapping can be done very effectively with:

- a whiteboard, or
- post-it notes on a large wall, or
- butchers paper and colour coded pens

3.3 Collect baseline data

The project lead will need to determine an accurate representation of the current maternity service prior to being able to effectively propose sustainable and meaningful MCoC changes.

Consider collecting and collating:

- the staffing profiles of the involved services
- the clinical service capability
- birth rates
- the number of beds, staff per shift
- current vacancies
- the number of students and new graduates
- birth outcomes – including QIDS dashboards and PDC data, compared to State data
- any relevant history of MCoC projects or changes to service
- the consumer demographics
- a consumer survey to determine interest and engagement in MCoC
- a workforce survey to determine interest and engagement in MCoC

The project lead will use this information to:

- present data to the stakeholders in an understandable way
- summarise a 'snapshot' for the business case
- design an appropriately suitable MCoC for the service

Useful published evidence to incorporate in an MCoC project includes:

- cost effectiveness – MANGO trial[38]
- clinical outcomes – Cochrane review[8]
- evidence for caseload midwifery – COSMOS trial[39]
- student midwife experiences – ESME study[40]
- midwifery workforce wellbeing – WHELM study[41]

3.4 Consider the appropriate model of MCoC

Traditionally, midwifery continuity of *carer* models have been available to women with *uncomplicated pregnancies*, where care by a known midwife occurred across the continuum of the antenatal, intrapartum and postnatal period. Recent ongoing evolution of MCoC models has resulted in models that now, in collaboration with specialist obstetric/medical teams and supports, provide care for women experiencing risk or specific cultural groups to provide the best outcomes for individual needs.

In addition, a further option has emerged which offers midwifery continuity in the antenatal and postnatal period only, while birth care is provided by a "core" hospital birthing team *(see section 1.1.2)*. This model is now commonly known as Midwifery Antenatal and Postnatal Service (MAPS).

The overarching guidance as to the most appropriate MCoC model must be guided by the National Maternity Services Clinical Capability Framework. The clinical capability of the maternity service must be central to any change in service delivery in order to ensure strong risk mitigation. A project lead must consider the maternity service within the Tiered Maternity Networks and the possible impact on any referring services.

As there are a number of iterations of MCoC *(refer to 1.1.1)*, the project lead should consider early in the project which version would be most suitable to the workforce and community. A project lead should not be hesitant to think laterally as to how to adapt MCoC for a service, as no one MCoC is ever exactly replicated.

Points to consider:

- what does the existing staffing profile allow?
- current workplace culture and level of 'change fatigue'
- is there a strong community demand for a particular version of MCoC?

Some examples of the different ways MCoC models can be designed are summarised below:

	MGP	MAPS	Team
Pay arrangement	Annualised Salary *(see 1.2.7)*	State award working day shifts over a 7 day period	State award working 24 hour roster over a 7 day period
Scope of Continuity	Antenatal, birth and postnatal	Antenatal and postnatal	Antenatal, birth and postnatal
On call	Yes	No	No
Flexible working arrangement	Yes – roster/hours are variable month to month	Some degree – can have variable start times, work weekends and/or have set days	Some degree – need to negotiate shifts with team
Risk capacity	High and low risk	High and low risk	High and low risk
FTE/reduced hours capacity	Generally 0.7FTE and above to maintain continuity, job sharing possible	Minimum of 0.6FTE to maintain continuity, job sharing possible	Generally 0.7FTE and above to maintain continuity, job sharing possible
Annual leave	Planned as far ahead as reasonably possible. No women allocated when Annual Leave is taken	Planned as far ahead as reasonably possible. No women allocated when Annual Leave is taken	Planned as far ahead as reasonably possible. No women allocated when Annual Leave is taken
Roster	A structured rosters vs self-rostering e.g. 5 days on/2 days off – weekend on call vs 7 day roster with variable days off	Morning shifts over 7 days	Many possible roster structures
Meetings	Weekly team meeting	Weekly team meeting	Weekly team meeting
Service offered	24 hour Antenatal, Intrapartum, Postnatal service	Antenatal services 5 or 7 days a week, Postnatal services 7 days a week	24 hour Antenatal, Intrapartum, Postnatal service
Back up	Buddy or pods	Buddy	Buddy and/or small teams
Other	Need to consider the proximity of Midwives personal addresses to the Birthing Unit	Consider the option for midwives to also work shifts in the standard hospital service	

It is essential that any MCoC model being designed is woman-centred and meets the needs of the midwives and the service.

The following are important when considering what *type* of MCoC model is suitable:

- the woman and her clinical, cultural and psychosocial needs should be central to the model
- ways to maintain professional relationships with women, avoiding the development of co-dependency with the women in their care
- the reporting lines and escalation processes to line managers and obstetricians
- the required regular formal and informal communication
- transparency in the process of designing the MCoC
- generosity of spirit between stakeholders
- the developing of a shared philosophy – values clarification exercises early on in the development of the MCoC is important

3.5 Wide ranging consultation and engagement activities

Consumer consultation: Creating opportunities for consumer consultation early will help to foster engagement further in the project. Hosting focus groups, conducting surveys, recruiting a consumer representative/advocate to join the project, and even just sitting with women while they wait in clinic waiting rooms are excellent ways to gather information regarding the demand and interest in MCoC.

Workforce consultation: Early midwifery and obstetric/medical consultation is vital to ensure there is buy in from what could be a source of resistance to change.[22] Consultation also provides an opportunity to share education regarding MCoC, the benefits and the case for change. There are a number of creative and inventive ways to achieve this, including but not limited to:

- workshops, Q&A sessions
- presentations about what MCoC is and why it is being considered
- surveys regarding workplace satisfaction
- posters detailing the project – information about the types of MCoC
- attendance at ward or department meetings
- hosting informal quick sit and chat sessions after handover to listen to staff concerns
- design a “mail box” for anonymous questions to be asked and responded to on a shared board for all to learn from
- monthly staff email updates
- recruiting a midwife representative
- securing funded ‘study days’ to allow protected time for midwives to review operational documents
- establishing a dynamic where the project lead is transparent, available and welcoming of midwife contact and feedback

3.6 Supporting Midwifery students in MCoC

Exposure to continuity of care is a mandated practice-based experience for all midwifery students completing a degree leading to registration as a midwife. The entry-level programs within Australia are varied, including:

Undergraduate (clinical placement model):

1. **Bachelor of Midwifery**
2. **Bachelor of Nursing/Bachelor of Midwifery**

Postgraduate RN MidStart (employment model):

1. **Graduate Diploma of Midwifery**
2. **Graduate Entry Masters of Midwifery**

All midwifery students are exposed to continuity of care during their education program. The minimum number of continuity of care experiences is mandated at 10 and can vary across programs up to a total of 20.[42] This experience provides students with a woman-centered learning experience which develops a unique set of skills and knowledge of continuity of care.[43]

Midwifery students in their undergraduate or postgraduate program are well positioned to have an active caseload within a continuity of care model under the supervision of the registered midwife. The opportunity to complete the continuity of care experience requirement for their degree should be aligned with a continuity of care model where possible. Options to enable this approach should be explored to enhance the student learning experience, optimise continuity for the woman and prepare future workforce to work in continuity models.

Midwifery students are well prepared for working with women in MCoC models, and can transition well into these models as newly emerging practitioners with appropriate supports and structures.

3.7 Including New Graduate/ Early Career Midwives in MCoC

New graduates and early career midwives are well positioned to transition into practice in continuity models. The midwifery student program either undergraduate or postgraduate pathway leading to registration as a midwife, is strongly underpinned by learning based in continuity. The mandated continuity of care experience ensures exposure to providing care in a woman centered continuity model.

The inclusion of new dedicated new graduate positions in continuity models via the GradStart recruitment campaign is a successful workforce enhancement strategy. New graduates and early career midwives should be included in the continuity model workforce profile to consolidate and further scale up the capability and capacity for midwives in continuity. Options to support new graduates and early career midwives in continuity models include:

- tailored caseload number
- buddy programs
- supportive on-call options
- Mentoring in Midwifery (MiM)
- rotations through different MCoC models

New graduates and early career midwives should be included in the continuity model workforce profile to consolidate and further scale up the capability and capacity for midwives in continuity.

3.8 NSW Health Aboriginal Nursing and Midwifery Cadetship Program

The NSW Health Aboriginal Nursing and Midwifery Cadetship Program supports Aboriginal undergraduate students studying a Bachelor of Midwifery to be employed within a District. Cadets are supported with an additional 60 days of work placements for the duration of their degree and additional mentoring.

A NSW Health Aboriginal Midwifery Cadet's Scope of Practice will mimic the level of clinical experience in accordance with the Cadets undergraduate education. Therefore, it is expected that Cadets scope of practice evolves as they progress through their undergraduate years.

Aboriginal Midwifery Cadets can be supported in MCoC which will build capacity for a future workforce of Aboriginal Midwives working within such models. These future Midwives are vital to supporting Aboriginal families by promoting and protecting a strong connection to culture.

The NSW Health Aboriginal Midwifery Cadetship Program is a core workforce initiative that links to continuing employment and contributes to the growth of NSW Health's midwifery workforce.

3.9 Regional and rural considerations

Evidence suggests regional maternity services would benefit from MCoC models,[45] particularly due to the higher proportion of vulnerable populations who have increased rates of poor maternal and neonatal clinical outcomes, such as Aboriginal communities. Through increased efforts of the NSW Health system and programs such as the AMIHS, MCoC has shown a reduction of the rate of preterm birth in Aboriginal mothers.[35]

Regional and remote maternity services face challenges distinct from their metropolitan counterparts, including

- lack of choice and accessibility to services
- increased travel distance to local maternity service
- reduction or closure of maternity services
- fluctuating annual birth rates

The *National Strategic Framework for Rural and Remote Health*[44] reports a critical need to expand the rural workforce's existing scope of practice and create new roles to optimise capacity. There is a well-recognised necessity to reorganise the health service to better meet the needs of both consumers and workers.

Considerations specific to regional and remote communities may include:

- ensuring the model aligns as closely as possible with the workforce capacity and preferences
- MCoC as a recruiting tool, especially for midwifery students and early career midwives
- having very clear escalation and tiered network relationships for higher level care
- designing the MCoC with more 'structures' (such as rosters) that may help prevent burnout and fatigue, especially in an MGP MCoC
- ensuring there is education support
- fostering networks among other rural and regional MCoC models

Phase two – Key steps of successful MCoC design

- 3.10 Establishing midwifery leadership
- 3.11 Designing MCoC for clinical safety
- 3.12 Model testing and FTE
- 3.13 Writing a business case
- 3.14 Writing an operational plan
- 3.15 Ways of working – rosters
- 3.16 Costing, equipment and resources
- 3.17 Conducting a Risk Assessment
- 3.18 Seeking Executive approval

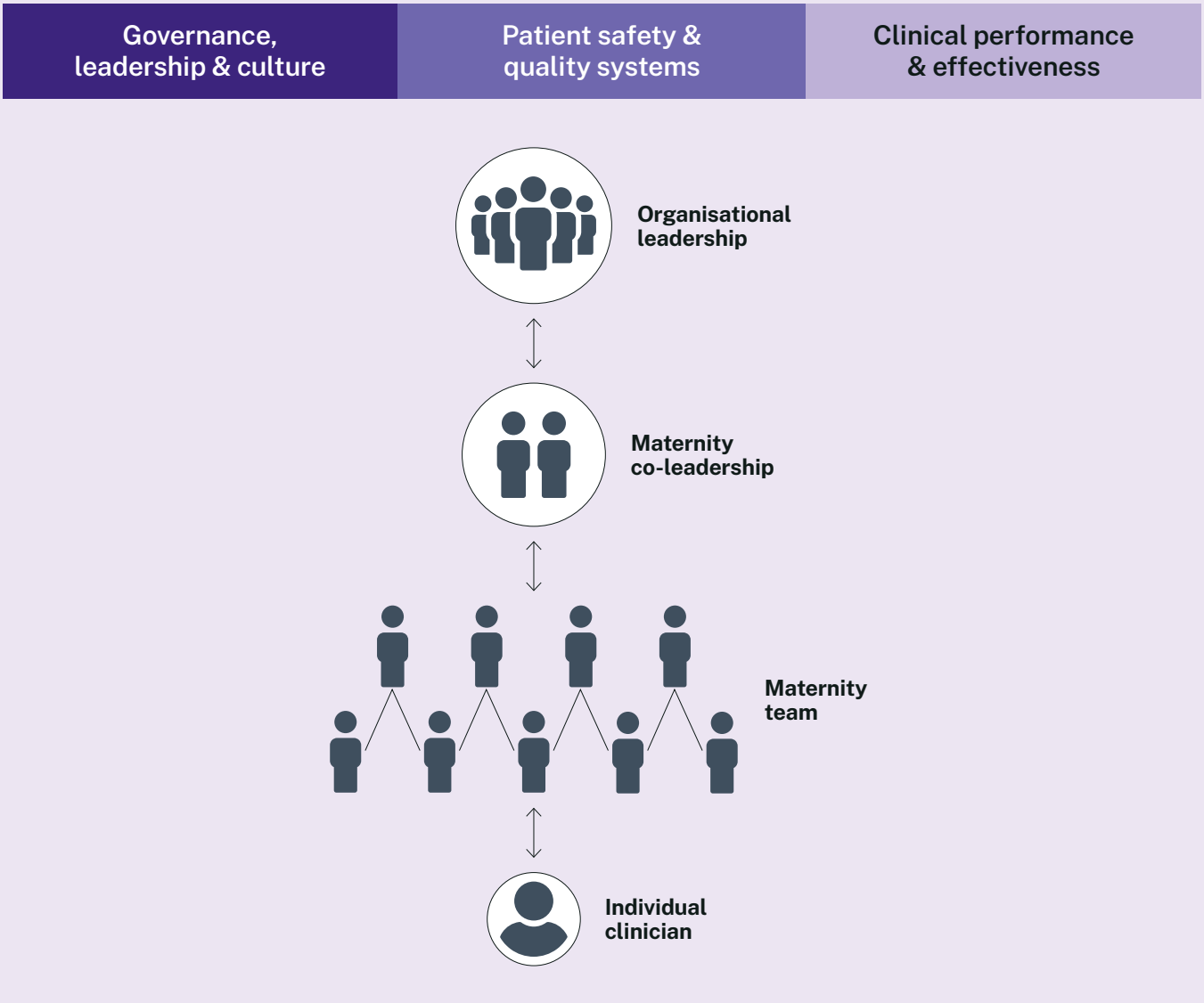
3.10 Establishing midwifery leadership

Midwifery leadership is key to supporting midwifery professional practice, leading innovative change and introducing models of care that met the needs of women and their families. Midwifery leaders are in a unique position to create a supportive culture that ensures that the workforce is future-ready, resilient and able to deliver safe, high quality women-centred care.

The Nursing and Midwifery Office (NaMO) of NSW Ministry of Health has mechanisms in place to create a state-wide network for strategic, expert midwifery advice and collaboration within and between Districts, this includes the *NSW Midwifery Leaders and Managers Network* and the *MAPS Community of Practice* groups.

The CEC's Governance and Accountability in NSW Health maternity services (February 2021) document[46] describes clearly the need and benefit of strong midwifery leadership in maternity services.

Midwifery leaders are in a unique position to create a supportive culture that ensures that the workforce is future-ready, resilient and able to deliver safe, high quality women-centred care.



In maternity services it is crucially important that co-led (obstetric/medical and midwifery) models for leadership are implemented. It is essential that collaboration between professions is modelled from those leading and managing maternity services. Organisations with positive safety cultures have:

- strong leadership to drive the safety culture
- strong management commitment at all levels, with safety culture being a key organisational priority
- a workforce that is engaged and keen to drive safety and quality improvement
- acknowledgement at all levels that mistakes occur
- ability to recognise, respond to, give feedback about, and learn from, adverse events without a blame culture.

Clinical leaders and managers of maternity services need to support clinicians to:

- understand and perform their delegated safety and quality roles and responsibilities, and ensure that the performance of individuals, teams and services are evaluated – from an accountability and learning perspective
- operationalise and strengthen the clinical governance principles and practices to ensure they are practiced every day for every patient.

The development of MCoC is a prime opportunity to review and realign midwifery leadership strategies. The models themselves require strong clinical leadership, often in the form of Team Leaders, and can lead to the establishment of new Midwifery Unit Manager positions if there is an identified need. This requires review of governance and reporting lines within the whole District to ensure there is appropriate governance structures in place.

Team Leader positions are often graded as Clinical Midwifery Specialist (Grade 2) or MUM1 due to the nature of the positions, though District and industrial advice must guide the ultimate determination.

3.11 Designing MCoC for clinical safety

The MCoC must match the clinical capacity of the maternity service within which it is being established and reflect consideration of the National Maternity Services Clinical Capability Framework.

MCoC is an opportunity for midwives to demonstrate clinical risk management and work in a collegial way with obstetric/medical staff.

Each MCoC model can develop individualised methods of in-built risk management and mitigation, many of which will stem from the outcomes of the risk assessment process itself.

Some examples of risk management processes that are commonly found in MCoC are:

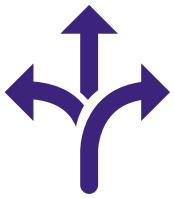
- establishing compulsory weekly meetings for staff where risk management/governance is tabled as a standing item. These meetings also serve to encourage collegial support within the team and foster team morale, important for team functioning
- monthly quality meetings to review statistics and individual care plans, established as multidisciplinary with the obstetric/medical MCoC lead
- incorporating a multidisciplinary clinical notes review process for each women in the MCoC
- requesting obstetric/medical staff to oversee clinical reviews and management of complex pregnancy care plans
- write the operational plan in a manner that incorporates and mandates local CERS

3.12 Model testing and FTE

A number of different versions of MCoC models will likely need to be developed before one can be pursued. The project lead should be willing and able to apply many different forms of MCoC to see which model may fit the existing FTE, or highlight areas of additional need.

Visually representing different versions of a model to key stakeholders is an important way to generate valuable feedback to guide the ultimate decided upon model. These can be presented on PowerPoint at Steering Committees on "Continuity Boards" on the wards, and disseminated at focus groups as needed. This design may alter slightly, or even in its entirety, throughout the project. This does not necessarily meant the project lead has the incorrect design, more that they are responding to consultation and circumstances as it presents.

Advertising 'Expressions Of Interest' at well-timed intervals can allow a project lead to determine the actual number of midwives willing and wanting to work in a MCoC model.



A number of different versions of MCoC models will likely need to be developed before one can be pursued.

3.13 Writing a business case

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

The use of state and national policy can assist with supporting the drivers underpinning the proposed changes. A business case template is included in *Appendix A*, though any local District templates should be used if available. It may be helpful to consider the following when writing a business case:

- consistency and coherency between different sections are more important than fitting the plan to a set format
- visual appearance is important – use pictures, graphs and colour
- ensure the title is clear, relevant and succinct
- insert relevant headers and footers and a contents page
- ensure language is inclusive, culturally appropriate and clear
- clearly identify and define the project
- the strategic directions of the District and NSW Ministry of Health
- include any consultation completed
- clearly defined performance measures and outcomes identified
- project sustainability issues – workforce retention and recruitment
- ensure the business case mirrors the project plan

3.14 Writing an operational plan

The operational plan describes how the MCoC model will function and outlines its day-to-day workings. An example of an operational plan structure is included in *Appendix B*.

The business case and operational plan are often recommended to be drafted simultaneously as one may inform the other. For example, identifying equipment needs in the operational plan will assist in calculating the operational costs in the business plan.

Once a full draft of an operational plan is completed, revisit the map of relevant stakeholders, and engage in a process of consultation where each key role or organisation has an opportunity to provide their input, this especially includes midwives. This can be a time consuming process so should be allocated a large portion of project resources.

The Steering Committee should also be included in the process of endorsing important service delivery aspects in the operational plan, such as the agreed midwifery leadership model, any proposed changes to staffing profile and the final model itself.

3.15 Ways of working – rosters

The day-to-day functioning of the MCoC will differ across Districts.

Rosters are a tool to ensure the ongoing sustainability of the MCoC and establish clear ways of working, especially for the midwifery leadership team. A Team Leader should have identified and protected management days for operational matter.

Rosters in any MCoC can be individualised to meet the needs of the maternity service. Feedback from midwives should be considered during the design phase to ensure there is sufficient support.

3.16 Costing, equipment and resources

Understanding the budget and funding model is important in developing a MCoC model. Making an appointment with the local finance manager can assist with understanding how the model will be funded. An *activity based funding model* ensures increases in both inpatient and outpatient activity captures the associated National Weighted Activity Unit (NWAU), and therefore the budget for the work undertaken. Whereas if a service is *block funded*, any changes in activity cannot be so easily captured, and this will need to be considered when introducing a new model of care. It often takes some years for changes in activity to be reflected in the block funding. Once the Steering Committee has endorsed a proposed model is often an appropriate time to make contact with the local finance manager, after which the model can be reviewed and refined as needed, prior to seeking Executive approval.

Another consideration with costing is related to cost centres. Ensuring all cost for the MCoC model are captured in one cost centre can assist with managing the model in the future. All staff including midwives, admin and any dedicated managers for the service, can sit within a dedicated cost centre. This assists with reporting and managing all of the associated outgoings for the clinic and home visiting. Any assets such as dedicated pool vehicles can also be added into the cost centre.

Moving staff into the new cost centre can be easily achieved. People and Culture can assist with identifying which local processes are in place. Appropriate positions must exist within the cost centre, or have these created prior to moving the staff, as they will have to have a position to sit against. The local workforce support officers can assist with creating these positions if required.

It will also be necessary to create the demand for shifts in health roster to ensure staff can be rostered once the model is 'live'. Completing a demand template form will enable you to identify how many shifts will need to be created in the cost centre. Your local health roster support team can assist with this process if required.

Utilising Birthrate Plus® methodology and working with the Midwifery Manager for Industrial Relations and Workforce at the Ministry of Health will enable the Full Time Equivalent staffing numbers to be identified, based on the MCoC model and complexity of care being managed. This will also enable the project lead to identify where the staff will come from, e.g. traditional Postnatal Midwifery Support Programs and Antenatal Clinics, or through recruiting extra staff.

Equipment/resources that may be required to establish a MCoC model should be written into all business cases and costing documents, and can include:

- clinical supplies – Dopplers, tape measures, birthing bags, baby scales
- laptops, phones, tablets
- additional office and clinical space
- educational opportunities
- any increase to staffing profile
- costing of establishing leadership roles, e.g. CMS2 Team Leader positions
- fleet cars

Understanding the budget and funding model is important in developing a MCoC model.

3.17 Conducting a Risk Assessment

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

This process requires a wide group of stakeholders to ensure thorough identification of the potential and actual risks of the proposed service. The risk assessment process enables ownership, commitment and engagement, while identifying and assessing these associated risks within a hospital or District.

The process has proven to be valuable in providing an opportunity for facilitated, open communication between stakeholders so that the identified risks can be constructively addressed. This encourages collaboration between clinicians to ensure the design of new models of care is efficient and safe.

Each District has a representative, either a Midwifery Manager or Clinical Midwifery Consultant who are members of the NSW Maternity Safety and Quality Network. They will have been provided education as well as having expertise in supporting a risk assessment process.

The risk assessment template

Appendix C is a template that may be adapted to local processes. This is intended to be a guide only and further information and assistance is available and should be sought prior to undertaking a risk assessment.

This template will assist to examine:

a. outcomes for mothers and babies

b. impacted clinicians, and how teams work together

c. tiered Maternity Networks and escalation processes

d. resources and supports required for implementation and sustainability

The risk assessment process will produce a working document that can be used to report to the District and Steering Committee, and includes:

a. map of the woman and the neonates journey, describing the model of care and identifying potential risks and threats for the women, neonates and health service

b. an in-depth table of the potential risks and threats of the implementation of the new MCoC model

c. an in-depth table of the existing controls that are in place to minimise and/or negate these risks

d. a summary of any additional opportunities for mitigation strategies for the identified risks

A risk assessment is best conducted within a team environment. This ensures there are multiple viewpoints available for consideration of the risk in its context. Gathering a dynamic team ensures wide ranging participation of stakeholders, encourages open communication and enables the workload to be shared. Suggested team members include:

- District executive sponsorship, Executive Director of Nursing and Midwifery, Obstetric, Paediatric/ Neonatal, midwifery, nursing (example: ED or the ward environment, CFHS, AMIHS services) and local GP's and management at the site. Ambulance personnel (if transferring is required for escalation), Aboriginal representation and consumer involvement.
- any health service considered as having an impact due to the change in the model of care must be considered as a stakeholder for the risk assessment process.

A Risk Assessment is proactive in its approach, attempting to predict the impact of risk before it takes place.

3.18 Seeking Executive approval

Seeking executive approval is essential before embarking on any change to the MCoC within the existing maternity services.

A Business Paper/Brief will need to be written using District templates and protocols. This document is then approved and signed by positions with the appropriate delegation. This process can take some time so it is advised to factor in sufficient time for the Business Brief/Paper to reach the Chief Executive, as well as make any amendments that are required.

In preparation for executive approval the follow documents will need to be completed, endorsed by the Steering Committee and then attached to the Business Paper/Brief:

Business case: including a summary of the existing services as well as possible financial considerations and impacts on FTE – it is good practice to get input from your local financial advisor during this step.

Operational plan: describes the day to day functioning of the MCoC, may include impact statements, draft rosters (if appropriate), equipment and resource lists, links to established models or programs in other Districts or birthing services. This document should demonstrate how the MCoC will enhance care and provide value added service.

Costings: Including any new positions being created and resources required.

Risk Assessment: describes how the MCoC will interface with existing services while documenting the proposed changes and any clinical or organisation risks that have been identified, as well as strategies to mitigate them.

4

Implementing Midwifery Continuity of Care

Implementing MCoC requires a coordinated team approach with careful planning and considerations given to all the needs of the involved stakeholders.

4.1 Midwifery scope of practice – preparation/skill retention/ development

The design of a MCoC model, for example high-risk, normal-risk, all-risk, should also be indicative if extended skills may be an additional recruitment consideration. However, it should be highlighted that meeting Midwifery Registration requirements, including early career midwives, demonstrates capacity to work across the full scope of midwifery care, as in MCoC models. An important factor in regard to preparation for a MCoC model is education and professional development across four main focuses.

Focus 1. Clinical skills across the full scope of a midwife:

Registered midwives' scope of practice cover the entire continuum of pregnancy, birth and the postnatal period up to 6 weeks following birth. Midwives who work in an MGP MCoC model, in particular, are required to have, or be working towards, competency and skills across their entire scope. Those working in a MAPS MCoC have a clinical focus of outpatient care, and so benefit from educational support in antenatal and postnatal care.

If a maternity service has relied on midwives being skilled in one aspect of care, such as labour and birth or postnatal care prior to the implementation of MCoC, it will be important to support Midwives' in opportunities to develop the required knowledge and skills to care for women and babies suitable to the model of MCoC being introduced.

Services may also wish to support midwives in developing their skills in perineal suturing, venepuncture and cannulation.

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

Focus 2. Advanced clinical skills for complex care:

The Advancing in Maternity Safety *(AIMS – Course Information (amare.org.au))* is an educational opportunity to develop emergency and complex care skills. Building on experience of caring for women experiencing normal-risk pregnancy and birth, this two part course is available to clinicians who have completed at least one year of clinical experience in maternity care. Midwifery students must first complete the Preparation in Maternity Safety (PIMS) course prior to enrolment in the AIMS program.

The PROMPT (PRractical Obstetric Multi Professional Training©) program also offers skills development in complex and emergency maternity care. *Australia & New Zealand | PROMPT Maternity Foundation*.

Focus 3. Developing organisational and policy/framework literacy

Within the recommendations of the First 2000 Days framework,[12] midwives will benefit from education regarding the roles of integrated primary health services and relevant local community based referral services. Women in turn will benefit from midwives being able to adequately engage them in ongoing services guided by the First 2000 Days framework.[12]

It strengthens a woman's engagement with integrated services if clinicians have a strong awareness of each other's roles, purpose and scope. Shared knowledge of these services is crucial for appropriate referral and clinical handover and therefore it should be recognised as essential knowledge when working in MCoC.

A comprehensive understanding of CFHS will allow greater collaboration between staff, and greater uptake by families and foster stronger working relationships between the services.

Focus 4. Administrative and operational skills

Providing midwives with the skills to attend to their own scheduling and capturing of outpatient clinical activity ('Napping') prior to a MCoC model launching will increase the capacity of the midwives to work flexibly and independently. This is also very important to accurately capture clinical activity for funding purposes.

4.2 Recruitment considerations

A key step to the development of the MCoC model is recruitment and subsequent long-term retention of the midwives. The amount of time to enable successful recruitment must be taken into consideration early in the implementation phase. Good recruitment processes underpin a strong workforce. Steps of successful recruitment include:

1. Drafting a thoughtful, well written position description
2. Clearly describe the work to be undertaken by the midwives, the expected scope of practice as well as the expectations and obligations of both the service and the midwife. This process will assist in determining the essential criteria and interview questions
3. Defining the essential criteria needed to work in the new MCoC model
4. Consider Identified or Targeted positions
5. Considering the expectations of ongoing Continuing Professional Development (CPD) for the MCoC model. For example, ongoing CPD is a requirement of all midwives and is included in every position description. However, midwives working in a stand-alone or publicly-funded homebirth model may be required to undertake additional advanced life support training.
6. Seeking those who are willing to work in a team, with good communication skills
7. Securing executive/HR/industrial approval of job description
8. The management of applications
9. Short listing and interviewing applicants
10. The appointment of successful applicants who then require:
    - orientation, and
    - the provision of any specific additional education if required, e.g. perineal suturing or cannulation skills.

As with any employment in NSW Health, recruitment of midwives to a MCoC model is undertaken in accordance with NSW Health policy. Guidance can be found at the *NSW Health Recruitment and employment policies* website.

Historically it may have been considered that only 'advanced career' midwives are suitably skilled to work in MCoC models, this is no longer the case. Early career midwives and students should be considered for inclusion into MCoC models, recognising that they may need additional support as they transition into this model of care – an important strategy for succession planning. The support can be provided internally from other midwives in the model, as well as externally from other staff in the maternity service, and should be individualised, planned and documented. These needs can be identified through the recruitment process, so that both the service and the midwife clearly understand their expectations and responsibilities at the commencement of employment.

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

4.3 Designing a transition team and process

It is vital to convene of a small team to assist with the transition into and launch of the MCoC model. The transition team would need to be set up up well in advance of the launch. Members would meet frequently to plan the best way to either 'start' the new distinct group or move an entire service into an MCoC model. The transition team should consider key staff availability, significant local activity (hospital accreditation etc.), school holidays and public holidays when determining the launch date.

The steps for the launch/transition can involve:

- have a clear written timeline
- implementing the community engagement component of the media plan
- source required equipment
- where possible recruit the Team Leader positions first and early
- do rosters for the time period
- begin to advise the community early of the upcoming change and what it means for them. Be guided by the media and communication plan
- determine how much orientation to the MCoC the midwives require – consider are they external recruits and the number of staff
- design room use matrixes and allocate clinical space to each MCoC midwife
- plan orientation days to give each staff member any equipment they require (phones etc.), a copy of the operational plan, any supporting documents to step the midwives through contacting the women on their caseload, their allocated clinic space, how to book/use fleet
- with the Team Leaders, allocate women to their midwives
- ensure the "Core" or Base team roster is adequately covered
- in the weeks leading up to the launch, have the midwives call their allocated caseload of women and explain their next appointment will be with them instead of the antenatal clinic
- try to maintain a positive, calm and systematic approach to the transition process as it can be unsettling to introduce change to so many people at once
- consider planning a support "on call" roster for senior clinicians/CMC/CMS/MUM to assist the team for the week

Have processes in place to closely monitor, identify and fine tune any unanticipated issues in the first few weeks. These should be expected and will allow the MCoC to establish safely and within the intended operational plan.

4.4 The launch

The celebration should reflect all the hard work of those engaged with the project throughout and showcase the exciting changes that have been made. Including CFHS, AMIHS and the obstetric/medical team is symbolic of forging strong relationships and partnerships.

Incorporating Aboriginal and Torres Strait Islander recognition and ceremony into the launch is considered good cultural practice and respect. Discussion regarding this should be had with the local Aboriginal Health Directorate.

Incorporating Aboriginal and Torres Strait Islander recognition and ceremony into the launch is considered good cultural practice and respect.

4.5 Promoting MCoC

Once the MCoC has launched, continue promotion activities as detailed in the media and communication plan to ensure ongoing community awareness and engagement. An annual celebration of the launch date can be held ensuring appropriate local Aboriginal ceremonies and community members are included. The Senior Executive Team and other Executives who supported the development of the model should be included in this event.

Depending on the District, the use of visual reinforcers of MCoC can maintain workforce and community interest, such as a visual identity and/or branding, posters with information about the MCoC model, community awareness events and internal promoting of the model on IT systems/screensavers etc.

Brochures and public relations tools (public internet sites) should be updated to reflect the new MCoC so that the community are able to learn about the service when researching their local maternity services.

By external/referral services being made aware of the MCoC model and the associated benefits to women, this will encourage the community to proactively seek access to the service. Annual check-ins with local GPs may be useful to provide education as to how the MCoC works.

Once a model has launched, within the District and NSW there are opportunities to promote the model such as through the Innovation Awards.

It should not be underestimated how important it is to celebrate and promote the new MCoC model for midwives and women. This helps to validate and reiterate the evidence-based investment being made into the midwives' career and a woman's maternity care.

Activities

1. Design a plan for midwifery workforce education/ preparation
2. Commence recruitment process
3. Write a transition plan
4. Plan a launch celebration

5

Sustaining Midwifery Continuity of Care

After the launch of the MCoC model, further work commences to ensure longevity and sustainability. The project lead is often retained to oversee the initial evaluation. It is important to have predetermined systems of data collection, as well as inbuilt mechanisms to monitor midwifery staff wellbeing.

For MCoC to be successfully sustained, it will:

- reflect the preferences and needs of women and community
- accurately match the preferences and needs of the workforce
- have well established medical collegial relationships
- fully embrace and support early career midwives and midwifery students
- have been designed with, and then led by, a strong philosophy of positive team culture, incorporating midwifery leadership

5.1 Monitoring caseloads/ allocations

To ensure ongoing workforce wellbeing and proactively manage burnout or fatigue, those overseeing the operation of the MCoC should review the caseloads/ allocations of the individual Midwives as well as the MCoC as a whole every three months.

This is to ensure Midwives caseloads are balanced and equitable according to parity and risk, safeguarding an even spread of complexity within the MCoC.

5.2 Midwife wellbeing in MCoC models – consistent connection

It has been shown that across comparable high-income countries, midwives may experience burnout and work-related stress.[47] There is also evidence to suggest that when the midwifery workforce experiences emotional distress, this can impact on morale and attrition.[41] Maternity services should give consideration to the emotional wellbeing of the workforce and can view MCoC as a strategy to address, revitalise and invest in the future workforce due to the favourable working conditions reported in these models.

A significant difference for midwives who work in MCoC models compared to those in current mainstream services is that they sometimes work in isolation due to their more fluid and mobile work patterns. This is due to the ad-hoc nature of some of the MCoC models. This isolation can be from their MCoC peers as well as other colleagues in the hospital or community.

The importance of regular meetings and contact is therefore paramount to ensure that they maintain links with each other and the organisation as a whole, and are a forum for ensuring clinical governance. Weekly meetings are extremely effective and need to be included in the midwives' roster. These meetings require a clear structure/purpose, and include an agenda and minute taking.

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

- meet with their manager for general service updates
- management of any issues (including conflict resolution)
- provide each other with peer support
- manage the day-to-day workings of the model
- organise back-up and annual leave
- referral clinical cases
- undertake mandatory education sessions
- provide opportunity for clinical supervision and mentoring

Regular meetings provide an opportunity to share food and create a protected time for team building and emotional check-ins. An effective Team Leader will see these meetings as a tool to create a welcoming, encouraging and collaborative environment that communicates to midwives that they are valued and supported.

Maternity services should give consideration to the emotional wellbeing of the workforce and can view MCoC as a strategy to address, revitalise and invest in the future workforce due to the favourable working conditions reported in these models.

5.3 Clinical supervision

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

In addition to this, there are specific aspects of working in MCoC models that can increase stress and tension in their work life, and where clinical supervision can become a proactive strategy for sustainability.

These aspects include on-call working hours, being a highly visible group within the greater team and the relationship developed with the women which can at times create anxiety, tensions and possible co-dependence. The intensity of the relationship can also create anxiety if there is an adverse outcome, and the MCoC group and the woman share that difficult journey as one entity.

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

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

HETI provide an excellent resource to support those providing clinical supervision *Home – HETI: Clinical Supervision Training Space (nsw.gov.au)*

5.4 Mentoring in Midwifery (MiM)

A structured Mentoring in Midwifery (MiM) program is currently being implemented throughout NSW maternity services. This program is dedicated to the mentoring and support of Midwives.

Mentoring in Midwifery (MiM) aims to develop a reciprocal learning relationship that expands opportunities for connection, learning and growth for midwives and midwifery students.

The program centres around a value based relationship practice. Relationships being the heart of learning, however they simply do not happen, they need to be nurtured and developed. It is known however that relationships simply do not just happen, they need to be nurtured and developed. The MiM vision is to embed Mentoring within all aspects of midwifery practice, training and clinical facilities to enhance learning within our workplace and enriched experiences through the Senses Framework and Caring Conversations (see below). The MiM program supports the midwifery profession, developing leadership and support retention of a strong, confident, and skilled midwifery workforce.

For more resources contact the local Essential Of Care (EOC) Manager and visit Nursing and Midwifery – ESME Findings and resources at Professor Belinda Dewar's Homepage: *myhomelife.uws.ac.uk*

A structured Mentoring in Midwifery (MiM) program is currently being implemented throughout NSW maternity services.

5.5 Workforce development, retention and succession planning

Succession planning is essential to the sustainability of any MCoC model. One of the best ways to achieve this is by providing experiences for midwifery student and early career midwives to practice within these models in a supported environment.

Bachelor of Midwifery students (clinical placement model) are supernumerary, facilitating their placement and participation within these models.

Postgraduate midwifery students (employment model via MidStart) may be facilitated to gain exposure to continuity of care experience either via agreed supernumerary time or paid caseload model.

Flexibility is key to ensuring that they have the opportunity to experience MCoC. Some facilities may wish to utilise the supernumerary time allocated to each employed student, built in to Birthrate Plus®, for this purpose.

Embedding midwifery students in continuity models optimises the continuity of care experience required as part of their program.

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

Other strategies to improve succession planning are to encourage midwives to act in higher grade roles, such as Team Leaders, MUM, Midwife Managers, CMC, CME or Midwifery Educator, to increase exposure and operational knowledge for future workforce planning.

A concept that may benefit from exploration is building in the ability for midwives to move between MCoC models as well as existing maternity services. This may encourage them to feel confident to apply for MCoC models if they know it is not a permanent move. District processes should guide this process of staff transfer.

Activities

1. Source clinical supervision
2. Attend local MiM training program
3. Plan strategies for midwifery wellbeing

6

Evaluating Midwifery Continuity of Care

The evaluation phase of a MCoC should have been clearly defined in the design phase. The evaluation will determine local strategic planning and priorities and reflect on the consumer experience.

6.1 Evaluation and outcome measures

Evaluation of the MCoC model is an essential aspect of the implementation and the ongoing sustainability of the model. Until an evaluation has been completed, it cannot be determined if a MCoC model is meeting the intended aims and objectives. It is also important to include the midwives in this process. It will enable them to take ownership of the model and understand firsthand how the model is performing. The quality meetings are an effective time to discuss the evaluation methods and coordinate responsibilities for these ongoing evaluation requirements.

The design of the evaluation will be guided by the outcomes defined in the project plan and/or business case. Most services focus on three areas for their evaluation:

1. clinical outcomes of mother and baby
2. woman's satisfaction with the model
3. midwives satisfaction.

Clinical outcomes for mother and baby can be collected, for the most part, through eMaternity, MatIQ or the Health Intelligence Unit (HIU). Key Performance Indicators (KPIs) should reflect the model of the MCoC and can include:

Mother

1. Gravida and parity
2. Gestation at booking
3. Antenatal complications/admissions
4. Onset of labour
5. Gestation at birth
6. Mode of birth
7. Intrapartum complications
8. Pain relief used (pharmacological and non-pharmacological)
9. Perineal trauma
10. Blood loss
11. Postnatal complications
12. Postnatal readmissions

Baby

1. Apgars
2. Birth weight
3. Admission to nursery or NICU
4. Admission after discharge with mother
5. Breastfeeding on discharge

Outcomes that may also be considered:

1. Continuity of antenatal care (number of midwives seen)
2. Primary midwife during labour
3. Primary midwife at birth
4. Backup midwife at birth
5. Perineal suturing by primary midwife/back up midwife
6. Length of inpatient stay in hospital after birth
7. Early discharge rates
8. Rate of presentations not in established labour/ early labour presentations
9. Length of postnatal care at home
10. IIMS data to track any incidents.

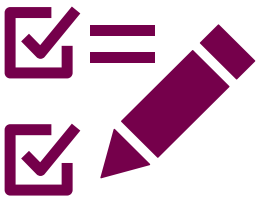
6.2 Engaging with Research

In a Cochrane systematic review midwifery-led continuity models vs other models of care, many of the studies used were team models.[7] So the benefits of team midwifery have been well established. However, arguably the Antenatal Postnatal only models (e.g. MAPS) have not as yet. This is an area of priority for NAMO, which commenced in 2022 the first large scale research into MAPS MCoC.

Designing and implementing MCoC particularly for a high risk or vulnerable cohort of women is an opportunity to study the management and sustainability requirements of a model that addresses complex needs.

Other areas within MCoC that would benefit from further research include:

- review of challenges maternity services face in gaining approval/endorsement/implementation/ establishment of a MCoC model
- early carer midwives and midwifery students in MCoC
- sustaining factors for MCoC



Women's satisfaction with a MCoC model can be ascertained via a postnatal survey or questionnaire.

6.3 Women's experiences

Robust consumer participation in the planning stages of new services, will help to establish models that meet the needs of local women. Ongoing consumer input with established models helps ensure that the service continues to be woman focused and continues to meet consumer needs as the model inevitably changes.

Research demonstrates women's improved experiences with MCoC models. It is important to analyse and understand the impact on women's experiences for the purpose of promoting MCoC within the district. Any means of gathering woman's experience data should be designed to be minimally strenuous and consistently employed by the midwives working in the model.

During the implementation phase of a MCoC model, it may be beneficial to have quick "check in" evaluation with women. An example of this could be a brief questionnaire, asking for any issues/ concerns, and if there is anything the woman feels could be improved. This is usually more effective if captured anonymously. Attending to assessment of a woman's satisfaction during pregnancy while the new MCoC is establishing, enables the team to make adjustments in real time.

Women's satisfaction with a MCoC model can be ascertained via a postnatal survey or questionnaire. A digitally completed survey allows for simple collation, however it is important to consider the woman's preferences in provision of feedback, so a paper based or verbal collection option could also be adopted. The project lead needs to consider when the postnatal survey/questionnaire should be completed by the woman. To capture the full experience, it may be considered conducting as a discharge survey/ questionnaire.

Other methods of obtaining a woman's satisfaction level with their experience can also be through submission of complaints and compliments. These can be tracked, complaints addressed, and compliments acknowledged. It may be useful to record numbers of letters and cards of thanks.

6.4 Midwives experiences

Engaging midwives in the planning of new models of care and in the ongoing steering of the model, encourages ownership of the service, improving sustainability.

Midwives' satisfaction with the model can be ascertained in a variety of ways. Formal ways of ascertaining their satisfaction are via tracking employment retention rates, recruitment into the model, sick leave, questionnaires and feedback gained in annual performance appraisals.

Informal methods include meeting with the midwives regularly to discuss any day-to-day issues working in a MCoC model. The relationship with the midwives enables the manager to monitor any changes in morale and evident issues which may need an urgent response.

Within a newly establishing MCoC, it may be beneficial to have more frequent opportunities for assessment of midwifery satisfaction. At the implementation of a new service, this could be attended through more frequent team meetings to discuss how processes are working, recruitment of women to the MCoC, and any issues faced. Additionally, collection of midwives feelings of satisfaction could be obtained through brief survey/ questionnaires, which could be attended in an identified form or anonymously.

Activities

1. Start data collection
2. Seek out research opportunities for the MCoC model

Appendices

Appendix A

MCoC business case template

Title of the project – the Maternity Service and District name

Contents Page

Executive Summary

Include a clear and concise outline of the whole proposal, including the purpose and rationale for proceeding. Provides a useful 'big picture' overview, should be brief (one page maximum) and include:

- what is the broad scope of the business case proposal?
- what is the very brief background to the project so far?
- how will the proposal support the District's core interests and priorities (i.e. provide better service to women, address Strategic Priorities etc.)?
- what is the case for change? Look at National and State context
- provide brief summary of all key stakeholders involved
- briefly describe the role of the project lead.

Highlight the project definition

Describe the current situation and how your project could be addressing a problem that needs solving

Project Objectives

How will the proposed project support the District's core interests and strategic priorities (i.e. provide better maternity care to women)? What strategies will be employed to achieve the objectives? What training, resources and post implementation support will be needed?

Determine measurable objectives to demonstrate how the project will achieve its goals.

	Objective	Indicator
Maternity services		
1		
2		
3		
4		
5		
Aboriginal perspective		
1		
2		
3		
Workforce		
1		
2		
3		

Project personnel

Name	Position
Project Team	
Steering Committee	

Background – maternity services context

The Australian Context:

Briefly describe the national context of maternity services and any policies or evidence that support your review.

The District Context:

Briefly describe current maternity services in your District.

Consider:
Demographics, any local reviews, reports or policies relevant to maternity, the Aboriginal and Torres Strait Islander community issues, rural and regional considerations, any previous MCoC projects, any unique insights into the community or area to demonstrate a clear understanding of the unique needs of the consumers.

The Hospital Context:

Briefly describe the maternity service/Unit where the project is proposed. Include any consumer feedback that may have been gathered.

Consider:
Birth rates, service capability, infrastructure, AMIHS, number of beds, referral hospitals, how the service currently functions, and significant clinical outcomes.

Workforce analytics:

Briefly describe the maternity workforce and any relevant challenges or strengths.

Consider:
Staff profile, midwife and doctor workforce, anticipated challenges/recruitment issues, historical issues.

The project voices

Consider creating a summary of some of the feedback from involved stakeholders.

Midwifery Continuity of Care options

Give a summary of MCoC, the availabe models, the benefits and challenges of each version. Demonstrate the options of care available.

Give a strong rationale as to why the proposed model is the right one for this District/service.

Proposed models

Describe or include a chart of the proposed model

Proposed changes summary

Include a clear list of the foreseeable most significant changes to the District/maternity service

Project Planning

Include here aspects of your project plan that demonstrate how the project will progress and be time managed. Describe how the Steering Committee will be updated of progress.

Project timeline and deliverables

Project funding

Describe how the project lead role will be funded. Include a brief analysis of the financial impact of the MCoC.

Stakeholders

Map out the relevant stakeholders.

Financial Analysis – pending full Cost Analysis once business case approved

Consider these examples:

Item	Status	Plan
Associated project costs		
Likely future costs to implementing MCoC		
Possible future costs to implementing MCoC		

Foreseeable challenges and solutions

Demonstrate an understanding of the possible challenges and solutions for them

Challenge	Solution

Risk management

Describe the risks to the Health Service that are *managed* by the Project, as well as the risk of the project not being successful.

Consider the following areas of risk:

- medicalised maternity services
- financial
- community perception
- workforce
- clinical safety

Evaluation mechanisms

Framework of the MCoC evaluation:

Does the District have an existing evaluation framework for evaluation?

Project Evaluation:

How will the project be evaluated once implemented?

References

Appendix

Appendix B

MCoC operational plan template

Insert District logo

Explanation:

Title of section

Brief description of the section

An example of possible text

Title of the project – the Maternity Service and the District

Contents page

Executive summary

Briefly describe the background to the work done by the project lead.

This operational plan aims to provide all staff within XX (Hospital, District) information that describes the functioning of the new Midwifery Continuity of Care (MCoC) model being designed and implemented. Describe how the new model will sit either within or across the entire existing maternity service. The model will offer midwifery care for women with [XX] risk, in a [MAPS/MGP] MCoC model.

Objectives of the MCoC model

Use this section to outline the overarching concepts of your new model, including the benefits of MCoC.

MGP example:

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

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

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

Women receiving MGP care will still be able to access all other services offered to women booked at Hospital XX e.g. Social Work, Diabetes Clinics. All midwives providing MGP care will continue to utilise the Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral (as per NSW Health Policy Directive 2020_08).[1,2] The National Midwifery Guidelines for Consultation and Referral (©ACM 2021) describe the parameters for identifying normal risk pregnancy and supports midwives to make appropriate consultation and referral to other clinicians and allied health staff if risk factors arise in pregnancy, labour and the postnatal period. Acceptance into the model will be based on normal risk criteria. Midwifery care may continue even when referral to care by a secondary or tertiary level health care provider is necessary i.e. the midwife continues to provide midwifery care and support to the woman in collaboration with other health care providers.

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

MAPS example:

MAPS is a model where a woman is provided with continuity of care with a known midwife or team of midwives during antenatal and postnatal care. Intrapartum care is provided at the birth site of the woman's choice and dependent on risk factors. It is designed to articulate with existing services such as General Practitioner Shared Care program and the Child and Family Health Services.

It is becoming a popular MCoC choice as it does not require substantial additional financial resources to establish. The MAPS model of care has a focus on outpatient services where women birth with, and receive any inpatient/ unplanned care from an identified team of Midwives who work within the Birthing Unit/Maternity wards.

The model design aims to increase women's satisfaction with the maternity service through improved parenting skills and confidence, breastfeeding initiation and duration, women's knowledge of physical and psychosocial support, reduced hospital length of stay. AMIHS has been providing this model of care for many years to Aboriginal women who elect to use that service and can be looked to as an example of effectively functioning MAPS.

Philosophy of care

Outline the philosophy of the MCoC. For example:

- the XX model of care that reflects a philosophy that is woman centred and focuses on pregnancy, labour, birth and the postnatal period as normal life events.
- continuity of care for women and their families is woman centred, evidence based, individualised and holistic. Midwives and women work in partnership and aim to develop relationships that facilitate women's active participation in their care and decision making across the continuum.
- there is collaboration with other health professionals when required, to ensure safety and quality in health care.

Proposed changes from current maternity service

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

- offer midwifery continuity of care model and describe exactly which model
- describe the scale of the MCoC model
- any changed work conditions including annualised salary, flexible work arrangements, on-call if implementing an MGP
- transition from hospital to home 4 to 6 hours after birth if mother and baby are well
- when risk is identified and the woman is referred to a medical practitioner the individual situation of the woman will be evaluated and documented agreement will be made about the responsibility for the provision of continuing maternity care

MCoC objectives

What are the objectives of your MCoC. Align them with local and state recommendations where possible. For example:

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

Midwifery leadership

Describe any proposed changes to midwifery leadership within the District, consider governance and reporting lines. Using a chart here to demonstrate this may be useful. Describe any new Team Leader roles being implemented.

Integration with other services

Reference the First 2000 Days Framework and how the MCoC will work to collaborate and work with Child and Family Health Services.

Describe the importance of Midwives understanding the benefit of early referral to services.

Midwives should be given the opportunity to increase their knowledge of CFHS and relevant local community based referral services prior to the launch of the MCoC. An explanation of Child & Family Health Nursing service (with possibly a script for staff to use in introducing the service to families at booking in), would be useful for the Midwives. A knowledge of these services is crucial for appropriate referral and clinical handover and therefore it should be recognised as essential knowledge.

Furthermore, a comprehensive understanding of CFHS will allow greater collaboration between staff, and greater uptake by families.

Aboriginal cultural inclusion

Consider describing the local Aboriginal community and culture and how the MCoC will reflect the identity and inclusion of families who identify as Aboriginal or Torres Strait Islander.

Evaluation

Add in here any specific data items as outlined in the project plan. Include details such as the list of agreed upon KPIs along with copies of any questionnaires, surveys or audit tools. For example:

There will be a process evaluation of the model including specific outcomes for the women at six months after implementation and then ongoing annually. Predetermined MCoC Key Performance Indicators will be monitored on a yearly basis and more frequently where there are identified adverse outcomes, or identified concerns about processes. The Steering Committee will continue to meet for reporting of the evaluation data.

Clinical Processes

Antenatal period

Describe how the MCoC will offer midwifery care for the antenatal period.

MGP – location of clinics

MAPS – Monday to Friday or 7 days a week antenatal clinics, location of clinics

Booking-in 1st visit

Describe the Booking-in process, consider using flow charts.

Detail here the local arrangements for co-ordination of booking appointment and how this will interact with the MCoC and women will be triaged into the MCoC. For example:

Women access maternity services by GP referral via xxxxxx, or women self-refer.

Describe with clear points the information you want Midwives to share with women regarding the MCoC at booking in.

Consider writing a standardised script or description of local CFHS services and offer any printed resources available. Refer to the First 2000 Days Framework to ensure any early referrals are being made where needed.

Antenatal clinical risk management

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

Describe any measures in place or to be implemented that address any clinical risk identification.

Midwifery triage

Detail how will women be allocated into the MCoC if it will be a smaller entity within a larger service, or if there are multiple MCoC. Ideally this should be prior to the first booking appointment.

Describe how women will be allocated within the MCoC to their known midwife. For example:

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

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

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

MGP/MAPS Database:

It is useful for the MGP/MAPS to have a data base on which they can record women accessing the model and other relevant data for audit and evaluation processes. MGP/MAPS midwife or Team Leader will enter woman's information on database (i.e. woman's name, MRN, parity, EDB, suburb and midwife's name.) This database will be maintained by the MGP/MAPS and will facilitate tracking of the women and will provide data to contribute to the process evaluation of the model.

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

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

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

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

Should women in the MCoC require assessment during pregnancy outside their scheduled antenatal visit, they will contact their allocated midwife. The MGP/MAPS midwife may arrange for the woman to be assessed in the Birthing Unit (BU) by the "Core birthing team/Base Team". The MGP/MAPS midwife will usually meet the woman in BU for assessment and will organise a consultation with senior obstetric medical officer/Obstetric Staff Specialist if medical management is required. Any antenatal care episode provided in BU will be recorded in the woman's medical record as per local practices.

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

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

The MGP/MAPS midwife will make arrangements to facilitate the woman meeting the other midwives in the MCoC group.

Antenatal admissions

Outline the arrangements for a woman's care should she need to be admitted during the antenatal period or require unplanned outpatient assessment. Consider the impact on the workload "Core/Base Team/Birthing Team". It is useful to clearly determine an agreement as to who will attend to unplanned outpatient care so as to minimise disruptions to the service as a whole. For example:

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

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

Preparation for labour and birth, and parenthood

Outline provision for antenatal education for women within the MCoC, who conduct any antenatal education classes. For example:

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

Supporting families early Safe Start strategic policy

Detail process of referral for vulnerable women in the service. For example:

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

Post-dates Pregnancies

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

From 41 weeks gestation, MCoC women will receive collaborative care with the midwives and senior medical officer/ Staff Specialist. A clear management plan will be developed and documented. The MGP midwife is to attend to the usual care of women at this gestation, following the policy GL2014_015.

Note the difference here between MAPS and MGP Midwives is that MAPS Midwives will continue to coordinate and support during any antenatal post-dates medical appointments, however will not be providing care if an Induction takes place.

Induction of labour (IOL) for post-dates pregnancy

Detail the arrangements for care of a woman requiring a post-dates induction of labour. Specify that women in a MAPS model will be cared for by the "Core/Base Team".

However remember that MGP Midwives provide intrapartum care, including for any Induction planned. For example, in an MGP:

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

Cervidil/Prostin IOL

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

ARM/Syntocinon IOL

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

Elective lower segment caesarean section (LSCS) Operation

Detail the arrangements for care of a woman requiring an elective LSCS operation. Specify that women in a MAPS model will be cared for by the "Core/Continuity Base Team". However remember that MGP Midwives provide intrapartum care, including for any elective LSCS. For example, in MGP:

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

Intrapartum care

Detail the process and arrangements for care of a labouring woman in any MCoC For a MAPS model, this will mean describing the "Core/Base Team/Birthing team" will be providing care and women should contact that team directly in labour. For MGP, further detail is required. For example:

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

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

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

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

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

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

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

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

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

Postnatal care

Detail the process and arrangements for a woman's postnatal care. Clearly describe the processes for MAPS women linking back in with their allocated midwife. Describe how the MAPS may be notified of a woman preparing to discharge so that they may initiate their outpatient postnatal care. For MGP, describe detail as to when care is handed back to the Core/Base Team. For example:

Discussion regarding the expected postnatal pathway begins when the woman "books-in" to the MCoC. The expectation is that a woman will transfer home within 4-6 hours provided her condition remains uncomplicated and her baby is well.

Midwives should provide appropriate support to women at home, especially within the first 24 hours. This may include a postnatal visit on the day of birth to monitor maternal and infant wellbeing, allay anxiety for the woman and her family and support feeding.

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

Beyond 4 hours post birth – Transfer to ward

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

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

Referral to CFHS

Use this as an opportunity to develop a clear process for referral and feedback between maternity services and CFHS. This is vital for collaboration of care and to ensure a smooth process and handover to other relevant service providers.

Describe how CFHS will know how to contact the allocated MCoC midwife in order to coordinate care, which is especially important if there is no existing reliable central phone or email in place.

Transfers to a non-XXXX maternity services facility

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

Maternal

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

Neonatal

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

Readmissions

Neonatal

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

Maternal

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

Referral to Child and Family Health (CFHS)

Describe how women are referred to CFHS. For example:

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

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

Management structure

Detail the management structure that the MAPS and MGP will work within. Outline reporting pathways and line management responsibilities, tailored for the MCoC that is being implemented. For example:

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

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

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

Clinical referral

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

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

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

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

Professional development

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

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

As with all midwives opportunities to attain and maintain clinical skills will be provided to ensure MCoC midwives maintain competency. Essential education requirements such as Perinatal Safety Education: Maternal/Fetal Safety will continue for all staff. MCoC midwives will participate in education programs as required by the organisation.

Clinical supervision

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

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

Operational Processes

Workforce processes

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

Weekly MCoC meeting

Describe the purpose and detail of the weekly meetings. For example:

A weekly meeting held will be an efficient time to attend to clinical and operational processes, as well as be an opportunity to build team rapport and supports.

Consider a standing agenda for each week to ensure there is consistency, this can include:

9.00-10.00	Housekeeping, general issues: *Standing items:* 1. Obstetrician report 2. Monthly stats review 3. Allocation of new bookings 4. Roster discussion/Leave planning 5. Partnership updates (CFHS, AMIHS) 6. CBT or 'Core/MAPS/MGP' Check in 7. Student and New Graduate Check In
10.00-10.30	Notes review of new bookings and 36/40 notes review with Obstetrician
10.30-11.00	Case reflection – Midwives present an educational experience/reflection from their week. Replaced once a month by structured group clinical supervision.
11.00-12.00	Skills, education and collaboration session e.g. Child and Family Health Nurse attend to do an in-service and check in
12.00-12.30	Report from the MUM/Team Leader regarding operational issues

Annualised salary (for MGP only)

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

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

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

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

State Award (for MAPS and Core/Base Team)

The MAPS MCoC Midwives will be paid as per the State Award, with penalties for weekends as stipulated in the conditions.

Midwifery student MCoC program

Detail the way that midwifery students will be included, encouraged and supported in the MCoC.

Early Career midwives MCoC program

Detail the way that early career midwives will be included, encouraged and supported in the MCoC.

On-call (Specific to MGP)

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

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

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

In accordance with the pilot salary agreement MGP midwives will work a maximum of 12 consecutive hours. If and when it becomes clear that intrapartum care and/or pre-arranged visits are likely to exceed this 12 hour limit, the midwife will arrange hand over of intrapartum care as indicated to the MGP midwife on-call and where possible re-organise scheduled visits.

Scheduled visits that cannot be rearranged for another time will be provided by the next available MGP midwife on call.

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

Use of on-call phones in MAPS

Consider describing exactly how the mobile phones will be used, clinical appropriateness and guidelines. Describe what happens when the MAPS midwife is on a day off, who answers the phone, and how you communicate to women they must call the Core/Base Team if the MAPS service is out of business hours.

Rosters

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

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

Rostering will be entered into Health Roster by [X] and maintained by [X].

MAPS – Rosters will be completed by [X] and clearly show the use of clinical rooms, and when each midwife is either on antenatal clinics or postnatal visits.

Managing leave in the MCoC

Detail how the MCoC will manage their leave. For example:

Annual leave:

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

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

MAPS – Where possible annual leave will be booked as far in advance as possible. The midwife will not allocate or accept women into her caseload whose EDB falls within her approved holiday period (+ 7 days either side if taking more than 2 weeks). She will need to re-distribute her antenatal and postnatal visits between the other group midwives prior to commencing leave.

Sick leave:

Detail how the MCoC will manage their short term and long term sick leave. Describe any capacity for a leave relief position within the MCoC. For example:

Short term

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

Long term

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

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

MCoC office/telephone number

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

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

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

Clinic rooms

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

MCoC Midwives will utilise clinic rooms in the Antenatal Clinic or established outreach clinics in the community. Create a room use matrix for all to see. Remember to consider others who use the clinical spaces such as gynae clinics.

Home visiting

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

The MCoC midwife will conduct an OH&S risk assessment (Home Safety Checklist) on eMR with the woman prior to the first home visit.

Consultation with CFHS is important to ensure handover of clinical care is given if necessary, and that women are clear on who is visiting and why. The Midwives should ensure women are engaged and offered CFHS services early in pregnancy and reiterated in the postnatal period.

Communication technology

Detail arrangements for the midwives to have access to mobile telephones, ipads and/or laptops. iPads and laptops provide midwives with point of care data entry capacity and the ability to view clinical results.

Consider the difference between a MAPS and MGP use of a work phone. For example:

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

Motor vehicles

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

As the MCoC midwives will be continuing the care in the community after discharge from hospital there will be considerations for vehicle use. The MCoC midwife will use the cars allocated to maternity when available or an alternate hospital fleet car.

Where neither of these options are possible or practicable the MCoC midwife will use her own car.

All work use of the midwife's private car will be recorded in District log form with reasons for using own car. All personal car usage documented on the District form will be signed off monthly by the maternity services manager and reimbursed according to business rates as per *NSW Health Policy Directive Official Travel* (PD2016_010). The MCoC midwife will need to demonstrate the comprehensive insurance status of her/his private vehicle and a valid driver's license.

Medical records

Detail the type of medical record that the midwives will use, for example woman held records, electronic records, hospital medical record etc. Outline processes for filing, handling and storage of information. Ensure local processes are described. For example:

Medical records will be maintained in accordance with NSW Health Policy Directive PD2009_057 Records Management – Department of Health[8] (currently under review).

Equipment

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

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

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

All MCoC midwives will be issued with a diary to facilitate management of antenatal appointments and postnatal care visits. MCoC Midwives will use all the usual stationery/stock items that are available in the Maternity Unit.

References

Appendix items

Appendix C

MCoC Risk Assessment template

Insert District logo

Title of MCoC project

Risk Assessment

Date: / /

Project lead:

Team Members:

Facilitated by:

Table of Content

Executive Summary

Provide a general description of what the new service will be and outline its operation. Describe staffing, facilities and connected health services where applicable.

Steps for the Risk Assessment

Step 1: Gather a Risk Assessment working group and establish the context

Gather relevant stakeholders and schedule an agreed upon time to conduct the risk assessment. It may take a number of sessions to complete.

Establishing context

Establishing the context is often the most difficult part. The context needs to be established in order to set the boundaries of the risk assessment. In facilitating a risk assessment it is *essential* that you are clear on what it is that you are assessing. For example, when considering the risks associated with changing a maternity service the context is the entire process, starting with the referral of a woman to a service and concluding at its end point – discharge of mother and child. Along the way there will be points where the service interacts with external agencies – the impact of your service change on these agencies needs to be included in the risk assessment process i.e. ambulance, tertiary facilities, NETS.

It is helpful to document and distribute the planning documents and templates to the risk assessment team prior to your first meeting. In addition you will want to provide an invitation and overview to key stakeholders such as hospital executive, clinical directors and the hospital's risk manager.

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

Step 2: Identify and collate the 'Proposed Changes'

Review the operational plan against current practices/systems and record any change from current practice in the proposed changes' table *(Appendix A)*.

Group the 'Proposed changes' into the categories of:

1. Maternity services – include a breakdown of antenatal, intrapartum and postnatal areas and describe all the proposed changes to the specific areas
2. Organisational – any impact to the District
3. Medical – obstetric changes
4. Workforce – midwifery workforce impacts, changes
5. Communication – any change to how information is communicated to consumers
6. Evaluation – any change to data/processes to evaluate the maternity service.

Step 3: Identify 'Priority Risks'

1. Place the proposed changes (from *Appendix A*) into the 'Risk Assessment' table *(Appendix B)*
2. Using the Enterprise-wide Risk Management Matrix, allocate a SAC to each change
3. Record any *current* safety controls in place that address that issue
4. Develop any *additional* safety controls that can be introduced.

Step 4: Identified 'Priority Controls'

Complete the project plan for implementation of proposed additional controls *(Appendix C)*. Arrange the SAC numbers from 1-4 and colour code them if need be.

With the working group, allocate a person/role who is responsible for each control and report back to the Steering Committee.

The whole Risk Assessment and an Executive Summary should then be submitted to the required District governance structures/committees.

Consequence	Context
Catastrophic	Unexpected, or potentially preventable, death of multiple persons from the same event or cause; or Substantial reprioritisation of resources to salvage key strategic, operational or performance objectives
Major	Unexpected, or potentially preventable, death of a person; or Reprioritisation of resources to ensure delivery of key strategic, operational or performance objectives
Moderate	Major harm to a person (or persons); or Modest reprioritisation of resources to support strategic, operational and/or performance objectives
Minor	Minor harm to a person (or persons); or Reprioritisation of resources to support delivery of key objectives at a unit- or service-level
Minimal	Minor harm, not requiring medical treatment, to a person (or persons); or Short-term diversion of resources to achieve business unit or service objectives

Likelihood	Time scale	OR	Probability
Almost certain	Several times a month		Greater than 97%
Likely	Monthly, or several times a year		At least 70% but less than 97%
Possible	Yearly, or several times over a three-year period		At least 30% but less than 70%
Unlikely	Once every three years		At least 3% but less than 30%
Rare	Less frequent than once every three years		Less than 3%

		Consequence Rating				
		Catastrophic	**Major**	**Moderate**	**Minor**	**Minimal**
Likelihood Rating	**Almost certain**	**A**	**D**	**J**	**P**	**S**
	Likely	**B**	**E**	**K**	**Q**	**T**
	Possible	**C**	**H**	**M**	**R**	**W**
	Unlikely	**F**	**I**	**N**	**U**	**X**
	Rare	**G**	**L**	**O**	**V**	**Y**

Risk matrix key: Extreme (A – E) High (F – K) Medium (L – T) Low (U – Y)

Risk Rating	Extreme (A – E)	High (F – K)	Medium (L – T)	Low (U – Y)
Review period	28 days	91 days	182 days	364 days

Recommendations – A summary of the risk assessment once completed

Appendix A. Proposed changes

Process Step	Proposed change in service

Appendix B. Risk Assessment

Process Step	Proposed change in service	Threat	C	L	R	Current controls	Possible additional Controls

Appendix C. Proposed Additional Controls

Risk Priority	Process Step	Possible additional Controls	Responsible	Due Date	Status
1 Extreme Risk					
2 High Risk					
3 Medium Risk					
4 Low Risk					

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