Castlemaine Health Maternity Services

Collaborative Operational Model of Care

Document information

Document Owner	**CHMSGG**
Contributors	Project Consultant, Project Executive Leads, CHMSOMOC Working Group, CH Midwifery Practice Working Group, CHMSCC
Valid from	January 2021
Review date	

Document history

Version	Date	Amendment	Amended by
1.0	03 Oct 2020	Original version	Fiona Faulks
2.0	08 Oct 2020	Postnatal care additions and edits	Sarah Watts
3.0	10 Oct 2020	Review all components	OMoC Working Group
4.0	21 Oct 2020	Grammar, appendix, formatting	CHMSGG
5.0	15 Dec 2020	Final appendix additions	Fiona Faulks

Table of Contents

Acknowledgments

Castlemaine Health would like to acknowledge the work done by Dr Rupert Sherwood and Ms Lisa Smith in reviewing and advising on the Maternity Services model. In addition, the work done by Tracey Hynes in 2017, reviewing and advising on the service. This work has provided a framework for the development of this model of care.

Castlemaine Health Maternity Service Governance Group

Ian Fisher (CEO) (Chair)	Anna MacLeod (Board Member)
Anna Howard (Consumer)	Shane Robinson (DHHS)
Nicholas Yap (Board Member)	Tanya Farrell (Safer Care Victoria)
Nicole Allan (ANMF (VIC BRANCH))	Dr Peter Sloan (DMS, CHS)
Fiona Faulks (Project Consultant)	Dr Ronnie Moule (GPO, CHS)
Sarah Watts (Midwifery Lead)	Dianne Senior (Exec Director Clinical & Community)
Dr Nicola Yuen (Director O&G BH)	Samantha Ward (Midwife CH)
Moira Kean (Consumer)	

Castlemaine Health Maternity Services Operational Model of Care Working Group

Fiona Faulks (Project Consultant) (Chair)	Nicole Allan (ANMF (VIC BRANCH))
Dr Ronnie Moule	Samantha Ward
Sarah Watts	Lesleyann MacGill
April Jardine	May Pratt (Consumer)
Dr Nicola Yuen	Claire Nightingale (Consumer)
Mark Nally	Steve Warren

Castlemaine Health Maternity Services Clinical Practice Working Group

Sarah Watts (Midwife Lead) (Chair)	Fiona Faulks
April Jardine	Loretta Marchesi (ANMF (VIC BRANCH))
Jenny Oxley	Dr Ronnie Moule
Lesleyann MacGill	Dr Nicola Yuen (Advisory Role)
Samantha Ward	

Castlemaine Health Maternity Services Consumer Committee

Anna Howard (Chair)	Emily Condon
Fiona Faulks (Project Consultant)	Claire Nightingale
Dianne Senior (EDCC)	May Pratt
Sarah Watts (Midwifery Lead)	Frances Robb
Rebekka Sutton (Communications)	Moira Kean
Kaitlyn Hough	Lucas Maddock

The term “Aboriginal” is used respectively in this document as an all-encompassing term for Aboriginal and Torres Strait Islander people and culture identifying Aboriginal Women and Aboriginal Partners.

Australian Aboriginal Culture is the oldest living culture in the world and yet Aboriginal people continue to experience the poorest health outcomes compared to non-Aboriginal Australians.

Abbreviations and acronyms

Aboriginal	The term Aboriginal is used respectively in this document as an all-encompassing term for Aboriginal and Torres Strait Island people and culture.
ANMF (Vic Branch)	Australian Nursing and Midwifery Federation
ACM	Australian College of Midwives
BDAC	Bendigo and District Aboriginal Co-operative
AMUM	Associate Midwifery Unit Manager
CAFHS	Child and Family Health Service
CHMS	Castlemaine Health Maternity Services
CTG	Cardiotocography
CRM	Case Review Meeting
DON	Director of Nursing
EDON	Executive Director of Nursing
EN	Enrolled Nurse
EPDS	Edinburgh Postnatal Depression Scale
GPO	General Practitioner Obstetrician
PIF	Priority Information Form
PN	Postnatal
MaCCS	Maternity Care Classification System
MCP	Maternity Care Planning Meeting
MGP	Midwifery Group Practice
MoC	Model of Care
MUM	Midwifery Unit Manager
MDT	Multidisciplinary Team
NICU	Neonatal Intensive Care Unit
PPG	Policies, procedures, guidelines
RN	Registered Nurse
SCV	Safer Care Victoria
WHA	Women's Healthcare Australasia
VMR	Victorian Maternity Record

Executive summary

Castlemaine is a small rural town in the goldfields of central Victoria and the Shire of Mount Alexander is a local government area that covers an area of 1,529 square kilometres with a population of around 19,000. The Maternity Service is a Level 2 maternity service meeting the Victorian Capability Framework for Maternity & Newborn Services with an annual birth rate of between **40-60 births**.

In May 2020, Castlemaine Health Board suspended the operation of the maternity service in order to enable an external review of the service in response to concerns about quality and safety within the service. Historically, the Castlemaine Health Maternity Service (CHMS) has been embraced and honored by the community who have a deep appreciation for the value of care in their own community and the ongoing relationships that continue way beyond the pregnancy and birth. Primarily, this service has been a GP led maternity service which has provided some degree of continuity for women and families but has not enabled midwifery staff to work to their full scope of practice and has lacked a collaborative approach to care.

The external review was undertaken by Dr Rupert Sherwood (FRANZCOG) and Lisa Smith (Senior Midwife) with a focus on documenting a future state for CHMS that would be safe, sustainable and meet the needs of the community. The final report proposed the following:

What does a safe, collaborative and sustainable maternity service look like for Castlemaine Health?

1. The service works within a recognised governance framework of safety and quality, to which all stakeholders subscribe and support.

2. The delivery of care is according to agreed clinical procedures and guidelines, as endorsed by CH, Bendigo Health and Safer Care Victoria.

3. Variation in practice is minimised.

4. The model of care on which the service runs is evidence based and is an agreed collaboration between women and their partners, midwives and GP obstetricians. This model is one in which each care provider (midwife and GPO) works within their full scope of practice, supported by peers and hospital management.

5. Local midwifery and medical leaders are supported and respected amongst peers, and able to respond to change, control variations in practice, manage and learn from adverse events and meet the expectations of the community.

6. The service has a plan for sustainability that includes attracting women to use the service, providing excellence in existing range of care options and future planning for additional scope of practice should the resources be available.

This Operational Model of Care (OMoC) has been developed addressing the recommendations provided in the Sherwood/Smith report and ensures the model of care is woman centred. The development of the OMoC has

been overseen by the Castlemaine Health Maternity Services Governance Group reporting to the Board of Executives who are committed to remodelling their Maternity Service in a way that is collaborative and sustainable into the future.

In line with the Strategic Plan 2020-2022, there will a strengthened partnership with Bendigo Health. This will be established using formal mentoring roles with key senior staff, clinical advice and collaboration on care pathways for women as required.

This model of care incorporates the ***four pillars*** of our Strategic Plan:

> *We strive rigorously to ensure that **everyone** needing our clinical, emotional, and psychological support gets the best care, treatment and advice.*
>
> *Together we are better and smarter than we are apart. We commit to **collaboratively** working with the community, staff and partners to positively impact the health and wellbeing of all.*
>
> *We build on the foundation of a proud history and a progressive present to steward Castlemaine Health into a thriving **future**.*
>
> *We are interested in everything around us. We are knowledge seekers who apply our learning in practical ways to make a tangible **difference**.*

This Maternity Care model will provide care that is accessible, equitable, safe and woman centred. This model will also seek to provide care for the most vulnerable in our community, enable our workforce to work in a collaborative model that enables them to work to their full scope of practice and places the woman and her family at the centre of care. We are committed to operationalising, evaluating and maintaining this model of care now and well into the future.

Mr Ian Fisher

CEO Castlemaine Health

Woman centred care

The woman's experience of pregnancy and labor and birth should be at the centre of any decisions made regarding models of care in Maternity settings. The philosophy by which the Castlemaine Health Maternity Services developed their model of care is woman centred and focuses on safety and sustainability.

The National Maternity Services Plan *(AHMAC, 2011)* defines woman-centred care as:

> *Care that is responsive to women's needs and preferences, and enables them to access objective, evidence-based information that supports informed choices about their maternity care* (AHMAC, 2011, p. 25).

The following guiding philosophy was developed by the CHMS Governance Group and has been central to all decisions and planning in developing the model of care (MoC) and implementing the recommendations of the Sherwood/Smith report.

> ***To develop a maternity health service that is woman centred, culturally safe and collaborative, whereby services and professionals care for women and families ensuring pregnancy, birthing and care after birth is safe and effective meeting the physiological, psychological and spiritual needs of the woman. The model of care utilises the skills and strengths of every member of the care team, as well as principles of mutual respect and understanding, in a manner that is efficient, effective and sustainable.***
>
> ***Castlemaine's maternity service commits to providing comprehensive, safe and high-quality care with an open and transparent clinical governance structure that embeds the woman's experience at its core and embraces opportunities for continuous improvement.***

This guiding philosophy has provided a strong foundation on which all elements of the model have been developed enabling care to be safe and high-quality meeting the needs and expectations of the community and the health service.

Stakeholder Voices

Critical to the model was ensuring that the care is valued by community, midwives and medical staff. Therefore, the OMoC working group sought feedback and developed the 8 ***guiding principles that underpinned the*** model's development. Table 1 is a summary of the elements of care valued by the three key groups and table 2 articulates the guiding principles for the OMoC.

Table 1: Elements of care valued in a maternity service

Women value	Midwives value	Medical staff value
▪ Continuity of care +++ ▪ Being heard ▪ Supportive ▪ Birth plans considered, discussed and respected ▪ Continuity even when transferred ▪ Collaborative care (communication between members of the care team) ▪ Informed consent (reduce birth trauma experienced by women) ▪ Communication with women during care – what is being done and why? ▪ Use of technology to support women in staying closer to home ▪ Non-judgmental care that also supports vulnerable or disadvantaged women ▪ Midwifery model of care ▪ Choice ▪ Flexibility ▪ Agility ▪ Flexibility ▪ Inclusivity	▪ All women should have access to a midwife during pregnancy, birth and after birth care ▪ Continuity midwifery model ▪ Supported practice that builds competence & confidence ▪ Midwives working as midwives ▪ Family centred, individualised care ▪ Lactation support ▪ Childbirth and parenting education ▪ Pregnancy care and birth locally ▪ Safety and quality ▪ Collaborative care ▪ Evidence based practice ▪ Have an opportunity to build relationships with women and families ▪ Women should be supported to achieve the birth they want. ▪ Sustainable workforce. ▪ Option for waterbirth or at least water immersion for pain relief. ▪ Students/graduates supported to practice	▪ Clinical communication that is timely, accessible and accurate ▪ Every woman does not need a medical visit ▪ Choice in pregnancy care ▪ Respecting relationships ▪ Elective Caesareans in future ▪ Regular MDT meetings/review ▪ Midwives should be supported in their full scope of practice ▪ All women should have GPO's/Obstetric visit at 34-36 weeks ▪ Triage to the most appropriate pathway of care ▪ Continuity of care ▪ Recognizing differences in valued components ▪ Supports new practitioners (Junior GPO's) ▪ Women have a voice ▪ Respect and allow birth to be a healing experience ▪ Low risk treated as such ▪ Continue to practice as GPO's – no loss of skill use or development.

Guiding principles

Table 2: Guiding principles for the OMoC

Principle	Statement
The woman will have a midwife for the whole continuum of care including pregnancy care, intrapartum care and post birth care both in hospital and at home.	To achieve this principle women will be supported by a 'known midwife' in collaboration with a multidisciplinary team. This will ensure her pregnancy, labour and birth, and postnatal care choices are informed, safe and appropriate to her needs.
The woman will be a valued participant in her care.	A woman and her family will be at the centre of any decisions that are made about her care and be consulted about any changes to her plan of care.
The woman will receive midwifery care close to home	A woman will be supported by a midwife, acknowledging her geographical location and choice of birthplace. Videoconference and telephone consultations may also be considered during pregnancy

	and care following birth. Flexibility in care delivery will be considered.
The woman will continue to receive pregnancy care with their chosen doctor if this is the woman's preference in collaboration with the midwives	A schedule of appointments with the most appropriate care provider will be negotiated between the team and the woman. This schedule will be determined by individual risk factors and the woman's personal preference. This principle will focus on enabling the development of a relationship with the midwifery team who will care for her during labour and birth. An on-call roster for GPO's will ensure every woman has access to a GPO should she require it when in labour.
The woman and family should receive consultations with medical workforce, midwifery team and timely referrals to all care providers as required.	Care will be escalated as required by the woman or babies' clinical condition throughout pregnancy, labour and birth and early postpartum period. This is to ensure the woman and family receive the most appropriate level of care and enables the ability for shared decision making. There will be clear escalation pathways for every member of the care team.
The woman will have a personalized discharge plan completed with ongoing support	The woman will be provided with care by their midwife in the early postpartum period. Care will be individualised and include a clear discharge criterion from hospital to home. Ongoing postnatal support will continue at home after discharge.
Aboriginal or Torres Strait Islander women and families will receive culturally appropriate and respectful care 	A woman or her Aboriginal partner, who or who's baby identifies as Aboriginal or Torres Strait Islander, may have an Aboriginal Health Liaison Officer allocated to ensure culturally respectful care is provided. Midwives will provide culturally safe care to the woman and her partner seeking professional guidance and support to meet all needs.
Women of all cultures and backgrounds will be provided with culturally safe care at CHMS throughout pregnancy, birth and the postnatal period.	The woman will be provided with culturally respectful care across the continuum. Midwives will provide culturally safe care to the woman and her partner seeking professional guidance and support.
CHMS will measure and deliver best clinical practice in the model of care.	A woman's experience will be recorded in accordance with Vic Health's privacy and confidentiality policies and procedures. This is to assist in the collection of data through participation in surveys as well as clinical audits to ensure the model of care is being delivered. Monitoring of perinatal performance indicators will occur via the SCV Dashboard and the annually published Perinatal Services Performance Indicators. In addition, case review and mortality and morbidity meetings will occur at least monthly to monitor clinical practice within the maternity service.

The Collaborative Model of Care

The model has been specifically developed to sustain maternity services for Castlemaine and provide a high standard of care to women. This collaborative model of care requires collaboration between midwives,

doctors, nurses, allied health, Maternal and Child Health Services (MCHS) and Aboriginal Health workers ensuring women receive care that is comprehensive, safe and effective. In addition, ***this collaborative model relies upon a strong relationship with the regional health service (Bendigo Health)*** supported by clear communication and referral pathways in alignment with the *Capability framework for Victorian maternity and newborn services*. This model of care is underpinned by continuity of midwifery care where midwives work in collaboration with General Practitioner Obstetricians (GPO). In some circumstances the lead carer will be a midwife and, in others, a GPO. This will be determined by woman's needs, choice and her clinical profile.

Midwives are recognised as professionals able to care and support for women throughout the continuum and have clearly outlined professional responsibility and accountability, and work in collaboration with other healthcare professionals (Watkins, Nagle, Kent, & Hutchinson, 2017). *Collaboration between midwives and obstetricians is a process in which they work together toward a common purpose: to provide safe, effective, patient-centred care for women and their families, guided by shared rules and structures, both formal and informal, which govern a mutually beneficial relationship, a relationship which seeks to optimize the context in which the collaboration is convened* (Homer, 2019; Smith, 2015). This model of care has the potential to positively impact not only on cost and efficiency but also on ***access and choice*** for women (Smith, 2015). In rural settings, collaborative care will enable a sustainable maternity service where midwives can work across their scope of practice and GPO's work in partnership with midwives and there is the ability to balance on call requirements and strengthened working relationships.

The CHMS model provides for women to be allocated to one of ***three care pathways*** when seeking care at Castlemaine Health Maternity Service:

> ***Midwifery Group Practice:*** *Women who are assessed as low risk can elect for midwifery led care whereby, they have a primary known midwife throughout the pregnancy, labour, birth and postnatal period.*
>
> ***Collaborative Shared Care:*** *Women who are assessed as low risk may elect for collaborative maternity care whereby, they have a select number of visits with their GPO in addition to selected visits with a known midwife who will provide care in collaboration with their GPO.*
>
> ***Complex Maternity Care:*** *Women who are not suitable for care at CHMS due to a higher risk profile will be cared for at Bendigo Health or higher-level service but may be suitable for transfer back to CHMS for post birth care.*

Women who are considered low risk and appropriate for care at CHMS will be able to choose between the MGP or the collaborative shared care model for pregnancy care. Women who are planning to birth at Bendigo Health may also access the midwifery model of care at CHMS during pregnancy (if clinically appropriate) and following the birth of their baby. This will provide opportunity for women to be close to home during their pregnancy care and following the birth of their baby should this be desired.

Midwifery Group Practice

Women cared for in this model of care will be low risk women who are seeking continuity of midwifery care. They will be cared for by a known primary midwife who develops a strong connection with the woman and her family throughout the pregnancy and birth journey. The primary midwife will provide pregnancy, childbirth education, labour and birth care, and lactation and early parenting support through the midwifery home care program. "Women who are at low risk of adverse perinatal outcomes benefit from physiologic care that supports minimal intervention" (Phillippi et al., 2019). The woman will have the choice to have a 6 week visit with her primary midwife should she wish to.

Collaborative Shared Care

Women cared for in this model will be low risk women who wish to birth at CHMS receiving midwifery led care but have a connection with their GP Shared Care Affiliate/GPO that is valuable to their pregnancy journey. This will facilitate a unique level of continuity between the woman's community GP and the midwives working at Castlemaine Health Maternity Service. Women will see their GP Shared Care Affiliate/GPO in this model up to 4 times during their pregnancy. They will also see their primary midwife at key appointments to enable a relationship to develop prior to labour. The midwife will then provide care for labour and birth, postnatal care, lactation support and midwifery home care.

Complex Maternity Care

Women who are considered high risk or not suitable for birthing at Castlemaine will be cared for at the regional centre (Bendigo Health) or any other higher-level service. It is well understood that women with risk factors for poor maternal or fetal outcomes may benefit from higher-level services, facilities, and health care providers whose scope of practice includes the care of women with these conditions (Phillippi, Holley, Thompson, Virostko, & Bennett, 2019). This is supported by the Capability Framework for Victorian maternity and Newborn services. If the woman becomes suitable for care at a level 2 Maternity service at any stage throughout her pregnancy or post birth, care will be transferred back to CHMS if this is her preference.

Continuity of midwifery care

The principles of this model align with the best evidence. ***Continuity of midwifery care*** is defined as care whereby:

> *"A midwife provides the majority of the woman's care through pregnancy, labour and birth and the postnatal period, is the first point of reference for her and is responsible for the co-ordination of her care" (Homer, 2019).*

Evidence demonstrates that women experience better outcomes when midwives are the primary maternity care providers and work collaboratively with other providers to coordinate maternity care. Women in these care models have high rates of spontaneous vaginal birth, breastfeeding initiation, feelings of control during labour, and a known attendant in labour (Freytsis, Phillippi, Cox, Romano, & Cragin, 2017). Midwifery continuity of care, where women have continuity from a 'known' midwife during pregnancy, labour, birth and postpartum, is associated with improved clinical and psychosocial outcomes (McLachlan et al., 2012; Sandall, Soltani, Gates, Shennan, & Devane, 2016). An Australian randomised controlled trial (RCT) of caseload midwifery for low risk women (McLachlan et al., 2012), the world's largest, found that infants of women allocated to continuity midwifery care were less likely to be low birthweight or admitted to a Neonatal Intensive Care Unit (NICU) (McLachlan et al., 2012). Women's outcomes were also improved – compared with women allocated to standard care options, they had 22% fewer caesareans, more spontaneous vaginal births,(McLachlan et al., 2012) better self-reported childbirth experiences (Forster et al., 2016a), improved satisfaction,(McLachlan et al., 2016) and higher breastfeeding initiation (McLachlan et al., 2012). A recent study from Queensland found that continuity midwifery was associated with a major reduction in preterm birth for one of our most vulnerable populations – Aboriginal and Torres Strait Islander women (Kildea et al., 2019). The Cochrane review (gold standard systematic reviews) of midwife-led care with 15 trials (including Australian trials), and over 17,000 women, reported that women randomised to receive continuity of care by one named midwife, or a small group of midwives during pregnancy, birth and the postnatal period were significantly *less likely to experience preterm birth, or fetal loss/neonatal death before 24 weeks, and had fewer fetal/neonatal deaths in total* (Sandall, Soltani, Gates, Shennan, & Devane, 2015). ***The review concluded that given the benefits, most women should be offered midwife-led care.***

Midwives working in midwifery group practice are on-call to provide care during labour and birth, and available for women to contact at any time for advice or queries. The midwife knows the woman's medical and social history, enabling earlier identification of issues, and implementation of additional care and collaboration as needed. Women allocated to midwifery led continuity of care in randomised controlled trials report feeling more safe and trusting of their care providers (Forster et al., 2016b), more listened to, and that concerns were taken seriously (Forster et al., 2016b) compared with women in standard care models. Women are also more likely to accept additional support when needed, e.g. from mental health or alcohol/drug services (Viveiros & Darling, 2018), and felt more comfortable to talk to their midwives about health behaviours like smoking and breastfeeding (Rayment-Jones, Murrells, & Sandall, 2015).

It is clear in the Castlemaine context that retaining rural maternity services is important to women and the community. The evidence suggests that midwifery continuity models have significant potential to improve the quality and sustainability of services for women in Australian rural and remote areas. *(Homer, C., et al., Women's experiences of continuity of midwifery care in Australia: A randomised controlled trial, Midwifery, 2002. 18(2): pp. 102 - 112.)*

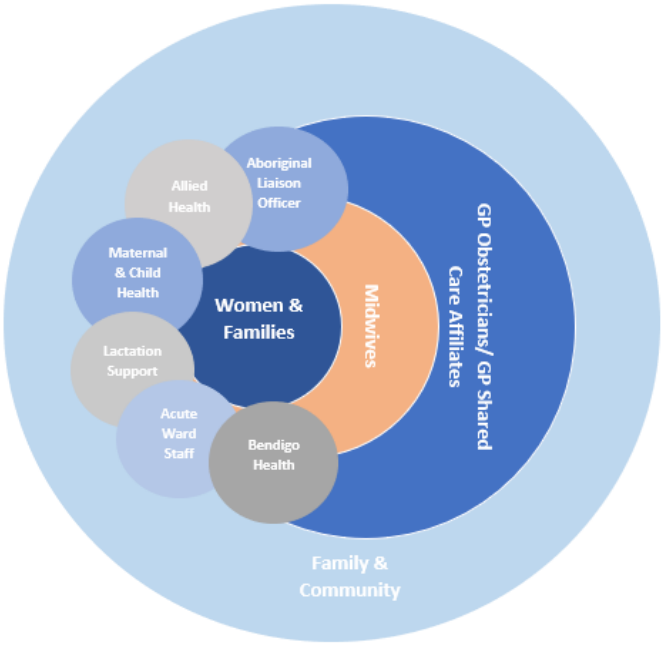


Figure 1: Collaborative Model of Care

Figure 1 demonstrates the linkages and connections between elements of the health service to ensure:

- That midwives work in partnership with all elements
- The partnership with medical workforce is productive, supportive and respectful
- The partnership with nursing and midwifery staff on the acute ward is effective and mutually satisfying.
- All elements have a clear understanding of their agreed roles and responsibilities.
- Professional support exists for all elements of the model
- The woman and her family remain at the centre of the model consistently and authentically.
- A regional approach supports all clinical practice at CHMS to provide the best practice care to women and their families.
- Perinatal care will be delivered in family centred settings to accommodate the woman and her individual needs and choices where necessary.

- Flexibility and accessibility of care will enable vulnerable and disadvantaged women to receive care as required.

Collaborative Communication

Inter-professional collaboration is considered essential in effective maternity care. The clinical governance framework, practice guidelines and model function and structure have been developed to enhance inter-professional relationships and improve communication between all maternity care providers in order to improve the quality of maternity care. This model of care will support positive partnerships, engagement and collaboration between the maternity service, midwives and doctors. Together there will be improved governance and professional support.

Figure 2: Collaborative communication

Collaborative relationships depend on mutual respect. Successful collaboration depends on communication, consultation and joint decision-making within a risk management framework, to enable appropriate referral and to ensure effective, efficient and safe health care.

All women will have access to comprehensive, responsive, multi-disciplinary care within the model.

Communication between health professionals and organisations will be seamless ensuring access to time critical clinical information is available to all professionals involved in the woman's care. *Figure 2* demonstrates how information should flow between CHMS and Bendigo Health to allow for seamless transfer of care back and forth between services. Birthing Outcome System (BOS) will be the mechanism by which this occurs with shared access of the woman's pregnancy and birth care for all clinicians.

This model of care will support positive partnerships, engagement and collaboration between the maternity services and the clinal team.

Clinical Governance Maternity Service

Strong clinical governance will underpin the successful implementation of the CHMSOMoC. This governance framework will be strengthened to ensure both midwives and GPO's working in the model are supported and care pathways are well defined. Bendigo Health, our regional centre, underpins the foundation for the management of safety and risk within the service through a collaborative relationship built on mutual respect and an understanding of capability and resources at both sites. Consultation and referral pathways will be clearly documented in addition to the triggers that indicate a need for further collaboration. Care within the model will be delivered in accordance with the ***Castlemaine Health Maternity Service (Level 2) Traffic Light Consultation and Referral System*** and associated policies, procedures and guidelines. *Figure 3 demonstrates the framework for* Clinical Governance Castlemaine Maternity Service.

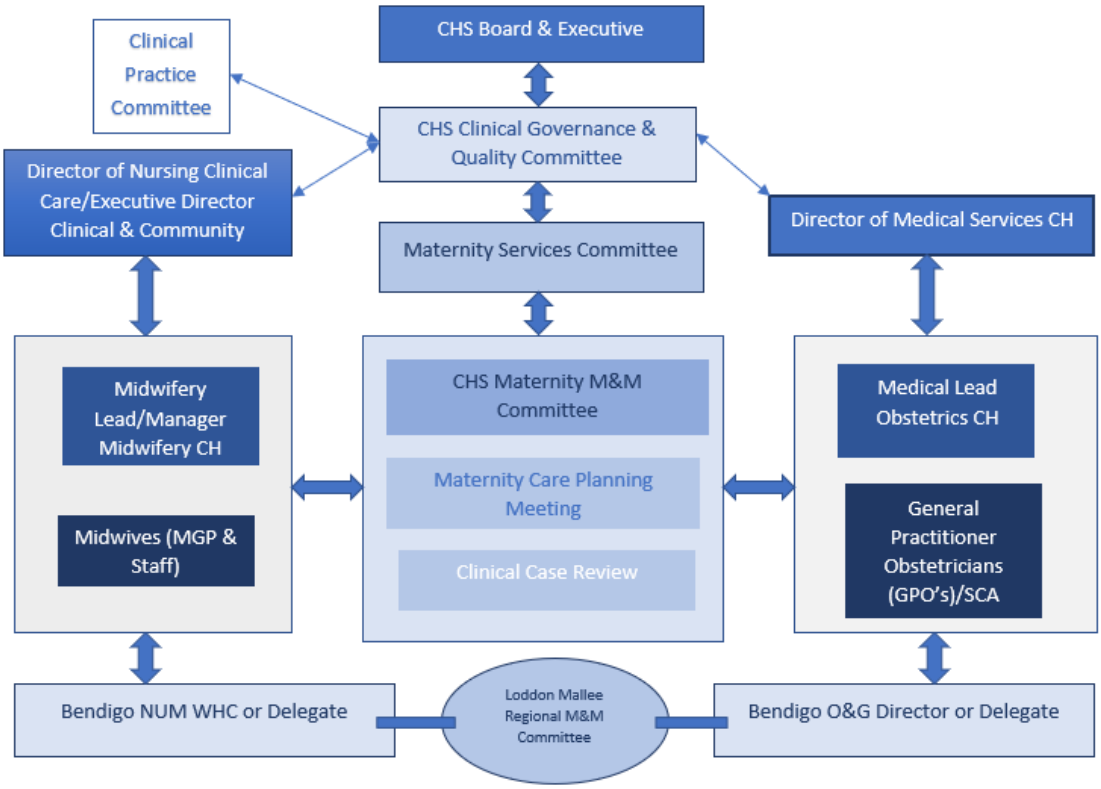


Figure 3: Clinical Governance Castlemaine Maternity Service

The governance structure will be commenced through the establishment of a meeting/committee structure that evaluates and determines care pathways for women who enter the service. There are three meetings that will support planning and delivery of care for every woman who books into CHMS for care. All three meetings will have the midwifery & GPO lead, the BH Director of Obstetrics & Gynaecology and BH Midwifery Unit Manager, Women's Health Centre (WHC) present for the first 6 months of the model implementation. This will provide an opportunity to build stronger regional relationships in addition to provide an opportunity for mentoring and support for all staff involved in the model. In addition, this will enable a deeper understanding of the capability and model function for the BH members. Membership will then be reviewed by the Maternity Services Committee.

The Maternity Care Planning Meeting (MCP)

The MCP meeting will assign all women booking into CHMS(CHMS) for maternity care to a model of care, taking into consideration the woman's preferred option. All women suitable for care at CH as per the green or amber pathway will be allocated a primary midwife. This will occur for women who choose Midwifery Group Practice or Collaborative Shared Care.

This meeting will ensure coordination, oversight and monitoring of midwifery and obstetric clinical care, and the management of risks throughout pregnancy. The MCP team will make recommendations and plan care of women booked to birth at CH and ensure communication of these recommendations to the midwifery and GPO team is clear and accessible. The MCP meeting will be co-ordinated by the clinical leads with senior Bendigo Health clinical staff participating to ensure consistency of clinical practice and to ensure a smooth transition for women between the services should this be required. This aligns with the Sherwood/Smith recommendation to ensure "improved communication and information sharing… to facilitate specialist advice for women under CHMS care," (2020).

The Clinical Case Review Meeting (CCR)

The case review meeting will review ***every woman's care - pregnancy, labour and birth and care after birth including all transfers of care*** that occurs in line with recommendations made in the Sherwood/Smith Report (2020). This process will provide an opportunity to evaluate care, systems, infrastructure, policy, workforce and governance in providing maternity care. Opportunities for improvement / change will be captured and actioned in addition to exemplar practices that will be shared and provide opportunities to learn from and/or replicate. The Clinical Case Review meeting will provide a learning environment that is safe and respectful and focuses on outcomes and professional practice. This meeting will be co-ordinated by the clinical leads with senior Bendigo Health clinical staff participating to ensure variations in practice and clinical decision making are discussed.

Castlemaine Health Maternity Service Mortality & Morbidity (M&M) Committee

The M&M Committee is responsible for:

- Creating a patient safety learning culture within the organization.
- Ensuring a consistent approach to the management and organizational learning that occurs following an adverse patient safety event.
- Reviewing all adverse safety events to identify the action required to prevent, or reduce, the likelihood it will reoccur
- Ensuring the systematic review of any adverse safety event or near miss. Aligned with SCV policy Adverse Patient Safety Events
- Focus on quality improvement process to foster shared understandings and learnings
- Maintain a permanent record of all proceedings and report to the Board via the Maternity Services Committee
- Receive and analyses recommendations from Regional M&M Committee and action as required.

This meeting will be co-ordinated by the clinical leads with senior Bendigo Health clinical staff participating to provide external peer review and mentorship for the clinicians working in the model of care.

Maternity Services Committee

The Maternity Services will then be governed by the Maternity Services Committee that is responsible for overseeing the implementation of the new model of care, evaluate progress and monitor clinical outcomes in order to inform the CHS Clinical Governance & Quality Committee and, report into the , the CHS Executive and up to the Board.

CHS Clinical Governance & Quality Committee

The Castlemaine Health Clinical Governance and Quality Committee will assist the CH Board of Management in fulfilling its clinical governance and oversight responsibilities in relation to:

- clinical reporting
- internal control structure
- risk management systems
- internal and external audit functions
- Operational Risk Register

The Clinical Governance and Quality Committee is the key committee responsible for effective clinical governance and quality at CH. It is responsible to:

- Ensure that the Clinical Governance and Quality activities are consistent with the CH Board Strategic Plan.

• Review and evaluate clinical governance and clinical services improvement strategies
• Set measurable targets and KPIs for clinical datasets.
• Oversee the CH Clinical Governance and Quality Audit Schedule and the Clinical Dataset
Review and discuss audit outcomes and recommendations to ensure that clinical risk is mitigated
• Ensure Audit recommendations are implemented
• Review CH Strategic Risk Register to ensure areas of high clinical risk are reflected and appropriate controls in place
• Ensuring that clinical risk/care translated into effective practice
• Review and monitor improvements in the safety culture [including Open Disclosure principles] of CH
• Undertake a yearly review of the Clinical Governance and Quality Committee's structure, performance and skillset
• Receive and review complaints data and subsequent outcomes
• Note credentialing reports on all relevant clinical staff
• Review and evaluate the Clinical Governance and Quality Dashboard

First Nations Advisory Group

The First Nations Advisory Group will perform an advisory role to assist Castlemaine Health Maternity Service in providing care that is culturally safe and welcoming for First Nations families. The Australian Commission on Safety and Quality in Health Care Standards Action 1.2 states "The governing body ensures that the organization's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people" which has the intent of the health needs of Aboriginal and Torres Strait Islander people are identified in partnership with local communities, and improvement actions are supported by the governing body. This advisory group will ensure that Castlemaine Health meets this requirement and is actively consulting with First Nations communities to ensure the voices of First Nations women and families are heard. The responsibilities of this advisory group are as follows:

- To advise on issues that are valued and/or necessary to ensure First Nations families feel respected, cared for and safe within the Maternity Service.

- To provide feedback to the Maternity Service regarding community concerns or practice issues that need review with respect to culturally safe care

- Review information on the number and needs of Aboriginal and Torres Strait Islander families using the Maternity service

- Review feedback, outcome data, incidents and complaints to identify potential barriers for Aboriginal and Torres Strait Islander people in using the organization's services

- Review the appropriateness and effectiveness of models of care for Aboriginal and Torres Strait Islander people.

Referral Pathways

Pregnant women should be offered evidence base information that enables informed decision making about their care. Referral into the Maternity Service can be achieved via a GP or self-referral. Figure 4 demonstrates the referral management flowchart for CHMS.

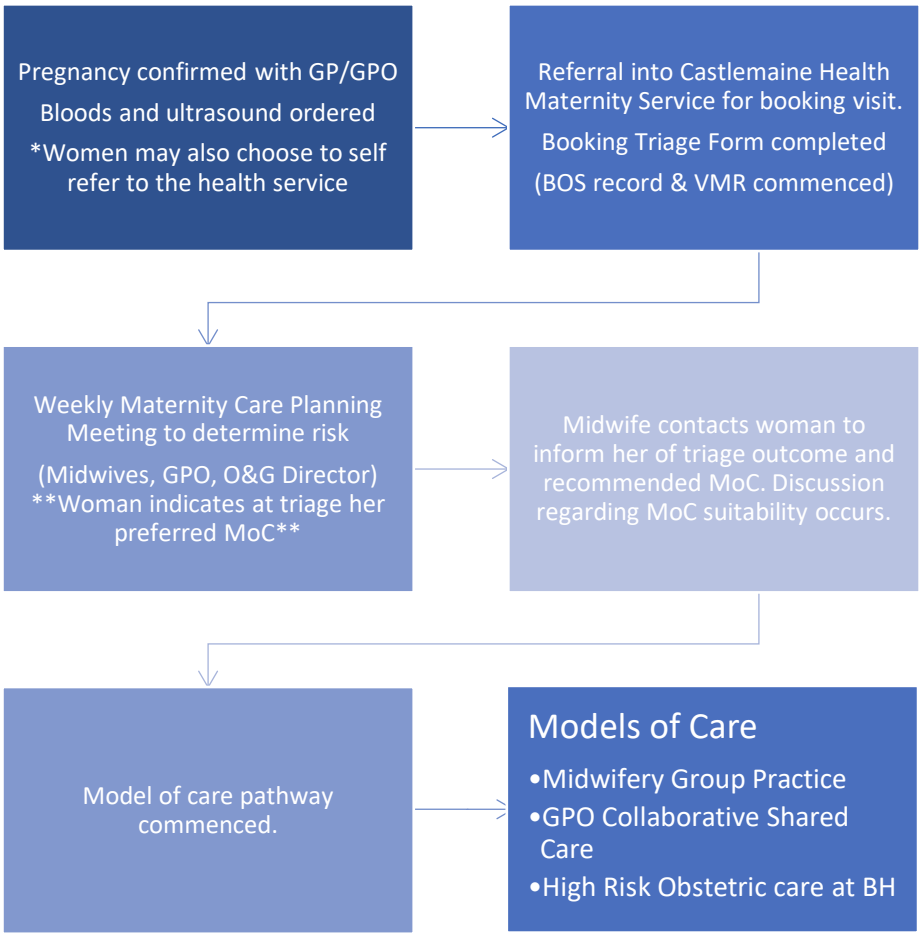


Figure 4: Referral pathways for maternity care

Following triage and allocation of a pathway it is important to note that women may move between pathways throughout the pregnancy, labour and birth in line with defined pathways

A care pathway will be determined following review and discussion at the Maternity Care Planning meeting taking into consideration the woman's preference, her clinical risk profile and her birthing history. Any other referrals required will be completed by the midwife or GP as necessary. Appendix 5 outlines the referral pathways for allied health and support services.

Evidence-Based Practice

Policies, procedures and guidelines developed should be evidence-based ensuring practices are consistent and to reduce unwarranted variations. Evidence-based maternity care uses the best available research on the safety and effectiveness of specific practices to help guide maternity care decisions and to facilitate optimal outcomes for mothers and babies (Sakala & Corry, 2008). To this end, the OMoC for CHMS seeks to utilise the evidence-based practices and guidelines that are supported by our regional, state-wide and national peak bodies. The following resources will be utilised:

Victorian Maternity Record

Each woman will receive a Victorian Maternity Record (VMR) handbook at their first pregnancy visit after confirmation of pregnancy.

The woman should be advised to bring this with her to all appointments during her pregnancy, including those with other health professionals. The woman should be made aware that the VMR is the ONLY complete medical record maintained for her pregnancy care, and it is vital that it is used to record the care given to her at each visit.

Clinical Practice Guidelines for Pregnancy Care 2018

These Guidelines provide evidence-based recommendations to support high quality, safe pregnancy care and contribute to improved outcomes for all mothers and babies. The Guidelines are intended for all health professionals who contribute to pregnancy care, including midwives, general practitioners (GPs), obstetricians, maternal and child health nurses, Aboriginal and Torres Strait Islander Health Practitioners; Aboriginal and Torres Strait Islander Health Workers, multicultural health workers, practice nurses, allied health professionals and childbirth and parenting educators.

The way in which different professionals use these Guidelines will vary depending on their knowledge, skills and role, as well as the setting in which care is provided.

Effective models of pregnancy care have a focus on the individual woman's needs and preferences, collaboration and continuity of care. The National Clinical Practice Guidelines on Pregnancy Care provide evidence-based recommendations to support high quality, safe pregnancy care in all settings.

Further information is available at this link: Pregnancy Care Guidelines 2018 Edition.

Culturally Safe Care Guidelines

The maternity service will use as a reference the Victorian Koori Maternity Services Guidelines to develop culturally safe maternity care practices. Midwives will be trained to deliver care to First Nations families that is culturally safe and responsive.

ACM – National Midwifery Guidelines for Consultation and Referral

Midwives working throughout Australia, in all models of care, use these Guidelines to inform their clinical decision-making. The Guidelines are designed to be relevant in all midwifery practice situations. This edition of the Guidelines reflects the scope of practice of all midwives practicing in the Australian environment to offer pregnant women the highest standard of safe and collaborative maternity care.

Further information is available at this link: Australian College of Midwives National Guidelines Consultation and Referral (3rd edition)

RANZCOG Intrapartum Fetal Surveillance Guidelines

The principal aim of intrapartum fetal surveillance is to prevent adverse perinatal outcomes arising from fetal metabolic acidosis and cerebral hypoxia related to labour. Intrapartum fetal surveillance will be conducted at CHMS as per Intrapartum Fetal Surveillance Clinical Guideline (4th Ed) 2019

Safer Care Victoria eHandbooks – Maternity & Neonatal

The Victorian Safer Care Victoria eHandbooks (Maternity & Neonatal) outline the principles for managing pregnancy and newborn related conditions and/or performing a procedure related to pregnancy and/or the newborn. The eHandbooks have been designed as a guide for the following clinicians:

- Obstetricians
- Midwives
- GPO's

- General practitioners Trainee medical officers
- pharmacists

Further information is available at this link: https://www.bettersafercare.vic.gov.au/resources/clinical-guidance

Postnatal Care Program Guidelines

Postnatal care in the home will be delivered according to Postnatal Care Program Guidelines for Victorian Health Services and the relevant Castlemaine policies and procedures.

Workforce

Midwifery Workforce

Castlemaine Health ***has 2 birthing suites*** (family birthing suites) equipped with birthing beds, neonatal resuscitation equipment, a bath for water immersion for pain relief in labour and cardiotocograph (CTG) capability.

The Acute Ward workforce structure at Castlemaine Health would remain unchanged acknowledging that the current structure provides for the following:

- 15 overnight beds (Mon-Fri) - down to 10 over weekend - acute ward beds
- At least one midwife per shift rostered

Ratios on the acute ward would remain as per The Safe Patient Care Act (2015).
This model of care assumes a birth rate of 50 births per annum with a view to introduce elective caesareans which will further increase opportunities for women to birth close to home.

Staff Midwives

Midwives working on Acute Ward roster will be providing inpatient postnatal care to mother and baby and pregnancy assessment for women who are not booked for care at Castlemaine Health Maternity Service. This will involve clear escalation processes to the primary midwife or the GPO on call should they be concerned about the wellbeing of either mother or baby on the postnatal ward. Following birth, the primary midwife will provide a written handover to the staff midwife clearly articulating any concerns or observations that are outside of normal range for both mother and baby. Any escalation required at this point should be attended to by the primary midwife prior to handing over.

If no staff midwives are rostered for unbooked pregnancy presentations an MGP midwife may need to be contacted to attend. Staff midwives will be supported in developing and maintaining pregnancy assessments skills to ensure competence and confidence.

Changes required to current workforce: Nil. The CHMS must consider attrition of the staff midwifery group (current workforce) and impact on future operationalisation of the model longer term with regular review of staffing profile and operational impact.

Midwifery Group Practice

Midwives working within the Midwifery Group Practice (MGP) will be capable of working across the full scope of midwifery practice including pregnancy care, labour and birth, postnatal care and midwifery home care. This will require the ability to perform newborn examinations, perineal suturing, IV cannulation, fetal scalp electrode placement and advise on optimal fetal positioning. In this model of care each employed midwife is salaried and takes a caseload of women to care for and support through their whole continuum of care. This is

in accordance with the relevant clause of the Nurses and Midwives (Victorian Public Health Sector) (Single Interest Employers) Enterprise Agreement 2016-2020.

Low risk women who have an uncomplicated vaginal birth will be offered early discharge to have postnatal care delivered in their own home by their known midwife if that is their preferred option. Daily home visits will then occur as required. Women who are not considered uncomplicated will have a discharge plan commenced following birth to determine required support and flexible delivery of care. Contact with the primary midwife up until 6 weeks post birth will be available to the woman with an option of a 6-week visit concluding the care episode. This continuity model of care will not operate, in any way, to reduce or preclude the provision of MCH nursing services to women and families in accordance with Clause 107.4 (P) Nurses & Midwives (Victorian Public Health Sector) (Single Interest Employers) Enterprise Agreement 2016-2020.

Changes required to current workforce: Recruit to MGP model based on modelling in Appendix 7.

Managing Increasing Demand

As demand for the model increases the caseload will need to be reviewed to ensure compliance with *Nurses & Midwives (Victorian Public Health Sector) (Single Interest Employers) Enterprise Agreement 2016-2020*. **6 monthly review** for the first **two** years will enable a clear understanding of the demand, staff wellbeing, caseload (actual vs projected) and cost. This will be the responsibility of the MGP Co-ordinator.

If there are occurrences whereby there are no available MGP midwives to support women in labour ***by-pass will be triggered*** requiring women to be transferred to Bendigo Health until resolved. Each by-pass will be reviewed for cause and effect by the Maternity Services Committee with a focus on workforce management and strategy.

Early Career Midwives

It is envisaged that this model will in future support an ***early career midwifery program*** that supports a midwife working at Bendigo Health (in the caseload midwifery model) initially for a period of time and then employment in the Castlemaine Health MGP following this which will contribute to sustainability of the model longer term. This arrangement would be developed through an MoU between the services as a strategy to replenish the midwifery workforce and allow for rotation in and out of the model for midwives who wish to do so. The MOU will be compliant with consultation obligations with the ANMF.

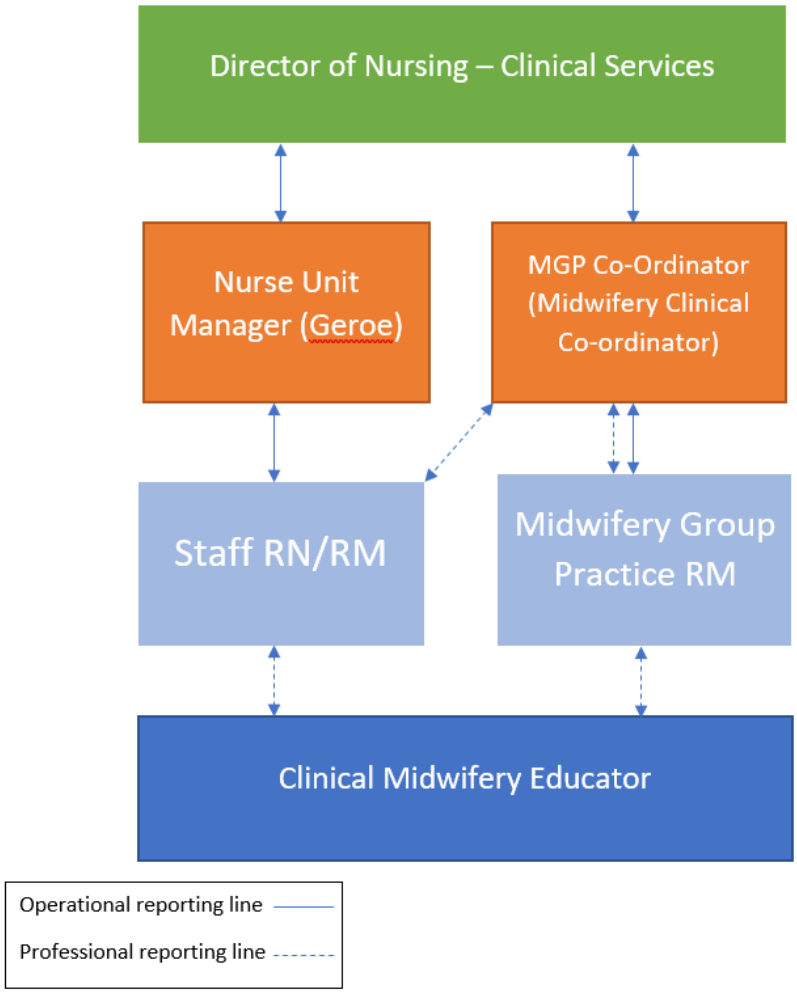
Clinical Co-Ordinator Role

The Clinical Co-ordinator of the MGP will be responsible for monitoring clinical risk and performance within the maternity service. They will be responsible for performance management of midwives working within the group practice and for supporting their professional development and growth. This role may include clinical practice within the model when unplanned leave is required by midwives working in the model.

Clinical Midwifery Educator

The CME is responsible for overseeing the education and skill maintenance requirements for all midwives working at Castlemaine Health. The CME will monitor and respond to any issues raised by management, midwives or medical staff with respect to clinical skill and decision making in the clinical space. The CME will liaise closely with the MGP Co-ordinator to support MGP midwives in skill development and skill maintenance both at implementation of the model and into the future.

Figure 1: Midwifery reporting lines – Castlemaine Health



Scope of Practice

A midwife in Australia:

- is authorised to provide maternity care on their own responsibility to women with non-complicated pregnancy, labour and birth and during the postnatal period up to six weeks after their baby is born.
- provides care that is holistic, culturally safe, respectful and compassionate, and acknowledges the unique needs of the woman.
- provides evidence-informed information to support the woman's decision making across the childbirth continuum. This support may extend to the woman's sexual and reproductive health, as well as newborn and infant health.
- uses clinical reasoning and exercises clinical judgment to monitor and detect complications that may arise in the woman and her baby.
- may practise in any setting including home, birthing units, community health centres and hospitals, in urban, rural and remote geographical locations.
- regardless of setting, works in collaboration and partnership with the woman and other health professionals in a dynamic process of facilitating communication, trust and pathways to ensure the provision of safe, woman centred care, and promotes normal physiological pregnancy and birth, and care for the newborn and infant.

• works with other midwives and health professionals to facilitate consultation and referral when needing to access medical care or other assistance. The midwife initiates and provides relevant emergency measures as appropriate.

(Australian College of Midwives, SCOPE OF PRACTICE for Midwives in Australia, 2016)
https://www.midwives.org.au/sites/default/files/uploaded-content/field_f_content_file/acm_scope_of_practice_for_midwives_in_australia_v2.1.pdf

Transition to practice in the CH Maternity Model

There will be a transition period for midwives considering working in this model of care. Transition for midwives who elect to work in this model of care will be encouraged and supported. Participation in this model of care will be voluntary.
Midwives who are not working in this MoC will be supported to maintain their midwifery skills to enable working as the second midwife in Birth Suite as required and the provision of postnatal/pregnancy inpatient care.
During the transition period, staff midwives may wish to:

- Support the team with Childbirth & Parenting Education
- Cover on-call for a team midwife with planning and advanced notice
- Provide postnatal Care (early post birth care, post caesarean section care for PN returns from BH)
- Back up support in labour ward. Ratios will be maintained in accordance with the Safe Patient Care Act, 2015.
- Backfilling Annual Leave
- Attendance at all professional development/education sessions provided in the MoC.

All midwives will be supported to attend education sessions and be invited to attend weekly team meetings. Representation of both staff and MGP midwives at the monthly multidisciplinary team meeting will be required.
Recruitment into the model may be advertised both internally and externally to enable the recruitment of midwives who are ready to practice in a Midwifery Group Practice. This will enable re-opening of the service as soon as possible in addition to providing staff midwives with adequate time to build their confidence and competence in practicing autonomously.

Medical Workforce

The medical workforce at Castlemaine Maternity Service is comprised of GP obstetricians who have supported pregnancy and care during labour and birth and in the days following birth. This has occurred through a 'private' maternity care model whereby the GPO caring for the woman during her pregnancy provides labour and birthing care at Castlemaine Health Maternity Service. The advantage of this model was continuity of care was provided by the GPO and was attractive to women and professionally satisfying for their GPO.

The new collaborative model will involve GPO's working with midwives and the MGP. In order to continue to support maternity care at CHMS a GPO rotating roster for women choosing to labour and birth at CHMS will be required. This will enable escalation of care should this be required throughout labour and/or birth from the primary midwife to the GPO on call as outlined in the PPG's.

Pregnancy Care

Pregnancy care at CHMS will be provided in accordance with the ***Castlemaine Collaborative Pregnancy Care Schedule*** (Appendix 2) and the ***Castlemaine Health Maternity Service (Level 2) Traffic Light Consultation and***

Referral System (Appendix 1). Assessing a woman's suitability for pregnancy care and birthing at Castlemaine is an ongoing process. Suitability may change over the course of the pregnancy or during labour. Continuous risk assessment is important to assess ongoing suitability in line with the ***Castlemaine Collaborative Pregnancy Care Schedule*** (Appendix 2***) and the Castlemaine Health Maternity Service (Level 2) Traffic Light Consultation and Referral System*** (Appendix 1) and associated policies, procedures and guidelines.

Women will be given the contact details for the hospital in addition to their MGP midwife if for some reason she is unavailable/uncontactable. This will be communicated clearly at the beginning of care. If the MGP midwife is taking planned leave she will develop a clear plan for the women in her care with respect to contacts. This procedure will be developed as part of the operationalisation of this model.

The potential for transfer to the regional centre during pregnancy or birth should be discussed with the woman at her booking visit with clear discussion regarding the capability and scope of birthing care at Castlemaine. Ensure the woman is aware of and understands the reasons why transfer to Bendigo Health for further clinical advice/risk factors may be necessary.

Childbirth education/classes

Childbirth and parenting education for women and their partner/support person will occur with their known midwife. Education will be individualised, culturally appropriate and safe. The chosen venue may also need to be considered to meet cultural needs.

There will be group childbirth education classes offered and coordinated within this model of care utilising childbirth education resources. Childbirth and parenting classes will be designed to support the woman and her partner/support person in preparing for labour, birth, breastfeeding and caring for a newborn baby. Group classes may facilitate social network development and familiarisation with other midwives working within the model.

Pregnancy Information brochures and pamphlets can be found at this link: Castlemaine Health website

Intrapartum Care

Intrapartum care will be provided at CHMS in accordance with the ***Management of Women Through to Normal Vaginal Birth Guideline,*** the ***Castlemaine Health Maternity Service (Level 2) Traffic Light Consultation and Referral System*** (Appendix 1) and ***Castlemaine Maternity Service - Intrapartum Care – Roles & Responsibilities*** document.

Postnatal Care

Following the birth of the baby early discharge to home will be encouraged and supported by a known midwife. Postnatal care will either be in hospital for a period of time and then at home, or where the woman and her family are safe and most comfortable.

Postnatal care will be provided in accordance with the relevant policies and procedures endorsed for use at Castlemaine Health.

Postnatal Care on Ward

If the woman chooses to remain in the hospital for postnatal care the MGP midwife will provide postnatal care for 4 hours post birth (midwives can work an average full-time day standard or 8 hours, being the objective, with the absolute maximum of 12 hours in a 24-hour period) and then the following will occur:

- Once the mother and baby are stable, fed and all cares have been attended to by the known midwife, care will be handed over to the staff midwife/nurse on shift. This will be in accordance with the Safe Patient Care Act (Nurse to Patient and Midwife to Patient Ratios) (2015).
- ***If at any time the staff on duty are concerned, they are able to contact the known midwife to assess and/or to support care.***

Following discharge, a known midwife will visit for postnatal care and support of mother, baby and family in the home.

Postnatal Care at Home

Women may elect to have their postnatal care in their own home. This is often preferred when all care is provided by a known midwife from 4 hours following the birth. Women who elect for early discharge will receive additional home visits to support assessment, wellbeing and transition to parenthood.

Telephone support will always be available for women to contact a known midwife.

Discharge planning and discharge management

Discharge planning

Prior to birth, a woman planning to birth at CHMS will be aware of the need for discharge planning. Discharge planning is an iterative process from the initial booking appointment to discharge from the program. Women and their partner/support person will be involved in early discussion of early discharge to home, if no complications, stable and confident after birth. When early discharge to home occurs, the woman will receive early postnatal care at home from a known midwife.

When a woman is identified as Aboriginal, or has an Aboriginal partner, the Aboriginal Health Liaison Officer may be included in the discharge process.

Professional Development

Interprofessional development will be essential to improve working relationships between the maternity care team members and build productive and safe strategies for managing unanticipated obstetric risk. This will be achieved through the development of an interprofessional education strategy that leverages off the skills of every member of the care team. In addition, opportunities for education should be shared experiences for all clinicians. This will include (but is not limited to):

- Fetal Surveillance Education Program (RANZCOG)
- Neonatal Resuscitation
- Interdisciplinary Obstetric Emergency Training

Monitoring Performance

Performance of the maternity service will be monitored continuously through case review meetings and the M&M meeting process. In addition, CHMS will be required to report on standard perinatal indicators through both the Department of Health and Human Services and Women's Healthcare Australasia. For all births in Victoria, data should be submitted to Victorian Perinatal Data Collection unit. The Victorian Perinatal Data Collection (VPDC) collects and analyses detailed information on obstetric conditions, procedures and outcomes relating to every birth in Victoria.

Key Performance Indicators

The following key indicators are routinely collected by VPDCU and available on the dashboard for review:

- Rate of induction of labour in standard primipara
- Rate of caesarean section in Robson group 1
- Rate of caesarean section in modified Robson group 2
- Rate of third- and fourth-degree perineal tears during unassisted vaginal births to primipara
- Rate of third- and fourth-degree perineal tears during assisted vaginal births to primipara
- Rate of primipara who received an episiotomy during unassisted vaginal births
- Rate of primipara who received an episiotomy during assisted vaginal births
- Rate of term babies without congenital anomalies who required additional care
- Rate of severe fetal growth restriction in a singleton pregnancy undelivered by 40 weeks
- Rate of women who planned a vaginal birth after a primary caesarean section
- Rate of women who achieved a planned vaginal birth after a primary caesarean section
- Five-year gestation standardized perinatal mortality ratio for babies born at ≥ 32 weeks
- Rate of maternal readmissions during the postnatal period
- Rate of newborn readmissions during the postnatal period

In addition, all intrapartum and postnatal transfers should be reviewed and documented. The clinical governance framework also provides for every woman being cared for at Castlemaine to be discussed both throughout pregnancy and following birth at the Case Review Meeting and Maternity Care Planning Meeting.

Woman reported experience measures

It is important that CHMS understands the experiences of women who receive care in the Maternity Service. The Victorian Health Experience Survey (Maternity) is a valuable tool for evaluating the experiences of maternity clients within public health services. This will inform the evaluation of the model and will be an ongoing source of information with respect to patient satisfaction.

In addition, women cared for in the Midwifery Group Practice will be offered the opportunity to participate in an anonymous feedback survey regarding their experience. This will inform the management of the service and create opportunities for improvement with respect to the consumer experience.

Caregivers Experiences

It is important to evaluate the experience of the clinicians working within the maternity model of care. This will include MGP midwives, staff midwives and GPO's. This will occur through anonymous survey annually to ensure there is an opportunity for reflection and response to any cultural or clinical concerns raised through this process.

Model of Care Evaluation

The model of care will be evaluated as per the *Nurses & Midwives (Victorian Public Health Sector) (Single Interest Employers) Enterprise Agreement 2016-2020, clause 107.9* that states the following:

(a) Where a Midwifery Continuity of Care Model is introduced, nursing / midwifery management, ANMF (VIC BRANCH) nominated representatives and relevant staff will:

(i) during the first 12 months conduct an informal review on a monthly basis;

and

(ii) no later than 12 months after the introduction of the model, conduct a comprehensive formal review with further reviews at agreed intervals thereafter.

(b) Any new model will automatically be required to report on the model in an identical manner as all other maternity services providers, and this information will be provided to the evaluation parties as outlined in subclause 107.9(a) above.

Appendix 1: traffic Light Consultation & Referral System

Castlemaine Health Maternity Service (Level 2) Traffic Light Consultation and Referral System

This system of risk identification supports escalation to an appropriate service for assessment and care planning. Health services should utilise this tool in conjunction with the Capability Framework for Victorian Maternity & Newborn Services.

GREEN	**ACCEPT – Suitable for collaborative care**
AMBER	**CONSULT – Requires consultation with colleagues and consider consultation with HIGHER Level service. Following consultation may be suitable for pregnancy care and birthing**
RED	**REFER – Not suitable for care** **Requires referral and/or transfer to a HIGHER-Level service**

This traffic light assessment tool supports flexibility and enables progression of care through risk categories as appropriate depending on condition and clinical presentation.

GREEN - ACCEPT

Normal risk pregnancies are considered **'Green'** and are suitable for low risk models of care. Women identified to be normal risk at booking, will be offered continuity of care throughout the continuum of pregnancy in an agreed model of a care depending on the specific care models available at the given health service. All care should be provided within the clinician's professional scope of practice and within the Health Service's policies and procedures. Appropriate use of the traffic light tool should occur if a woman's pregnancy risk alters from normal risk and requires escalation.

AMBER - CONSULT

Pregnancies that are **'Amber'** are not suitable for midwifery-led shared care but may still be suitable to birth at the booking Health Service. These women are flagged as Amber for various reasons and will require increased monitoring during their pregnancy. Increased monitoring may include additional pregnancy reviews and testing, transfer to Consultant let care models and consultation with Medical Specialists.

Referral for any level of consultation should be clearly documented in the woman's clinical record including an individualised care plan and any change or transfer of care responsibility

At consultation with a higher-level facility further care may be required

1. ***Tier 1*** – consultation only with advice given that may include additional reviews, tests etc. at referring site
2. ***Tier 2*** – appointment at higher level facility and / or plan to birth a higher-level facility e.g., previous postpartum haemorrhage
3. ***Tier 3*** – some pregnancy care and birth planned at higher level facility with some potential for shared care between the referring service and the higher-level facility e.g., high BMI
4. ***Tier 4*** – requirement for transfer for all pregnancy and intrapartum care e.g., woman with complex medical needs such as antiphospholipid syndrome

RED - REFER

'Red' categorised women or infants are identified as high risk by the referring health service and are considered unsuitable to remain under their current care giver and/or health service. Referral to a higher-level maternity or neonatal service is required. These women may be identified as suitable for pregnancy shared care between current and higher-level maternity services.

Women who present in the *'refer'* criteria that require time critical management should have early consultation with the Paediatric Consultant or Paediatric Perinatal Emergency Retrieval (PIPER) or Ambulance Victoria.

Booking Assessment – Medical History	
Age	
<16 years	
17-24 years	
25-39 years	
>40 years no complications	
>40 with complications	
Anaesthetic difficulties	
Previous failure or complication (e.g. difficult intubation, failed epidural) – request anaesthetic consultation and referral	
Malignant hyperthermia or neuromuscular disease	
Body Mass Index (BMI) at booking	
BMI >17 or <35	
BMI <19 refer to dietitian	
BMI up to 35 refer to dietitian/allied health	
BMI 35-40	
BMI 40-50	
BMI >50	
Connective Tissue /System diseases	
Autoimmune Disease	
Rare disorders such as: Systemic Lupus Erythematosus (SLE) Anti-phospholipid syndrome, Scleroderma, Rheumatoid arthritis, Periarteritis nodosa, Marfan's Syndrome, Raynaud's disease	
Cardiovascular	
Cardiovascular Disease	
Essential hypertension	
Drug dependence or misuse	
Alcohol consumption	
Drug use	
Smoking	
Endocrine	
Pre-existing type 2 Diabetes Mellitis– diet controlled	
History of Gestational Diabetes Mellitis	
Diabetes Mellitis – requiring insulin or oral medication	
Thyroid disease including: Hypothyroidism & Hyperthyroidism	
Endocrine disorder requiring treatment such as: Addison' Disease, Cushing's Disease or other	
Gastrointestinal	
Hepatitis B with positive serology (Hep B S AG+)	
Hepatitis C (Hep C Antibody +)	
Genetic	
Genetic – any condition	
Haematological	
Haemoglobinopathy	
Thrombo-embolic process (family history)	
Coagulation disorders	
Anaemia at booking defined as Hb<10g/dl	
Anaemia at booking defined as Hb<9g/dl	
Infectious Disease (detected on booking or serology)	

HIV infection	
Rubella (active)	
Cytomegalovirus (active)	
Parvo-virus (active)	
Varicella/Zoster virus infection (active)	
Herpes genitalis (primary infection)	
Herpes genitalis (recurrent infection)	
Tuberculosis (active history of)	
Syphilis - Positive serology and treated	
Syphilis - Positive serology and not yet treated	
Syphilis - Primary infection	
Toxoplasmosis	
Any recent history of a viral, microbial parasitic infection	
Mental Health Disorders	
History or current mental health disorder with **main care provider** GP	
History or current mental health disorder with **main care provider** psychiatrist/primary mental health care team	
Musculo-skeletal	
Pelvic deformities including previous trauma, symphysis rupture, rachitis	
Spinal deformities (e.g. scoliosis, slipped disc, etc) arrange anaesthetic review	
Neurological	
Epilepsy without medication and no seizures within the last 12 months	
Epilepsy with medication and/or seizure(s) in the last 12 months	
Subarachnoid haemorrhage, aneurysms (history of)	
Multiple sclerosis	
AV malformations	
Myasthenia gravis	
Spinal cord lesion (para or quadriplegia)	
Muscular dystrophy or myotonic dystrophy	
Renal function disorders	
Disorder in renal function with or without dialysis	
Urinary tract infections (recurrent/symptomatic)	
Pyelonephritis	
Respiratory disease	
Mild asthma	
Moderate asthma (oral steroids in the past year and/or maintenance therapy)	
Severe lung function disorder	
Cervical abnormalities	
Cervical surgery / cone biopsy	
Other cervical surgery	
Cervical Surgery with Subsequent vaginal birth	
Abnormalities in cervix cytology (diagnosed/follow up)	
Pelvic floor reconstruction	
Colposuspension following prolapsed uterus (if considering vaginal birth)	
Fistula and / or previous rupture and vaginal repair	
Uterine abnormalities	
Myomectomy	
Bicornuate uterus	
Other	

Intra Uterine Contraceptive Device (IUCD) insitu	
Infertility treatment (this pregnancy)	
Female genital mutilation (FGM) (consider organisation recent practice)	

Past Obstetric History	
Fetal growth disturbance	
Previous baby > 4.5 kg Must have clear collaborative plan with BH**	
Previous baby > 4.0 kg	
Previous baby diagnosed FGR and/or <2.5kg	
Haematological disorders	
Active blood group incompatibility (Rh, Kell, Duffy, Kidd)	
ABO-incompatibility	
Hypertensive disorders	
Hypertension	
Pre-eclampsia	
Eclampsia / HELLP syndrome	
Obstetric emergency or assisted birth	
Forceps or vacuum extraction	
Caesarean section	
Caesarean section >3	
Septate uterus with previous caesarean section	
Shoulder dystocia	
Parity	
Multiparous parity (P4 or 5) with history of uneventful pregnancies	
Grand-multiparous parity >5 previous births	
Perineal trauma (severe)	
3rd degree tear	
4th degree tear	
Poor perinatal outcomes	
Asphyxia (APGAR <7 at 5 mins)	
Perinatal death	
Child with congenital and/or hereditary disorder	
Previous baby with serious birth trauma requiring ongoing care	
Postpartum depression	
Requiring ongoing medication	
Puerperal psychosis	
Postpartum haemorrhage as result of	
Perineal trauma	
Cervical tear	
Other causes	
Pregnancy abnormalities	
Recurrent miscarriage (3 or more times)	
Pre-term birth (<37 weeks) in a previous pregnancy	
Pre-term birth (32 weeks) in a previous pregnancy	
Cervical incompetence (requiring cervical suture)	
Placental abruption	
Cholestasis of pregnancy	
Symphysis pubis dysfunction	
Social	

Previous DHHS/CPU involvement (women and/or partner)	
Third stage abnormalities	
Manual removal of placenta	
Placenta accrete / morbidly adherent placenta	

Obstetric History Pregnancy

Pregnancy screening	
Risk factors for congenital abnormalities	
Suspected/confirmed fetal abnormalities	
Cervical cytology	
Cervical cytology – High grade (CIN II & III)	
Cervical cytology – Low grade (CIN I)	
Early pregnancy disorders	
Hyperemesis gravidarum (persistent)	
Suspected ectopic pregnancy	
Recurring vaginal blood loss prior to 16 weeks	
Vaginal blood loss after 16 weeks	
Endocrine disorders	
Pre-existing type 1 and type 2 diabetes mellitus	
Gestational Diabetes Mellitus	
Addison's disease, Cushing's disease or other endocrine disorder requiring treatment	
Proven hyper/hypothyroidism (stable)	
Proven hyper/hypothyroidism (unstable)	
Fetal presentation / growth concerns	
Non cephalic presentation at full term	
Breech presentation >34 weeks gestation	
Breech presentation >32 weeks gestation	
Multiple pregnancy	
Failure of head to engage at full term (primigravida)	
Symphysis – fundal height >3 cm or <3 cm above gestational age	
Suspected/confirmed FGR (<10th centile or incoordinate growth or <2400g at term)	
Suspected confirmed fetal macrosomia (>95th centile or greater than 4500g at term) Must have clear collaborative plan with BH**	
Gastrointestinal	
Hepatitis B with positive serology (Hep B S AG+)	
Hepatitis C (Hep C Antibody+)	
Inflammatory bowel disease including ulcerative colitis and Crohn's disease	
Haematological disorders	
Coagulation disorders	
Blood group incompatibility	
Thrombosis	
Anaemia >37 weeks (Hb<10g/dl)	
Hypertensive disorders	
Gestational hypertension (>20 weeks gestation)	
Pre-eclampsia	
Eclampsia/ HELLP syndrome	
Chronic hypertension	
Infectious diseases	
HIV infection	

Rubella	
Toxoplasmosis	
Cytomegalovirus	
Parvo-virus (active)	
Varicella/Zoster virus infection	
Tuberculosis (active history of)	
Herpes genitalis (primary infection) (infection late in pregnancy)	
Herpes genitalis (recurrent infection)	
Syphilis – positive serology and treated	
Syphilis – (primary infection) (positive serology and not yet treated)	
Mental health disorders	
First presentation mental health disorder during pregnancy with main care provider GP	
First presentation mental health disorder during pregnancy with main care provider psychiatrist/primary mental health care team	
Musculo-skeletal	
Disc prolapse	
Pelvic instability	
Placental abnormalities	
Low lying placenta ≥ 34 weeks	
Antepartum haemorrhage unknown cause	
Placenta praevia	
Placenta accreta/percreta/increta	
Vasa praevia	
Suspected placental abruption- Transfer if safe	
Post-term pregnancy	
>41 weeks completed gestation	
Oligohydramnios (AFI <5)	
Polyhydramnios (AFI >25)	
Renal dysfunction disorders	
Urinary tract infection(s)	
Pyelonephritis	
Respiratory disease	
Asthma – mild	
Asthma – moderate/severe	
Acute respiratory illness	
Social	
Previous DHHS/CP involvement	
Late booking (>28 weeks gestation)	
No pregnancy care (>28 weeks gestation)	
Concealed pregnancy	
Surgical	
Laparotomy during pregnancy	
Laparoscopy during pregnancy	
Threat of / actual preterm labour/birth	
Cervical insufficiency	
Pre-term pre-labour rupture of membranes <37 weeks gestation	
Pre-term pre-labour rupture of membranes <32 weeks gestation	
Threatened pre-term labour <37 weeks gestation	
Threatened pre-term labour <32 weeks gestation	
Pre-term labour <37 weeks gestation	
Pre-term labour <32 weeks gestation	

Uncertain duration of pregnancy	
Amenorrhoea >20 weeks and uncertain of dates	
Uterine abnormalities	
Fibroids	
Other high risk pregnancy issues	
No pregnancy care prior to 30 weeks	
Confirmed oligo/poly hydramnios on ultrasound	
Reduced and/or abnormal fetal movement patterns	
Concealed pregnancy	
Baby for adoption	
Fetal death in utero	

Intrapartum	
Gestation	
< 37 weeks	
< 34 weeks	
< 32 weeks	
Hypertensive disorders	
Pregnancy induced hypertension	
Pre-eclampsia	
Labour complications	
Meconium stained liquor	
Blood stained liquor	
Maternal pyrexia	
Cholestasis	
Suspected maternal sepsis	
Active genital herpes in late pregnancy or at onset of labour	
Abnormal fetal heart rate pattern with non-reassuring features	
Prolapsed cord or cord presentation	
Vasa praevia	
Arrival in labour unbooked	
Suspected placental abruption and/or praevia	
Fetal death during labour	
Shock/maternal collapse	
Prolonged first stage of labour	
Prolonged second stage of labour	
Prolonged third stage of labour	
Postpartum haemorrhage >500mls	
Retained placenta	
Shoulder dystocia	
Suspected uterine rupture	
Malpresentation/multiple pregnancy	
Abnormal fetal presentation	
Breech presentation	
Unengaged head in active labour in primipara	
Multiple pregnancy	
Pre-labour rupture of membranes (PROM)	
Term PROM (without signs of labour)	
Pre-term PROM <37 weeks gestation	
Pre-term PROM <34 weeks gestation	

Pre-term PROM <32 weeks gestation	
Severe adverse maternal morbidity	
3rd degree perineal tear (Transfer if no OT available)	
4th degree perineal tear	
Retained placenta with/without PPH	
Uterine inversion	
Postpartum Haemorrhage >1000mls	
Postpartum Haemorrhage >1000mls requiring blood products	

Postnatal – Maternal Indications	
Abnormal postnatal observations	
Suspected maternal infection	
Suspected retained products/abnormal fundal height	
Temperature over 38° C on more than one occasion	
Persistent hypertension	
Vulvar Haematoma	
Urinary/faecal incontinence	
Urinary retention	
Severe adverse maternal morbidity	
Thrombophlebitis	
Thromboembolism	
Haemorrhage > 500mls	
Anaemia requiring blood products	
Postpartum eclampsia	
Uterine prolapse	
Social/mental health problems	
Serious psychological disturbance	
Significant social isolation and lack of social support	
DHHS/CP involvement	

Postnatal – Neonatal Indicators	
Neonatal complications/abnormalities noted at birth	
Infant less than 2500g	
APGAR less than 7 at 5 minutes	
Suspected meconium aspiration	
Requiring respiratory support CPAP/IPPV (<4 hours)	
Less than 3 vessels in umbilical cord	
Excessive moulding and cephalhaematoma	
Abnormal finding on physical examination	
Excessive bruising, abrasions, unusual pigmentation and/or lesions	
Birth injury requiring investigation	
Birth trauma	
Bleeding from any site	
Congenital abnormalities (e.g. cleft lip or palate, congenital dislocation of hip, ambiguous genitalia)	
Major congenital abnormality requiring immediate intervention (e.g. omphalocele, myelomeningocele)	
Neonatal complications/abnormalities noted following birth	

Requiring respiratory support CPAP/IPPV (>4 hours)	
Requiring respiratory support CPAP/IPPV (>24 hours)	
Apnoeas/bradycardias	
Abnormal heart rate or pattern	
Abnormal cry	
Persistent abnormal respiratory rate and/or pattern	
Persistent cyanosis or pallor	
Jaundice in the first 24 hours	
Suspected pathological jaundice after 24 hours (low range phototherapy)	
Suspected pathological jaundice after 24 hours (requiring multiple light therapy)	
Hypoglycaemia	
Temperature instability	
Temperature less than 36^{o} C unresponsive to therapy	
Temperature more than 37.4^{o} C unresponsive to non-pharmaceutical therapy	
Suspected sepsis	
Vomiting and/or diarrhoea	
Bile stained vomit	
Abdominal distention	
Infection of umbilical stump site	
Feeding issues	
Significant weight loss >10% birth weight	
Failure to pass urine or meconium within 24 hours of age	
Failure to pass urine or meconium within 36 hours of age	
Suspected clinical dehydration	
Suspected seizure activity	
Social	
DHHS/CP involvement	

Appendix 2: Pregnancy Care Schedule

PREGNANCY CARE SCHEDULE FOR CASTLEMAINE HEALTH MATERNITY SERVICE

Midwifery led care: Women who are low risk can elect for midwifery led care whereby they have a primary known midwife throughout the pregnancy, labour, birth and postnatal period.
Collaborative shared care: Women may elect for collaborative maternity care whereby they have a select number of visits with their GPO in addition to selected visits with a known midwife who will provide care in collaboration with their GPO.
Complex maternity care: Women who are not suitable for care at CHMS due to a higher risk profile will be cared for at Bendigo Health but may be suitable for transfer back to CHMSfor post birth care.

WHEN WHO	WHAT Assessments, Investigations, Discussions
Diagnosis	Confirmation of pregnancy and expected date of delivery: https://www.bettersafercare.vic.gov.au/resources/clinical-guidance/maternity-ehandbook/accurate-pregnancy-dating-estimated-due-date
6-10 weeks **GP/GPO** *Women may self-refer to midwifery clinic. Path/diagnostic orders. Medical lead will support midwifery staff in getting these done. Forms need to be pre-filled and no changes made after signature.*	Pathology-initial routine investigation including: • Blood group and antibody screen • FBE and iron studies • Vitamin D screening • Baseline renal and liver function tests • Cervical Screening Test: date of last test & result, (as per national cervical screening program criteria) record in 'management plan' for PN follow up. http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/cervical-screening-1 • Assess risk factors for FGR (fetal growth restriction) https://www.health.gov.au/resources/pregnancy-care-guidelines/part-d-clinical-assessments/fetal-growth-restriction-and-well-being#221-fetal-growth-restriction Risk Assessment for FGR at booking and at each pregnancy visit, Chart Page 7: https://www.stillbirthcre.org.au/assets/Uploads/FGR-PositionStatement-Final-2018-V2.pdf - Recommend starting aspirin 100 – 150mg and Calcium 1.5gm if FGR risk factors present. • Screening for infections in pregnancy • Syphilis/TPHA • HIV

	• Hepatitis B • Hepatitis C • Mid-stream urine for MC+S • Chlamydia (15-29 years of age **OR** a recent change in sexual partner) • Rubella • Diabetes screening if any high-risk factors are identified- arrange an early Oral Glucose Tolerance Test (OGTT) ASAP • Previous Gestation Diabetes Mellitus (GDM) • Family member or a sister with GDM • Previous elevated blood glucose level • Maternal age ≥40 years • BMI > 35 kg/m2 • Previous macrosomia (birth weight >4500g or > 90th centile) • Polycystic ovarian Syndrome • Medications: corticosteroids, antipsychotic • Full medical and family history • Physical examination –breast, thyroid, heart • Routine pregnancy observations • Discuss previous pregnancy history • Calculate BMI • Explain VMR and encourage its use at all visits and presentations to a healthcare facility • Refer to CH Maternity Pregnancy clinic if GREEN or AMBER pathway. RED pathway will require referral for higher level care.
	Ultrasounds: ***8- 10 weeks*** - Dating scan if unsure of LMP ***12-13 week*** - Aneuploidy Screening Tests ***19-21 week*** - morphology ultrasound (gestational age, fetal number, placental position, and fetal morphology) **Aneuploidy Screening Tests:** First trimester combined screening test (10-12 week serum screen + 11- 13 week US) Maternal serum screening (This is a blood test collected between 15-20 weeks of pregnancy). Second trimester screening offered ***if 1st trimester screening has not been possible*** (between 14 and 20 weeks, if collected during the 14th week, no neural tube defect assessment is given) Non-invasive prenatal test (NIPT) This blood test is done after week 10 of pregnancy. https://www.vcgs.org.au/

	https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Resources/Prenatal-Screening-for-Chromosomal-and-Genetic-Con#close

14-16 Weeks **Booking-in appointment** **MIDWIFE**	**Consider the need for interpreter service.** 1.Review Previous Pregnancy History 2. Record a comprehensive health history • EDD calculated according to the Establishing the estimated due date procedure. (add hyperlink to Procedure) • Check screening tests for completeness (Refer to GP for any that may have been omitted) • Ensure copy of results are included on BOS including Ultrasounds 3. Perform examination • Maternal weight and height - calculate BMI. • Assess risk factors for FGR (fetal growth restriction) as per fetal growth restriction assessment. Risk Assessment for FGR at booking and at each pregnancy visit, Chart Page 7 https://www.stillbirthcre.org.au/assets/Uploads/FGR-PositionStatement-Final-2018-V2.pdf • Recommend starting aspirin 100 – 150mg and Calcium 1.5gm if FGR risk factors present. 4. Discuss and offer results and investigations (utilise the relevant printed information) • Blood group and antibody screen • FBE and iron studies: Hemoglobin Assessment and Optimisation in Maternity https://transfusion.com.au/system/files/resource_library/04%20Hb%20Assessment%20and%20Optimisation%20in%20Maternity%201pp_v6.0%20FINAL%20SCREEN_0.pdf • Vitamin D • Cervical Screening Test • Screening for infections in pregnancy - Syphilis/TPHA - HIV - Hepatitis B - Hepatitis C - Mid-stream urine for MC+S - Chlamydia (15-29 years of age OR a recent change in sexual partner) - Rubella • Diabetes screening. Follow Management of Gestational Diabetes Mellitus (GDM) procedure (needs development). - If any high-risk factor (below) order early OGTT asap - Previous GDM - Previous elevated blood glucose level

- Maternal age ≥40 years
- Family history of diabetes (immediate family or a sister with GDM)
- Previous macrosomia (birth weight > 4500g or > 90th centile)
- Polycystic ovarian syndrome
- Medications: corticosteroids, antipsychotic

- First Trimester screening: 10-week Serology and 12-week Ultrasound for combined first trimester screening. This must be organised by woman's GP; OR
- Second trimester screening (between 14 and 20 weeks, if collected during the 14th week, no neural tube defect assessment is given (information from VCGS request form)

NOTE: Serum screen PAPP-A - levels below 0.5MOM are abnormal and mean that the pregnancy is at greater risk of complications. - normal nuchal translucency measurement = 1-2.8mm);

UPDATE BOS WITH ALL PATHOLOGY RESULTS

5. Psychosocial assessment:

- Complete the Edinburgh Postnatal Depression Scale (EPDS)
- Complete Family Violence Screening questions if no other adult present **Or** child > 2yrs or speaking (this may require a secreted method of enabling the woman to alert staff of risk) (also see Family Violence – Assessment and Response Procedure. Hyperlink)
- Record appropriate code (DAN, DAY, or DAU) in the 'Pregnancy Management Plan where clinicians will see it immediately upon opening. * Note: the 'code' will print out on the management plan
- DAN (domestic abuse - No) If the questions have been asked and no disclosures made
- DAY (domestic abuse - Yes) If the questions have been asked, and a disclosure made
- DAU (domestic abuse – Unknown) If the questions have not yet been asked
- Take social history and document relevant information in BOS
- Enquire about all other pregnancies, where children currently reside and consider DHHS involvement
- Provide details of support services
- Recording in BOS Psychosocial Assessment adding notes to Psychosocial Notes

Document referrals and more complex psychosocial issues under Psychosocial section in BOS.

6. Provide health information / referrals

- Discuss models of care and address CH capability and need for referral to other health services as the pregnancy progresses and risk may change.
- Provide with a summarized schedule of care including visit to attend with GPO/midwives: Pregnancy Roadmap

	• Childbirth Education Classes - encourage attendance to classes to all primipara women and consider wit multigravida women who have a new partner, long spacing between children etc. • Obtain consent to share information from other healthcare providers (as appropriate). • Lifestyle considerations: Nutrition/diet/healthy weight gain (according to initial BMI) Pregnancy multivitamin including folic acid and iodine supplementation • Smoking behavior/cessation – offer and complete QUIT refer to NDCH if accepted • Oral and dental health • Discuss and document in BOS smoking, drug (herbal, recreational, prescribed) and alcohol use, for both the woman and the partner, making notation in the psychosocial notes if applicable. • Advise there are two vaccines currently recommended in pregnancy: - Pertussis Vaccine (whooping cough) recommended between 20 – 32 weeks of pregnancy as this maximizes the chance of the highest level of antibodies in the baby when it is born - Influenza Vaccine - can be given at any stage of pregnancy for protection of mother and fetus 7. Confirm booking • Complete all relevant fields in BOS. Print the woman's booking in summary from BOS. Have the woman sign the BOS summary and staple a copy into her VMR. • Explain VMR and encourage its use at all visits and presentations to a healthcare facility • Check BOS print out contains all information input into BOS • Add fundal height graph to VMR for women with normal BMI. • If BMI >35, refer to consultation and referral guideline, the woman will need an individual plan which may include some shared pregnancy care with BH • Discuss OFP • **Complete triage form and refer to triage meeting, -** GPO to Write order for Anti D (if Rhesus D negative) for 28 weeks and 34 weeks filed in woman's medical record. • Print Pregnancy visit summary for VMR
22.0-24.6 Weeks **MIDWIFE**	**Standard Pregnancy Check plus:** • Confirm suitability to birth at CH according to Safe Maternity Care Framework and Triage meeting • If risk factors identified referral to booking/triage meeting as required • Check Childbirth Education Classes have been booked and Dates written on front of VMR • Discuss limiting sugars and fats for last trimester and getting regular exercise. • Review 19-21week morphology ultrasound (gestational age, fetal number, placental position and fetal morphology) - Cervical length – normal is >2.5cm (up to 28 weeks gestation) - Low lying placenta is either a yes or no at 20 weeks, placenta praevia cannot be diagnosed until third trimester. Within 2 cm of the cervical os is low lying. Less than 5% of those diagnosed low at 20 weeks are actually low at term.

	• Review Early GTT results if completed • Check Hb, if low commence oral iron supplements, order Iron Studies • Check order for Anti D (if Rhesus D negative) for 28 weeks and 34 weeks is written up and book appointment at CH to have injection done. • Order FBE/antibodies/OGTT. • Give pathology slip and OGTT patient handout and instruction sheet to woman to complete test at 28 weeks. Inform patient that OGTT appointment needs to be booked by phoning the pathology collection center that they would like to attend. Note: advise the woman to have blood test done a few days prior to the next appointment to ensure results are available for this appointment. If requiring anti-D, the antibody screen must be completed within 72 hours preceding ant-D administration. • Remind women to monitor fetal movements and that any change in pattern of fetal movements warrants investigation. Refer to Your Baby's Movements Matter handout. http://movementsmatter.org.au/ • Recommend Pertussis Vaccine (whooping cough) between 20 – 32 weeks of pregnancy and Influenza Vaccine, if not given already. • Document all details on BOS – consider documenting in management plan if any risk identified and refer to triage meeting. • Discuss OFP • Print Pregnancy visit summary for woman's VMR

28.0 -28.6 Weeks **MIDWIFE**	**Standard Pregnancy Check plus:** • If risk factors identified, add to triage meeting or if urgent contact GPO on call to develop plan. • Results of investigations (GTT, FBE and Antibodies), check documented on BOS • Discuss any risk factors identified with the woman • Begin to discuss labour, birth, third stage and early parenting, book CBE if not already booked. • Anti D: - Check signed drug chart - Complete consent form for blood products - Document in BOS and VMR - Book appointment at CH for 34 weeks • Measure Maternal weight, recalculate BMI • Discuss OFP • Print Pregnancy visit summary for woman's VMR • **Referral to BH for women requiring BH 36-week appt**

31.0-31.6 Weeks **MIDWIFE/GPO/GP** **(Labour and birth planning appointment)**	**Standard Pregnancy Check plus:** • If risk factors identified add to Triage meeting or if urgent contact GPO on call to develop plan. • Discuss any risk factors identified with the woman • Ensure Childbirth Education classes are booked attended • GBS Swab explained, • Discuss GBS swab that GPO will provide slip for at next visit. • Check Anti D injection appointment at CH has been booked in • FBE and Iron Studies – consider Ferinject if Hb is low • Discuss labour, birth, early parenting. • Discuss management third stage clearly document discussion in BOS • If breech on palpation, discuss OFP and ECV • Discuss intention to feed. Discuss the importance of fetal movements during pregnancy and to attend CH if reduced fetal movements at any time. • Discuss and give handouts: - NST - Hearing screening - Keeping your baby safe - Perineal care 'bundle' reducing risk 3rd and 4th degree tear, give information sheet - Nonpharmacological methods of pain relief at home - Birth options/plan • Discuss OFP • Print Pregnancy visit summary for woman's VMR

34.0-34.6 Weeks **GPO**	**Standard Pregnancy Check plus:** • If breech, bedside USS required for confirmation. Referral for ECV. • If any risk factors add to triage meeting • Discuss any risk factors identified with the woman • Ensure Anti D appointment booked • Check GBS status and update BOS with result • Continue to discuss preparation for labour, birth, and early parenting • Discuss third stage and document in BOS • Assess risk of PPH and document in BOS management plan • Discuss the importance of fetal movements during pregnancy and to attend CH if reduced fetal movements at any time. • Discuss OFP

	• Print Pregnancy visit summary for woman's VMR

36.0-36.6 Weeks **BH OBS (Primips and amber referrals)** **MIDWIFE/GPO (Multips & low risk)**	**Standard Pregnancy Check plus:** • If risk factors identified add to Triage meeting or if urgent contact GPO on call to develop plan. • Check GBS status • Discuss the importance of fetal movements during pregnancy and to attend CH if reduced fetal movements at any time**.** • **Review of suitability to birth at CH** • Discuss OFP • Print Pregnancy visit summary for woman's VMR

38.0 -38.6 Weeks **MIDWIFE**	**Standard Pregnancy Check plus:** • If risk factors identified add to Triage meeting or if urgent contact GPO on call to develop plan. • Discuss any risk factors identified with the woman • Ensure all consents have been signed for mother and baby • Discuss labour, when to come to hospital and other relevant information • Discuss contractions 5 minutely lasting 60 seconds over 30 mins or if SROM call Hospital • Discuss the importance of fetal movements during pregnancy and to attend CH if reduced fetal movements at any time. • Discuss post dates process for CH • Discuss OFP • Print Pregnancy visit summary for woman's VMR

39.0-39.6 Weeks **MIDWIFE/GPO**	**Standard Pregnancy Check plus:** • If risk factors identified contact GPO on call to develop plan. • Discuss any risk factors identified with the woman • Discuss the importance of fetal movements during pregnancy and to attend CH if reduced fetal movements at any **time.** • Discuss OFP • Print Pregnancy visit summary for woman's VMR

40.0-40.6 Weeks **BH OBS (Primips & any amber referrals)** **GPO (Multips & low risk women)**	**Standard Pregnancy Check plus:** • Discuss any risk factors identified with the woman • VE to determine Bishop Score and consider Stretch and Sweep • Book CTG for 40 + 4 weeks • Plan and refer to Bendigo Health for IOL for primips, discuss induction methods and risks, obtain consent.

	• Book AFI, to be completed prior to 41 weeks • Discuss the importance of fetal movements during pregnancy and to attend CH if reduced fetal movements at any time. • Discuss OFP

Standard Pregnancy Check
Standard requirements • Introduce yourself and discuss the procedure with the patient. • Obtain consent. • Check patient identification. • Perform routine hand hygiene. • Document in the VMR using pen, include the date, time, signature, printed name and designation, or print out individual BOS visit and place in VMR.
1. Review history • Health and well-being – discuss weight gain as per Pregnancy Weight Matters page in pregnancy handbook. Refer the woman to the section on ideal weight gain per trimester. • Assess risk factors for fetal growth restriction • Review alerts and ensure allergies and alerts including any family violence issues are added on Digital Medical Record (DMR) (legal tab for FV risk) Smoking behaviour enquiry (all family members) and cessation advice and offer QUIT ref/healthy lifestyle referral if indicated (partner okay too)
2. Ask: • Is there anything you were particularly keen to discuss? • Is there anything you are concerned about? • Have there been any changes to your circumstances since your booking visit? (Refer to BOS summary) • If primipara: Have you been to classes?
3. Perform Examination • BP • FHR • S-F height determine lie and presentation (if over 24/40). - Refer to Symphysis-Fundal Height Measurement. Chart fundal height on graph in VMR. - Consider risk factors for fetal growth restriction as FGR Assessment flowchart. • Consider need for FWT
4. Discuss investigation results

- Review results of investigations ordered at last visit
- Arrange any further investigations as indicated
- Document investigation results in BOS under investigations

5. Provide education and information
   - According to clinical situation and as directed by the woman
   - Provide all pregnant women with education about fetal movements, referring to ***Your Baby's Movements Matter*** handout

6. Arrange ongoing care
   - Determine/offer next pregnancy appointment

7. Document in BOS
   - Complete all relevant fields in BOS including management plan as indicated
   - Document findings and all discussions in the patient's handheld record (VMR) or print out pregnancy events page and replace patients' previous copy with updated version

8. Consider opportunity to screen for FV (also refer to the Family Violence – Assessment and Response Procedure)
   - Ask FV questions if presenting without another adult (this may require a secreted method of enabling the woman to alert staff of risk) (also see family violence procedure) to be developed
   - **DAN** (domestic abuse - No) If the questions have been asked and no disclosures made.
   - **DAY** (domestic abuse - Yes) If the questions have been asked, and a disclosure made.
   - **DAU** (domestic abuse – Unknown) If the questions have not yet been asked.
   - Record appropriate code (DAN, DAY, or DAU) in the 'Pregnancy Management Plan' where clinicians will see it immediately upon opening. Note: the 'code' will print out on the management plan
   - Create an 'event note' in the 'Pregnancy events tab' to record further confidential details and select 'No' to 'Print on reports'
   - Complete psychosocial notes tab on BOS if relevant
   - Document referrals and more complex psychosocial issues in the psychosocial tab in BOS.
   - Complete social work referral, if required.

Appendix 3: IP Roles & Responsibilities

Castlemaine Maternity Service - Intrapartum Care – Roles & Responsibilities

The roles and responsibilities for Midwives and GP Obstetricians (GPO) have been outlined in this document to demonstrate a clear framework for accountability and decision making whilst caring for women during labour and birth.

A woman may move between the care pathways (green, amber, red) at any stage throughout labour and birth. Care will be escalated during labour and/or birth as per the ***Castlemaine Health Maternity Service (Level 2) Traffic Light Consultation and Referral System*** and associated policies, procedures and guidelines**.**

Women who are on an amber pathway during pregnancy care will have a clear plan for intrapartum care documented in their notes as outlined and agreed to at the **Maternity Care Planning** (MCP) meeting.

Women on a red pathway during pregnancy will not be cared for during labour and birth at Castlemaine Health Maternity Service. Should a woman move to the **red** pathway during labour and/or birth, care will be managed as per the table below.

Midwives employed in the model will work in accordance with the Nurses & Midwives (Victorian Public Health Sector) Enterprise Agreement 2016-2020, Clause 107, the Midwife Standards for Practice (NMBA, 2019), the Australian College of Midwives Scope of Practice for Midwives in Australia (ACM, 2016), the *Maternity Service (Level 2) Traffic Light Consultation and Referral System*, associated policies, procedures and guidelines for Castlemaine Health Maternity Service.

GPO's will work in accordance with their agreed Scope of Practice, credentialing, the *Maternity Service (Level 2) Traffic Light Consultation and Referral System*, and associated policies, procedures and guidelines for Castlemaine Health Maternity Service.

During the first 6 months of the model being operational the second midwife will be called to attend when the woman is determined to be in 2nd stage of labour. This will strengthen the communication pathways and build an understanding of roles and responsibilities. In addition, this will support midwives working in the model to build confidence in the structure that exists to support practice. This can then be reviewed after 6 months.

Note: PIPER to be consulted for care of women at <32 weeks (**first point of contact**). At 32-37 weeks Bendigo Health will be contacted and **PIPER** may need to be involved in care in collaboration with BH as outlined in the Maternity Service (Level 2) Traffic Light Consultation and Referral System, associated policies, procedures and guidelines for Castlemaine Health Maternity Service.

Care Phase	Green *Midwife primary clinical decision maker*	Amber *GPO primary clinical decision maker*	Red *GPO primary clinical decision maker in collaboration with regional service.*
Pre-admission Phase			
Phone call from woman regarding concern (i.e. SROM, early labour, etc.)	Primary midwife	Primary midwife	Primary midwife If reported clinical condition requires escalation immediately - advise woman to call ambulance if i.e. large APH. ***Contact BH (Birth Suite - MIC) and advise of pending arrival.***
Phone triage documented	Primary midwife	Primary midwife	Primary midwife and contact and consult with GPO re plan for care.
Assessment required – arrange to meet at the hospital	Primary midwife (ANUM to be notified of expected presentation and given updates throughout labour 2 hourly and PRN to enable operational requirements to be met for the 2nd midwife attendance and the service overall). ANUM to communicate with AHM. Midwife will arrive with/before woman.	Primary midwife (ANUM to be notified of expected presentation and given updates throughout labour 2 hourly and PRN to enable operational requirements to be met for the 2nd midwife attendance and the service overall). ANUM to communicate with AHM. Midwife will arrive with/before woman. Care will be provided as per the MCP plan or escalate as clinically indicated.	GPO will assess the woman and the GPO will communicate with BH to discuss clinical picture and plan for care. ***Birth Suite Registrar (BH) is point of contact for escalation.***
Clinical assessment (history, observations, obstetric assessment form, CTG if clinically appropriate.)	Primary midwife	Primary midwife and communicate findings to GPO to develop a collaborative plan. Review MCP notes regarding intrapartum care plan.	GPO will assess the woman and the GPO will communicate with BH to discuss clinical picture and plan for care.
Admission in Labour			
Admission in first stage of labour	Primary midwife to contact on-call GPO to notify of admission and assessment. Notification ***not*** required 2400-0600 hours if woman is stable and progress is as per the *Normal Labour and Birth Guideline* requirements.	Primary midwife will contact GPO to inform them of admission and plan for care as per Maternity Management Planning meeting.	GPO will assess the woman and the GPO will communicate with BH to discuss clinical picture and plan for care.
Reports to GPO throughout labour regarding progress	When progress/clinical condition alters care pathway (i.e. moves to amber pathway) or pharmacological pain relief required.	Primary midwife will contact GPO when decisions need to be made about care, or 4 hourly. + PRN progress reports as per the *Management of Women Presenting in Labour Through to Normal Vaginal Birth* requirements	

Second stage of labour	Primary midwife will call second midwife at commencement of second stage of labour.	Primary Midwife will notify GPO and second midwife at commencement of 2nd stage.	GPO will assess the woman and the GPO will communicate with BH to discuss clinical picture and plan for care.
Accoucheur	Primary midwife with second midwife present.	Primary midwife/GPO based on clinical picture.	GPO will assess the woman and the GPO will communicate with BH to discuss clinical picture and plan for care.
2nd Midwife	Support and documentation. Administration of uterotonic. Receival of the newborn Advise ANUM of birth and clinical condition.	Support and documentation. Administration of uterotonic. Receival of the newborn Advise ANUM of birth and clinical condition.	***Support and documentation of escalation/emergency management.*** Administration of uterotonic. Receival of the newborn Advise ANUM of birth and clinical condition.
Third Stage	Primary midwife with second midwife present.	Primary midwife/GPO based on clinical picture.	GPO will assess the woman and the GPO will communicate with BH to discuss clinical picture and plan for care.
Perineal Suturing	Primary midwife if suturing is within scope of practice. GPO if suturing is not within the midwives' scope of practice.	Primary midwife/GPO based on clinical picture and scope of practice of midwife at the birth.	If third- or fourth-degree tear transfer to BH required.
PIPER to be consulted for care of women at <32 weeks (**first point of contact**). At 32-37 weeks Bendigo Health will be contacted and **PIPER** may need to be involved in care in collaboration with BH as outlined in the ***Maternity Service (Level 2) Traffic Light Consultation and Referral System***, associated policies, procedures and guidelines for Castlemaine Health Maternity Service.			
Where neonatal condition warrants escalation or advice **PIPER** will be contacted.			

In the case of emergency **Code Blue** will be called and ANUM, AHM (and Code Blue Team) will attend for support and assist in response.

Appendix 4: Midwifery Group Practice

Midwifery Group Practice

Midwives working within the Midwifery Group Practice will be capable of working across the full scope of midwifery practice including pregnancy care, labour and birth, postnatal care and midwifery home care. This will require the ability to perform newborn examinations, perineal suturing, IV cannulation, fetal scalp electrode placement and advise on optimal fetal positioning. In this model of care each employed midwife is salaried and takes a caseload of women to care for and support through their whole continuum of care. This is in accordance with the relevant clause of the Nurses and Midwives (Victorian Public Health Sector) (Single Interest Employers) Enterprise Agreement 2016-2020

Low risk women who have an uncomplicated vaginal birth will be offered early discharge to have postnatal care delivered in their own home by their known midwife if that is their preferred option. Daily home visits will then occur as required. Women who are not considered uncomplicated will have a discharge plan commenced following birth to determine required support and flexible delivery of care. Contact with the primary midwife up until 6 weeks post birth will be available to the woman with an option of a 6-week visit concluding the care episode. This continuity model of care will not operate, in any way, to reduce or preclude the provision of MCH nursing services to women and families in accordance with Clause 107.4 (P) Nurses & Midwives (Victorian Public Health Sector) (Single Interest Employers) Enterprise Agreement 2016-2020.

FTE calculations for MGP:

Bookings for birth at CHMS 2017-2020	**173** women booked for birth (**57 per year**) • 39 Antenatal transfers • 21 Intrapartum transfers **134** women commenced labour at CHMS. ***This equates to 45 women who commenced labour at CHMS per year.***
Caseload	As per EBA caseload for **1.0 FTE= 45 women**
MGP model proposed 1.6 FTE **(plus 0.4FTE to be worked at BH)**	This will enable **72 women to birth at CHMS** annually remaining within the EBA clause 107 requirements.
Redundancy for leave cover	There is redundancy built into this FTE to provide for annual leave

Midwives working in the model will be paid a salary with a commuted loading of 32% in lieu of the following:

- public holiday penalties;
- Saturday and Sunday penalties;
- recall and overtime;
- on call allowance;
- shift allowance;
- telephone recall; and
- annual leave loading paid as “projected roster”
- based on the actual number and pattern of hours worked.

Midwives working in the model will be entitled to 6 weeks annual leave and can work an average full-time day standard of 8 hours, being the objective, with the absolute maximum of 12 hours in a 24-hour period. Midwives are required to manage their time carefully to ensure they are able to meet the needs of the woman whilst being mindful of self-care.

Midwives in the MGP must have ***four clear days*** off duty and free of on call requirements in every fortnight.

On-call arrangements will be flexible within this model of care. An on-call system will be determined within the Midwifery Group Practice. Midwives can determine within their group how they wish to work the on-call for professional and personal life flexibility.

Midwives working in the model will be required to complete non-clinical tasks to support the operation of the model.

Equipment required:

- Clinic space for consultations.
- Phone with texting capability and data allowance.
- Access to fleet/organisational car for home visits or policy for own vehicle use.
- Midwifery home care visits equipment (scales, neonatal blood collection consumables, etc.).
- Laptop (or other capable device) for data entry remotely.

Example of on call roster with two teams:

With this model of rostering there are two teams (two midwives in each team) who cover each other and attend as second midwife for birth. There are always two midwives on call which makes the model self-sufficient. This may be a future state model if demand makes it sustainable.

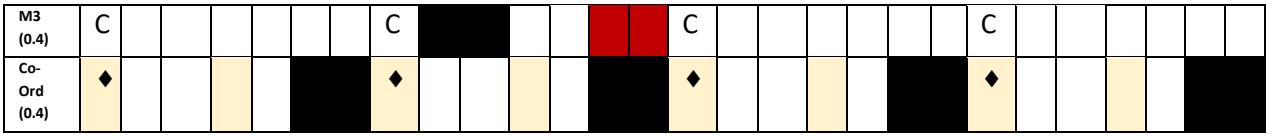
Staff	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
M1 (0.7)								C							C													
M2 (0.6)				C																								
M3 (0.7)	C										C											C						
M4 (0.6)																		C										
Co-Ord (0.4)	♦							♦							♦							♦			C			

Note: C= Clinic ♦=Management Day

Example of on call roster with one team:

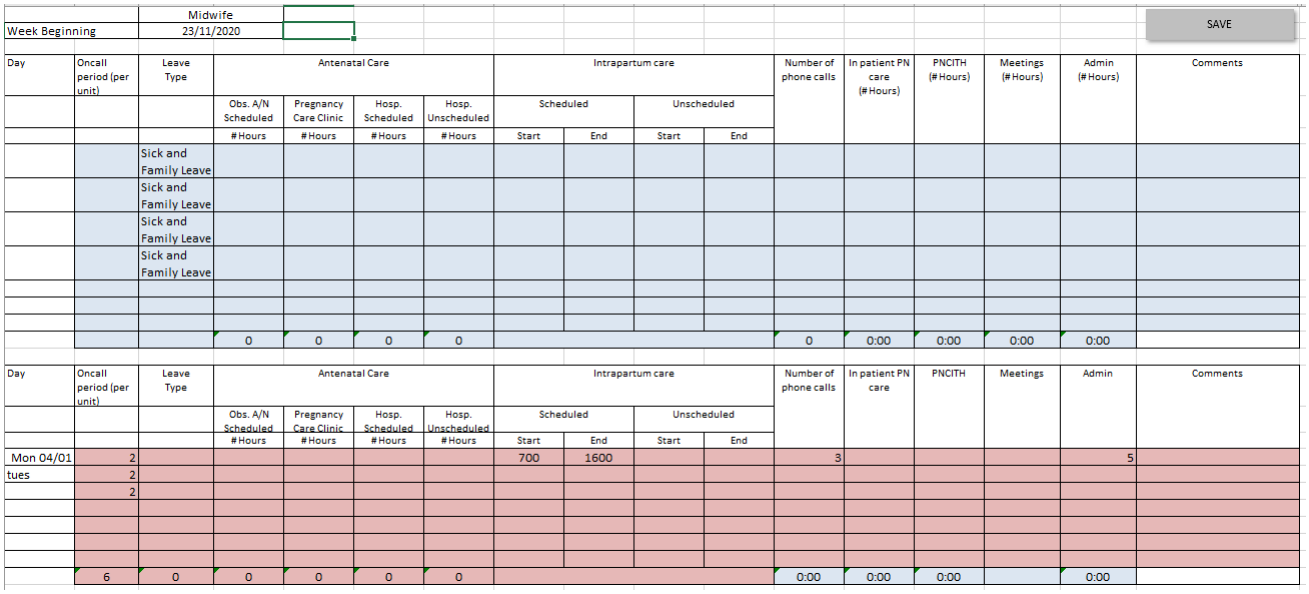
This roster model is more flexible and is built around one midwife being on call over the weekend to cover all births. When on call over the weekend midwives must have 2 days off throughout the week in lieu of this time. This should be taken on days when clinic is not operating for operational efficiency. Midwives will have their own caseload and must have four clear days off per fortnight. This can be negotiated with colleagues to provide balance between personal and professional lives.

Staff	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
M1 (0.5)	C							C							C							C						
M2 (0.5)	C							C							C							C						



Monitoring Hours

Midwives working in the MGP model will document and monitor their time working within the model. This will be documented using an audit tool such as depicted below:



		Midwife																SAVE
Week Beginning		23/11/2020																
Day	Oncall period (per unit)	Leave Type	Antenatal Care				Intrapartum care				Number of phone calls	In patient PN care (#Hours)	PNCITH (#Hours)	Meetings (#Hours)	Admin (#Hours)	Comments
			Obs. A/N Scheduled	Pregnancy Care Clinic	Hosp. Scheduled	Hosp. Unscheduled	Scheduled		Unscheduled							
			#Hours	#Hours	#Hours	#Hours	Start	End	Start	End						
		Sick and Family Leave														
		Sick and Family Leave														
		Sick and Family Leave														
		Sick and Family Leave														
			0	0	0	0					0	0:00	0:00	0:00	0:00	

Day	Oncall period (per unit)	Leave Type	Antenatal Care				Intrapartum care				Number of phone calls	In patient PN care	PNCITH	Meetings	Admin	Comments
			Obs. A/N Scheduled	Pregnancy Care Clinic	Hosp. Scheduled	Hosp. Unscheduled	Scheduled		Unscheduled							
			#Hours	#Hours	#Hours	#Hours	Start	End	Start	End						
Mon 04/01	2						700	1600			3				5	
tues	2															
	2															
	6	0	0	0	0	0					0:00	0:00	0:00		0:00	

Education

Staff Midwives

Staff midwives will be supported to maintain their competency as midwives through a program of professional development specifically designed to support their practice at Castlemaine Health. Staff midwives who wish to develop a plan for transition into the model can do so through consultation with the MGP Co-ordinator and the CME. To enable this access to clinical exposure in both pregnancy care clinics and Birth Suite will be enabled.

CPD/Education	Mandatory or frequency	Provider
Hospital specific Induction and orientation program ANTT – theory and practical competency Blood and Blood products competency	Induction	CH education department
Mandatory Training Compulsory Training requirements as per CH policy	As per CH Policy Annual	
Neonatal Resuscitation either as part of MANE or with PIPER Evidence of completion of the neoResus online module prior to successful competency assessment.	Annually	CH program or neoResus FR, MANE
Neonatal resuscitation practical assessment	Annual	CH education department

Fetal Surveillance Education Program (RANZCOG)	Annual	RANZCOG
Multidisciplinary Obstetric emergencies education Evidence of attendance at specific multidisciplinary training related to obstetric emergencies. Evidence must reflect training in maternity collapse, maternal sepsis eclampsia, postpartum haemorrhage, shoulder dystocia, cord prolapse and breech. Additionally, attendance at relevant conferences, study days or ward-based drills/education are also desirable	Annually	CH PROMPT team, MSEP, MANE
Breastfeeding education Evidence of minimum total of 8 hours of attendance at specific training related to breastfeeding education	Bi-annually	Clinicians may choose to access a variety of different resources. All evidence to be submitted to the education department for recording
Child at Risk / Child protection Online training can be accessed form http://www.vfpms.org.au/childrenatrisk/vuln.htm	Induction	VFPMS
QUIT smoking cessation Online training can be accessed from http://www.quit.org.au/resource-centre/training/training-forhealth-professionals/online-learning	Optional	Online
Newborn Screening Online training can be accessed from https://www.vcgs.org.au/	Induction	VCGS
Stillbirth CRE online education package	Optional	Safer baby bundle and IMPROVE online modules

MGP Midwives

Midwives working in the model will be required to maintain a higher level of continuing professional development and education to provide maternity care across the full scope of midwifery practice.

CPD/Education	Mandatory or frequency	Provider
Hospital specific Induction and orientation program ANTT – theory and practical competency Blood and Blood products competency	Induction	CH Education department
Mandatory Training Compulsory Training requirements as per CH policy	As per CH Policy Annual	CH Education department
Neonatal Resuscitation Evidence of completion of the neoResus online module prior to successful competency assessment.	Annually	CH program or neoResus FR/Advanced, MANE
Neonatal resuscitation practical assessment	Annual	CH education department
Fetal Surveillance Education Program (RANZCOG) All MPG Midwives to maintain Practitioner Level 3	Face to face second yearly OSEP alternate year.	RANZCOG
Multidisciplinary Obstetric emergencies education Evidence of attendance at specific multidisciplinary training related to obstetric emergencies. Evidence must reflect training in maternity collapse, maternal sepsis eclampsia, postpartum haemorrhage, shoulder dystocia, cord prolapse and breech.	Annually	CH PROMPT team, MSEP, MANE

Additionally, attendance at relevant conferences, study days or ward-based drills/education are also desirable		
Breastfeeding education Evidence of minimum total of 8 hours of attendance at specific training related to breastfeeding education	Biannually	Clinicians may choose to access a variety of different resources. All evidence to be submitted to the education department for recording
Child at Risk / Child protection Online training can be accessed form http://www.vfpms.org.au/childrenatrisk/vuln.htm	Annually	VFPMS
Speculum examination (including Amnisure and Fetal fibronectin) Initial education provided with face to face education or completion of specific learning package in addition to successful competency assessment or evidence of recognised prior learning in previous employment.	Induction	CH education team, PROMPT, MANE, MSEP,
Fetal scalp electrode application Initial education provided with face to face education or completion of a specific learning package in addition to successful competency assessment or evidence of recognised prior learning in previous employment.	Induction	CH education team, PROMPT, MANE, MSEP,
Perineal Suturing (desirable)	Initial course completion including theory and supervised practice (logbook) (Minimum 5 per annum)	Royal Women's Hospital, RANZCOG or Other Accredited courses, GPO can provide supervision
Newborn examination Initial education provided with face to face education or completion of a specific learning package in addition to successful competency assessment or evidence of recognised prior learning in previous employment.	Induction and annually (Logbook) (Minimum 5 per annum)	Maternity Connect Sunshine Hospital? GPO's can provide supervision
Intravenous cannulation Initial education provided face to face education/workshop Minimum requirements must be met for observed and supervised intravenous cannulation prior to successful competency assessment or evidence of recognised prior learning in previous employment.	Induction (theory and practical) (I	CH Education department, B. Braun rep
QUIT smoking cessation Online training can be accessed from http://www.quit.org.au/resource-centre/training/training-forhealth-professionals/online-learning	Induction	CH Education department
Newborn Screening Online training can be accessed from https://www.vcgs.org.au/	Induction	VCGS
Stillbirth CRE online education package https://learn.stillbirthcre.org.au/	Induction	Safer baby bundle and IMPROVE online modules

Appendix 5: Medical Workforce

Credentialing for GPO Scope of Practice

There is currently no standardised approach to credentialing GP's for GP Obstetrics at rural hospitals in Victoria. Services are guided by Better Safer Care Credentialing but there is not specific advice with respect to credentialing documentation or requirements. It may be possible to align scope of practice with training to ensure standardisation of practice across qualified GPO's.

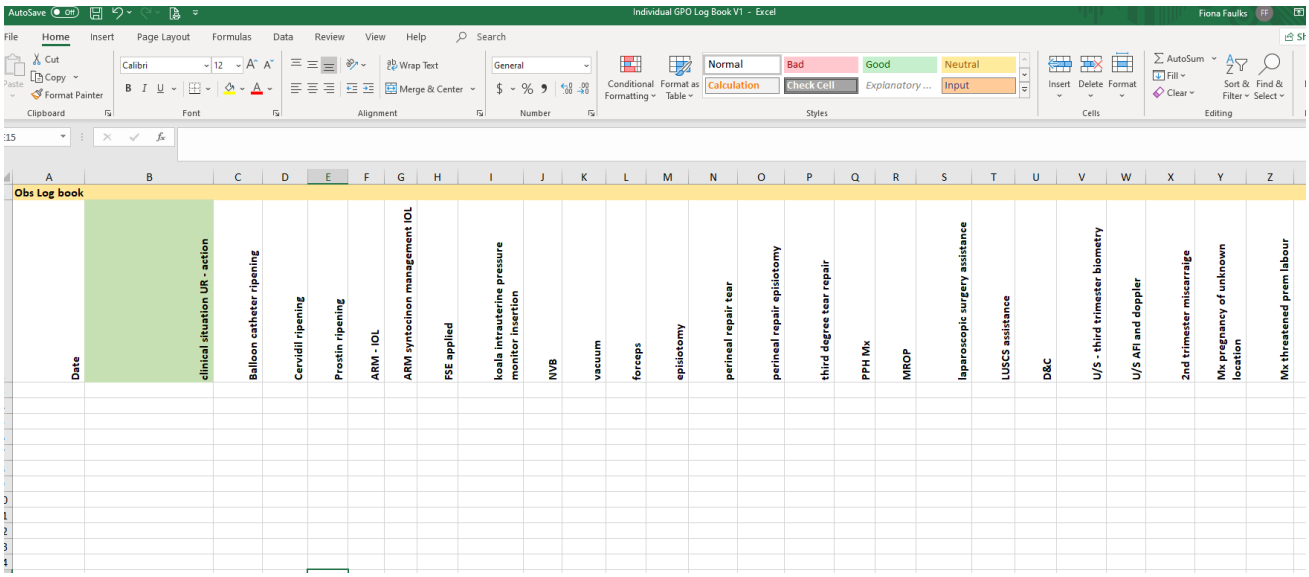
Castlemaine Health have developed the ***Credentialing Requirements for GP Obstetricians Procedure*** that will guide credentialing for the GPO's. In addition a log template (individual and workforce) has been developed for use to document and monitor progress across the triennium.

Figure 1: GPO workforce Clinical Audit log for use by Director of Medical Services to support credentialing

GP Obstetrician	Name	Level of training	Date assessed	Assessed for period		Uncomplicated Vaginal Birth	Instrumental Birth Forceps	Instrumental Birth Vacuum	Perineal Suturing	FSEP (Level 3) Date achieved	Adv. Neonatal Resuscitation (Date completed)
				Start	Finish						
1	GPO	Adv.									
2	GPO	Adv.									
3	GPO	Dip.									
4	GPO	Dip.									
5	GPO	Dip.									
6	GPO	Dip.									
7	GPO	Dip.									

Log Details				
Pt UR	**Date**	**GPO**	**Details**	**Complications**
Example UR	*20/11/2020*	*Dr Mayes*	*ie. G1P1, spont birth, abnormal CTG in labour*	*Note: PPH, 3rd degree tear, neonatal resuscitation, transfer intrapartum*

Figure 2: Individual Clinical Audit Log for use by all GPOs to support credentialing



Castlemaine to date has credentialed GPO's according to their ***Credentialing Procedure – Staff, Doctors & Contractors procedure*** and the ***Guidelines for Strategic Clinical Management 2019*** which refers to the Victorian Maternity and Newborn Services Capability Framework

Current educational requirements for training as per CWH, DRANZCOG & DRANZCOG Advanced Training Program Handbook (2020) https://ranzcog.edu.au/training/certificate-diploma/handbook-curriculum

The Conjoint Committee for the Diploma in Obstetrics and Gynaecology (CCDOG) offers three programs for medical practitioners providing care in women's health**.**

Certificate of Women's Health

This is a training program intended for medical practitioners who desire increased knowledge in aspects of women's health that centre primarily on office-based practice, including shared pregnancy and postnatal care, office gynaecology and family planning. All training and assessment requirements for the CWH must be completed within two (2) years from the date of commencement of training.
Suitable for Shared Care Affiliate under credentialing requirements specific to organisation.

Demonstrate knowledge & understanding of:

- The role and limitations of ultrasound in pregnancy care
- Maternal physiological adaptation to pregnancy
- Mechanisms of normal and abnormal labour, including an understanding of the principles of management of normal and abnormal labour
- State and national maternal and neonatal death rates
- Terms such as livebirth, stillbirth, abortion, neonatal mortality, perinatal mortality, maternal mortality, preterm birth and low birth weight
- Rationale and methodology for pregnancy screening tests
- Rationale and methodology for assessment of maternal and fetal wellbeing
- Basic principles of fetal biometry

Be able to independently:

- Perform preconception counselling, including taking a family history to enable development of a family tree to enable counselling regarding possible inherited/genetic disorders
- Perform early pregnancy counselling
- Recognise deviation from normal maternal and fetal assessment
- Identify obstetric risk factors, initiate appropriate management and appreciate when to refer to generalist practising obstetrics/specialist management, as appropriate.
- Conduct an initial pregnancy visit, including appropriate history, examination and screening tests
- Provide appropriate advice regarding routine maternity care
- Perform a pregnancy examination, including the gravid abdomen
- Provide normal pregnancy care, in collaboration with other healthcare practitioners, including ordering and interpreting appropriate screening and diagnostic tests
- Manage common symptoms of pregnancy
- Manage puerperium, including perineum, lactation, mastitis
- Manage immunisation of neonates

Demonstrate knowledge and understanding of:

- Principles of the inheritance of disease
- Principles of teratogenesis
- Principles of management of obstetric complications including pre-eclampsia, eclampsia, antepartum haemorrhage, iso-immunisation, gestational diabetes, abnormal fetal growth, premature rupture of membranes, pre-term labour, multiple pregnancy, abnormal presentation, prolonged pregnancy, hyperemesis gravidarum, fibroid complications, cholestasis and ovarian cysts
- Effect of pregnancy on common diseases and the effects of these diseases on pregnancy
- Principles of Caesarean section, postoperative management and common postoperative complications
- Principles of pharmacodynamics of the pregnant woman
- Diagnosis and principles of management of miscarriage and ectopic pregnancy
- Principles of grief counselling

Be able to independently:

- Identify, counsel and initiate appropriate management for women suffering postnatal depression or puerperal psychosis
- Appropriately prescribe for a pregnant woman and breastfeeding woman

Diploma of the RANZCOG (DRANZCOG)

The RANZCOG Diploma (DRANZCOG) builds on the knowledge and skills developed through the Certificate of Women's Health program. It is intended for medical practitioners who wish to gain skills in obstetrics and gynaecology to a level that will enable them to safely undertake non-complex deliveries and perform basic gynaecological procedures. All training and assessment requirements for the DRANZCOG must be completed within four (4) years from the date of commencement of training.
GPO credentialed with respect to scope of practice within the maternity service in alignment with skills outlined below.

In collaboration with the appropriate members of the healthcare team, be able to:

- Manage pregnancies in women with pre-existing or current medical conditions such as haematological disorders, diabetes mellitus, renal disease, cardiac disease, gastrointestinal disease or epilepsy
- Diagnose and provide immediate management of pregnancy-induced disorders, including hyperemesis gravidarum, pre-eclampsia, cholestasis, fibroid complications and ovarian cysts
- Diagnose and provide immediate management of obstetric complications including severe pre-eclampsia, eclampsia, antepartum haemorrhage, iso-immunisation, gestational diabetes, abnormal fetal growth, premature rupture of membranes, pre-term labour, obstructed labour, multiple pregnancy, abnormal presentation and prolonged pregnancy.

Demonstrate knowledge and understanding of:

- Principles and use of regional analgesia, including the principles of management of complications of regional anaesthesia
- Principles of 3rd and 4th degree tear repair
- Principles of medical and operative management of postpartum haemorrhage, including uterine balloon tamponade, emergency hysterectomy, bilateral uterine and internal iliac artery ligation and uterine brace sutures

As part of the maternity care team, be able to:

- Manage normal labour and delivery, including third stage
- Assess and chart the progress of labour
- Counsel a woman regarding pain management in labour
- Prescribe appropriate analgesia in labour
- Assess fetal wellbeing in labour by electronic fetal monitoring
- Manage the following emergencies: shoulder dystocia; maternal collapse; post-partum haemorrhage; retained placenta
- Perform the following procedures: induction and augmentation of labour; **low** instrumental delivery; episiotomy and repair; repair of perineal and vaginal tears
- Recognise and manage maternal and fetal complications which develop during labour, including pre-eclampsia, fetal compromise, antepartum haemorrhage, poor progress and intrapartum sepsis, including referral for assisted delivery and Caesarean section
- Perform cardiopulmonary resuscitation of a pregnant and postpartum woman
- Recognise failure to progress and initiate immediate management, including referral for Caesarean section

Demonstrate knowledge and understanding of:

- Requirements of the sick neonate prior to transfer
- Changes in the neonate at birth

In consultation with a specialist, be able to:

- Recognise, provide immediate management, stabilise and arrange transfer as appropriate of sick neonates, including those with sepsis, respiratory distress, hypoglycaemia and failure to thrive
- Evaluate a perinatal death in accordance with PSANZ guidelines
- Perform basic grief counselling, including counselling parents after a perinatal death

Be able to independently:

- Examine a neonate, recognize abnormalities requiring paediatric review (e.g. congenital dislocation of the hips, oesophageal atresia, cardiac murmurs) and perform appropriate management and testing of the neonate
- Manage neonatal jaundice
- Provide basic life support to a sick neonate
- Provide postnatal contraception advice
- Manage maternal problems arising in the puerperium, including primary and secondary post-partum haemorrhage, pyrexia, thrombo-embolism, depression, perineal complications, disorders of lactation, breast complications
- Perform post-natal review of mother

Advanced Diploma of the RANZCOG (DRANZCOG Adv)

This is a hospital-based training program intended for medical practitioners who have gained skills in obstetrics through the Diploma and who wish to develop them to a level that will enable them to safely undertake complex deliveries and perform more advanced gynaecological procedures.
GPO credentialed with respect to scope of practice within the maternity service in alignment with skills outlined below.

Demonstrate knowledge and understanding of:

- Principles of elective breech delivery

- Principles of twin delivery
- Principles of repair of torn bladder
- Principles of repair of lacerated cervix

Be able to independently:

- Diagnose and manage women with hyperemesis gravidarum
- Manage antepartum haemorrhage
- Manage women with pre-eclampsia
- Manage women with cholestasis, fibroid complications, diet controlled gestational diabetes, abnormal fetal growth, premature rupture of membranes
- Manage preterm labour, prolonged pregnancy, poor progress of labour, obstructed labour
- Manage normal labour and delivery, including third stage
- Assess and chart the progress of labour; manage poor progress
- Counsel a woman regarding pain management in labour
- Prescribe appropriate analgesia in labour
- Assess fetal wellbeing in labour by electronic fetal monitoring
- Manage fetal compromise during labour
- Manage women with eclampsia
- Manage maternal collapse
- Manage retained placenta including manual removal
- Perform induction and augmentation of labour
- Perform episiotomy and repair and repair of perineal and vaginal tears
- Manage intrapartum sepsis
- Perform instrumental delivery, both vacuum and forceps
- Manage shoulder dystocia
- Manage undiagnosed vaginal breech delivery
- Perform a Caesarean delivery, both elective and emergency
- Manage postpartum haemorrhage, including operative management (eg, uterine balloon tamponade, laparotomy and uterine brace sutures)
- Resuscitate a neonate, including endotracheal intubation

Ultrasound:

Be able to independently:

- Perform basic first trimester scanning, including localization, dating, viability and plurality of pregnancy, both transvaginally and transabdominally
- Perform late pregnancy scanning, including presentation of fetus, placental localization, basic fetal biometry and amniotic fluid volume

Recertification

The **CWH, DRANZCOG and DRANZCOG Advanced** are all re-certifiable and time-limited qualifications. They are granted for a period of ***three to five*** years, adjusted to align with the period of the RACGP Quality Improvement and Continued Professional Development (QI&CPD) Program. Recertification occurs every three years thereafter. Recertification is contingent on the Certificate or Diploma holder accruing a set of points in the RACGP QI & CPD Program or the ACRRM Professional Development Program.
https://www.ranzcog.edu.au/members/cpd/Diplomates-Certificants

Appendix 6: Referrals

Referral to Allied Health Services

A woman will be provided access to allied health and support services that have been identified as required. . The primary midwife or GP will refer the woman for care as appropriate giving a detailed handover of the woman and her needs within the referral.

The following allied health services may be accessed as required across the continuum. Additional unlisted allied health services may be required for meet specific needs.

- Diabetes educator will work with the woman with gestational diabetes and pre-exiting diabetes to ensure safe and effective management of their diabetes, pregnancy and postnatally, especially if the woman is breastfeeding.
- Dietetics will work with women whom are underweight, overweight with a large BMI, gestational diabetes and pre-exiting diabetes to ensure nutritional requirements are considered for pregnancy.
- Pharmacy will also be responsible for the education of the woman and her family with ongoing medications, when the woman is discharged.
- Physiotherapy will work with the woman to provide postpartum care support post a vaginal or caesarean section birth.
- Social Work will undertake a comprehensive psychosocial assessment and link the woman and her supports to sustainable community services. Social workers will assist in specific needs of the client i.e. financial stress, isolation, perinatal loss, adaptation.
- Lactation Consultant will provide breastfeeding support as required by the woman.
- Aboriginal Health Liaison Officer will provide cultural support and advice for both women and staff if identified as valuable to the woman.
- Perinatal Mental Health Service are available for women through a referral to the Perinatal Emotional Health Program at Bendigo Health.

The Post and Pregnancy Depression Association **(PANDA) National Helpline 1300 726 306** provides information, support and referral to women affected by depression and anxiety during pregnancy and after childbirth www.panda.org.au

Child Protection

General Practitioners and Midwives are mandated notifiers and are required by law to notify the Department for Child Protection and should make a report to Child Protection if they have formed a reasonable belief that a child has suffered or is likely to suffer significant harm as a result of abuse or neglect and their parent has not or is unlikely to protect them from harm of that type. The Children and Young People (Safety) Act 2017 is the guiding document for child safety nationally.

Staff will use the contact details as outlined in the DHHS Reporting child abuse page

To report concerns that are life threatening, ring ***Victoria Police: 000***

To report concerns about the immediate safety of a child after hours, call the ***After-Hours Child Protection Emergency Service: 13 12 78.***

Referral to Maternal and Child Health Service (MCHS), Women's and Children's Health Network

All women will be referred to her local Maternal & Child Health Service at discharge. The referral will be sent via telephone call directly to the MCH. The woman is given a copy of the BOS Discharge summary for both the MCH and her own GP.

A referral should be followed up with a phone call to the MCHN if there are concerns such as:

- High Edinburgh Postnatal Depression Scale (EPNDS)
- Parents known to Child Protection
- Growth or developmental concerns for the baby
- Safety concerns for the mother or the baby
- Social isolation or limited support network

Family violence or visiting safety concerns will also be clearly communicated to the MCHN at referral.

Appendix 7: Postnatal Care

Postnatal Care

Care will be handed over to the staff midwife/nurse using both a verbal and written handover. This is important to reduce the risk of error and ensure the fidelity of the information. Where possible, providing verbal handover in the presence of the woman, is considered best practice.

Handover

A written handover in the ISBAR format will be provided to the staff midwife prior to leaving the facility. **ISBAR** is a standard pneumonic created to improve safety in the transfer of critical information which stands for:

- Identify
- Situation
- Background
- Assessment
- Recommendation or request

Postnatal care in the home

All women will receive <u>at least one</u> postnatal visit at home. Additional visits may be required dependent on their individual needs. For women who are discharged early from CHMS further visits will be offered to support the woman and her family transition.

An example of a postnatal care episode *(Can be adjusted for clinical need):*

Day after discharge: (compulsory) – women can be seen up to 2 weeks post birth if clinical condition requires this. If requiring further care considered the need for HITH.

<u>If an early discharge:</u>

- Day 1
- Day 2 (Multigravida women may not require this – phone call follow up may suffice)
- Day 3 (NST, Weigh etc.)
- Victorian Infant Hearing Screening (VIHSP) will be arranged as per local procedure
- Further visits may be required depending on clinical picture.

Care will be culturally safe and include:

- Vital signs mother and baby
- Fundus and vaginal loss checks
- Voiding and bowel activity
- Education
- Breastfeeding/Feeding support
- Emotional wellbeing assessment
- Breast care
- Safe sleeping
- Weight and measurements of baby
- Settling support

Midwives arranging home visiting post birth will take into consideration the geographical distance and road conditions when arranging to visit. The maximum time to be travelled to visit a postnatal woman is around 1 hour one way. It may be necessary to plan to meet at the hospital or consider videoconferencing (if this is accessible to the woman) for women who live beyond this distance. Consider referral to the nearest domiciliary midwifery service if the woman would prefer this option. A home risk assessment tool (link to tool) will be completed prior to any visits.

Safety requirements for midwives making home visits must be considered. Visits will be logged prior to ensure the facility is aware of the visit schedule and location. ANUM will also be informed of schedule. Consideration should be given to the introduction of GPS duress alarms to be carried by midwives when conducting home visits. If the risk assessment ***precludes*** home visiting the woman and her family will be asked to attend the hospital for domiciliary care with their known midwife.

If, on assessment at home, the woman is considered clinically unstable for any reason an ambulance may be called to attend. The GPO on call must be contacted and advised of clinical situation. If the woman requires non-emergent care, she should be advised to attend the hospital for assessment and ongoing care with their known midwife. ***Consultation and referral in the postnatal period will be guided by the Castlemaine Health Maternity Service (Level 2) Traffic Light Consultation and Referral System***

Discharge Criteria from hospital to home

Early discharge to home will be encouraged and supported by a known midwife.

A woman may be discharged home from hospital post a **vaginal** birth when:

- Vital signs are stable and appropriate
- Pain is controlled with oral analgesia
- Discharge planning is completed.
- All relevant documentation is complete.
- The woman feels safe and wishes to return home.

A woman can be discharged home from hospital post a **caesarean birth** when:

- Vital signs are stable and appropriate
- Pain is controlled with oral analgesia
- Surgical wound is clean and dry
- Patient's medication assessment is completed and medication list (if appropriate) prepared
- Discharge planning is completed
- All relevant documentation is complete before discharge
- The woman feels safe and wishes to return home.

A discharge summary/letter to the woman's healthcare provider is to be completed and sent on discharge. (Obstetric Discharge Summary BOS)

Guideline for discharge criteria from the MoC

A woman can be discharged from the Midwifery Caseload MoC at any time should she choose this. The following should be considered when a woman is discharged:

- Is the woman managing well at home?
- Has infant feeding been well established?
- Has follow up with the MCHN been planned?
- Have all necessary community resources/referrals for ongoing support been provided to the woman and her family to access?

Discharge will occur in consultation between the MGP midwife and the GPO. A discharge summary will be completed by the primary midwife summarising the events of the pregnancy, birth and postnatal period (Obstetric Discharge Summary BOS).

Conclusion of Midwifery Caseload Care Model of Care

The woman may elect to see her primary midwife at 6 weeks for a final follow up visit. The purpose of this visit will be to discuss the pregnancy and birth, contraception, ongoing community supports available and future pregnancy care. This continuity model of care will not operate, in any way, to reduce or preclude the provision of MCH nursing services to women and families in accordance with Clause 107.4 (P) Nurses & Midwives (Victorian Public Health Sector) (Single Interest Employers) Enterprise Agreement 2016-2020.

Appendix 8: Operationalising the model

Organisation of work

Hard copy diaries will be provided for all MGP midwives to arrange appointments and schedule. Electronic diaries may also be used if this is their preference.

A smart phone will be provided for each MGP midwife to communicate with women, maintain an electronic diary and alert management to any safety concerns. This phone will not be used for personal use and women should NOT be given personal contact details for MGP midwives at any stage. MGP phones will have texting capability and data allowance.

IT Systems access

MGP midwives will be given access to all necessary IT systems to enable efficient and effective workflows. This will include (but is not limited to):

- BOS
- Pathology
- Radiology
- iPM
- Kronos
- Fleet booking system (WebFleet)

MGP midwives will have remote access (VPN) to enable them to complete BOS, etc from home when required. As Castlemaine Health is unable to provide VPN access to staff using their own devices MGP midwives will be provided with a laptop with VPN access.
The MGP will have a generic email address for contact from prospective women, referral management and organisational communications. This will be maintained by the MGP co-ordinator but all MGP midwives will have access to this.
An MGP folder will be placed on the shared drive for rosters, files, annual leave planner and important communications. All MGP midwives will have access to this folder.

FTE Caseload Allocation

MGP midwives will recruit the following number of women over a 12-month period based on contracted FTE. This is based on Clause 107.4 (P) Nurses & Midwives (Victorian Public Health Sector) (Single Interest Employers) Enterprise Agreement 2016-2020.

EFT	0.4	0.5	0.6	0.7	0.8	0.9	1.0
Expected Recruitment	18	23	27	32	36	41	45

Midwives working in the model will be paid a salary with a commuted loading of 32% in lieu of the following:

- public holiday penalties;
- Saturday and Sunday penalties;
- recall and overtime;
- on call allowance;
- shift allowance;
- telephone recall; and
- annual leave loading paid as “projected roster”

- based on the actual number and pattern of hours worked.

Midwives working in the model will be entitled to 6 weeks annual leave and can work an average full-time day standard of 8 hours, being the objective, with the absolute maximum of 12 hours in a 24-hour period. Midwives are required to manage their time carefully to ensure they are able to meet the needs of the woman whilst being mindful of self-care.

Midwives in the MGP must have ***four clear days*** off duty and free of on call requirements in every fortnight.

On-call arrangements will be flexible within this model of care. An on-call system will be determined within the Midwifery Group Practice. Midwives can determine within their group how they wish to work the on-call for professional and personal life flexibility.

Midwives working in the model will be required to complete non-clinical tasks to support the operation of the model.

Worktime (clocked) will begin when the midwife is onsite for care. Phone calls will be logged as per reconciliation log. On-call and recall will be calculated at reconciliation in accordance with the EBA.

Recruitment

Women are mostly recruited as per low risk criteria documented in the ***Castlemaine Health Maternity Service (Level 2) Traffic Light Consultation and Referral System.***
Women may be referred into the service via their GP/GPO or may choose to self-refer.
Women will be allocated to the MGP by the MGP Co-ordinator in consultation at weekly team meetings. Consideration will be given to geography, location of home, expected date of delivery, cultural safety and availability of midwives in the allocation to MGP midwives.

If at any time, a woman is uncomfortable with the midwife who is allocated to her care she will be informed at booking in of the process to raise this with the MGP Co-ordinator.

The allocated MGP midwife will then call the woman to offer her a booking in appointment and explain the program to the woman. This will include the expectation of early discharge, on-call process, leave cover and how the model works.

Recruitment Process

To ensure a standardised process is followed at recruitment the following will occur:

- Following receipt of the referral HIS will enter the woman's details into iPM.
- The woman will be offered a booking in appointment
- The MGP midwife will save the woman's contact details in her phone. She will also email her MGP partner and give her these details to save in her phone also. In addition, the woman herself will be given the MGP midwife's contact details with permission to share with her partner/support person/NOK.
- The woman will be added to the MGP database on the shared drive (password protected) with the allocated midwife listed.
- The MGP midwife will diarise appointments in their diary (either hard copy or electronically)
- Appointments will be made by the midwife on iPM
- The woman will be given the dates of all appointments as they are booked.
- The MGP team and primary midwife will be documented clearly in the BOS Management Plan.

- Ensure that in BOS the Care Model is documented as MGP – Green, MGP – Amber, MGP – CSC.

Initial Booking Appointment

1 hour will be allocated for the first appointment as a more detailed description of the MGP model will be given.
The woman will be informed of the structure of the MGP and introduced to their back up midwife in the second trimester.
Early discharge will be discussed and encouraged with MHC being clearly explained (including extra visits for early discharge)
Women, partners and families will receive education throughout the antenatal period from their MGP midwife with respect to newborn care, sleeping and settling and breast feeding.
Pregnancy Care will be provided in accordance with the ***Antenatal Care Schedule for Castlemaine Health Maternity Service.***

On Call Requirements

All midwives are on call for their own women unless they are on days off, or otherwise arranged.
If there is no scheduled care for the day, ***MGP midwives are not expected to come in to work***.
All clinical work will be documented in the time audit log including phone calls, checking results and texts to women.

MGP midwives are NOT to work or be on-call on their rostered days off.
On call will be managed by the MGP Co-ordinator to ensure work/life balance and equity across the team.

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

- Ensure to discuss the signs of early labour with the woman in the antenatal period to ensure that women realise how much time may elapse with contractions before 'active' labour commences and the midwife is needed continuously.
- When early labour phone contact is initiated, ensure time is spent on the phone discussing with the woman what is happening.
- The midwife should rest when possible whilst the woman is in early labour.
- If a woman is in early labour during the day, do not complete a full clinical day as the woman is likely to labour overnight.

MGP midwives will be available via phone or text for their women should they have any clinical concerns or need assessment out of business hours. This will be clearly discussed with the women at booking with respect to what may require contact out of business hours.

MGP midwives may work a maximum of 12 hours in any 24-hour period. When taking over care for a woman it is the MGP midwife's responsibility to:
- Inform her MGP partner and arrange for handover of care
- Inform the ANUM what time she needs to be relieved and who will be relieving and the MGP Co-Ordinator when on duty.
-Document on the patient flow board what time she will need to be relieved and who will be relieving.

MGP midwives may choose to work between 8-12 hours with 8 hours being the objective. If approaching maximum hours, MGP midwives will aim to be relieved at least one hour prior to handover or maximum hours reached.

After completing hours, MGP midwives are entitled to a 10-hour break. Therefore, for example, if leaving work at 0300hrs after completing maximum hours, the MGP midwife may return to being on-call at 1300 hrs.

During this 10-hour break the MGP midwife's phone should be diverted to their MGP team member and the ANUM and MGP Co-ordinator when on duty should also be informed. It is the responsibility of the MGP midwife to reschedule appointments or reallocate if unable to attend pregnancy care clinic appointments due to a birth or postnatal care.

Prior to diverting to her partner, the MGP midwife will inform the ANUM and document on the patient flow board the time they will be due back on-call.

The following practices will enable the MGP model of care:

- Buddy/back-up midwife to cover caseload during time off (Women will meet the back-up midwife or team of midwives throughout their pregnancy journey)
- On-call Monday-Friday for own caseload (Caseload is adjusted and determined on FTE)
- Weekend on-call rotated within team
- If weekend on-call, two days off during the week must occur.
- Midwives will have the flexibility to meet the needs of their caseload women Monday-Friday.
- Midwifery working hours are calculated over an eight-week period.

Clear Days Off (CDO)

MGP midwives are entitled to 4 x CDO's / roster fortnight regardless of EFT.

It is helpful for MGP midwives to organise days off with their partner, so they are not back to back. This way neither person has to lose time off or negotiate a divert time (sometimes this is unavoidable and requires negotiation of diversion time).

Days off begin at **20:00** the night before CDO at which time the MGP midwife's work phone is diverted to their MGP partner.

On-Call commencing after days off begins at **08:00** at which time the MGP midwife's phone should be undiverted from their partner. The MGP primary midwife is then expected to take over calls and care from their partner at this time. It is appropriate for their partner to send the primary MGP midwife a text message from 06:30 so they can be available to relieve them at 08:00.

If the MGP midwife is returning from days off to a **planned IOL** at CH they will be expected to start at 0800 hours.
If they are engaged at work and unable to leave at 20:00 (e.g. at a birth) prior to CDO/ARL, their partner should (own hours pending) be available take over from them at 20:00 and stay with the woman to the end of their scheduled hours (maximum of 12 hours total).

Managing time in a caseload model

Good time management processes are essential to sustainable continuity models. Management will be flexible and supportive, allowing midwives to develop systems that meet their needs. The midwifery group practice needs to negotiate mutually beneficial systems and adapt this over time. Individual midwives will develop time management skills that make caseload practice sustainable and enjoyable and discuss any concerns with the MGP Co-Ordinator.

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

Midwives providing continuity of care will plan their caseload work ideally around 6-12 months in advance, considering the following:

- Caseload mix – primiparous and multiparous
- Annual Leave planning in advance with consideration for the whole group
- Professional Development Leave

Unplanned (personal and carers) leave

MGP midwives requiring unplanned leave will inform the MGP Co-Ordinator/ANUM (if MGP Co-ordinator if on duty) via phone outlining which patients will be handed over to the ward for the period of leave and who will be managing any pregnancy care and MHC visits that cannot be rescheduled. Should the MGP Co-Ordinator not be available the MGP midwife will contact the ANUM Geroe. The MGP Co-Ordinator may take over pregnancy care visits and calls in the short term. This may mean the woman needs to attend on a different day. The MGP Co-ordinator will manage Kronos for the MGP midwives.

The midwife will also contact their MGP partner to organise pregnancy care appointments and MHC if they are unable to reschedule them. If their MGP partner is on leave another member of the MGP team will be contacted.

Unplanned leave is generally covered by the MGP partner in collaboration with the Staff Midwives and the MGP Co-Ordinator. Phones will need to be diverted to the appropriate member of staff during leave. Long term sick leave will be advertised for relief by Staff Midwives who wish to experience MGP practice.

Medical certificates/statutory declarations are to be emailed to MGP Co-ordinator in accordance with the EBA.

Annual Leave (ARL)

ARL is covered by the MGP partner midwife. With 4 MGP midwives working in the model only **one** MGP midwife will take ARL at any given time.

In planning for leave MGP midwives should try not to recruit women **with an EDD 10 days** either side of ARL as it is likely to leave their partner with unnecessary workload. MGP midwives will seek to minimise scheduled work for their partner during their ARL where possible.

Study leave

Study leave is covered by the MGP partner midwife. MGP midwives will negotiate study leave with their partner prior to applying. Study leave must be applied for at least two weeks prior to the study day.

Clinical Management

Births/assessments and inpatient postnatal care ***must take priority*** over Midwifery Home Care (MHC) and pregnancy care visits.

If a woman attends an appointment with the GPO or with an Obstetrician at BH it is the MGP midwives' responsibility to discuss this appointment with the woman and review BOS notes following this appointment.

Pregnancy Care

All pregnancy care for booked women (that is, women booked for pregnancy and birth care at Castlemaine Health who remain within the capability of Castlemaine Health) will be attended by the primary MGP midwife. If the woman requires an admission to the Maternity Unit care will be provided by their primary MGP midwife until the woman is stable for care to be handed over to staff midwives on duty or transfer occurs. The maternal pathway will be completed prior to handing over to ward staff.

Routine MGP pregnancy care appointments are usually scheduled when it is convenient for the client and MGP midwife. MGP midwives will limit pregnancy care visits to 1-2 days to ensure efficient use of time. Do not schedule routine appointments on weekends or public holidays.

MGP midwives will make appointments and follow guidelines as per the Pregnancy Care Guidelines.

All patient files will be available following receipt of the referral in the filing cabinet in the Maternity Unit. Please read file prior to seeing patient.

All new appointments and the 31-32-week (birth planning) appointment will be allocated **1 hour**. All review appointments will be allocated **30 minutes**.

The 36-week appointment for all primiparous/amber women at Bendigo Health should be arranged by the midwife (with the woman present) with a request for teleconferencing/e-health capability if the woman consents and if this is manageable for the midwife.

As per the ***Antenatal Care Schedule for Castlemaine Health Maternity Service*** all primiparous women and amber women at **40 weeks** will be seen at Bendigo Health for review. Multiparous women will be seen by the GPO to discuss a plan for labour and birth (postdates). The MGP midwife may choose to participate in this consultation (either virtually (BH) or in person (GPO)) with consent from the woman.

Assessments

Each MGP midwife is responsible for their own planned and unplanned assessments except for when off duty in which case their MGP partner will attend. Document all assessments on BOS and ensure an appointment is made on IPM in the "Assessment Clinic".

Postnatal Care

Inpatient postnatal care will be provided by the MGP midwife for the ***first 4 hours post birth***. All the key tasks should be attended by MGP midwife. If the midwife has exhausted her work hours her MGP partner will complete care as above. If the second MGP midwife has also exhausted their hours or is unavailable the MGP midwife will discuss with the ANUM to determine if workload will allow the staff midwife to take over care. If the current workload on the ward precludes this other MGP midwives will be contacted.

The MGP midwife will review the woman on the ward by **0830** for inpatient care. The MGP midwife will communicate with ward staff if unable to attend at this time due to other work commitments (e.g. at a birth).

Women who have had a normal vaginal birth (uncomplicated) will be discharged ***within 24 hours*** wherever clinically possible with additional support offered through MHC.

After seeing the woman on the ward, the MGP midwife will document in the medical record and provide hand over to ward staff verbally, leaving clear instructions about what time they will return to continue care or discharge. The MGP midwife should complete as much clinical care as possible whilst on the ward prior to handing over to staff midwives. This will be in accordance with the Safe Patient Care Act (Nurse to Patient and Midwife to Patient Ratios) (2015).

The MGP midwife will arrange MHC visits, which includes arrangements for the car as other teams may have scheduled MHC visits as well.

Discharge from Hospital

Early discharge is encouraged for all women unless mother or baby is unwell. Women who have had LUSCS (returned from BH) may be discharged postnatal Day 2 (if well) or Day 3.

Discharge medications should be organised as required by the GPO under which they are admitted.

Baby Check to be attended as well as hearing test if where possible. If hearing test cannot be completed whilst an inpatient the MGP midwife will arrange an appointment for this to occur at the clinic post discharge. Victorian Infant Hearing Screen Program (VIHSP) have a clinic at CH monthly. The MGP midwife will make the appointment using the VIHSP booking form and give the families the details of the appointment prior to discharge. This form is then faxed to VIHSP. Women are given their contact details. VIHSP give CH dates for the year. The hearing screen clinics runs in the same building as the Pregnancy Care Clinic. There is no need to weigh baby if discharging at 24 hrs of age as this will be completed during an MHC visit.

The MGP midwife will complete the Offsite Work Risk Assessment (MR600) prior to discharge. ***If the risk assessment precludes home visiting the woman and her family will be asked to attend the hospital for domiciliary care with their known midwife.***

The Offsite Work Risk Assessment, BOS summary, MHC pathways and stickers into plastic folder and stored in the MHC folder in the locked filing cabinet on the Maternity Unit.

Midwifery Home Care

The car for MHC will be booked through the fleet management system when the MGP midwife has confirmed the visit time.

Fleet cars will be managed as per the Webfleet procedure. Midwives complete booking form and take it to Support services. Collects allocated car keys, complete trip details and odometer on the booking form. As outlined in Motor Vehicle Procedure.

MHC basket and scales will be stored in the pregnancy care clinic. The MGP midwife will restock the basket when they use anything.

Clinical assessment details for both mother and baby will be recorded on the MHC pathway and any concerns escalated as per the ***Castlemaine Health Maternity Service (Level 2) Traffic Light Consultation and Referral System.*** If, on assessment at home, the woman is considered clinically unstable for any reason an ambulance may be called to attend. The GPO on call must be contacted and advised of clinical situation. If the woman requires non-emergent care, she should be advised to attend the hospital for assessment and ongoing care with their known midwife.

Babies should be weighed only every 2nd day and those with a 10% weight loss will be managed by putting a clear feeding plan into place and contacting the GPO. ***Babies who lose >10% will be assessed daily until adequate weight gain is observed.*** Any breastfeeding problems will require a feeding plan to be developed and a referral to the lactation consultant for review.

Breast pump loan is available through CH and are supplied to women either on discharge or throughout MHC care. There are currently two pumps available and there is no cost associated with loaning them.

Documentation of the visit in MHC visit section of Child Health Record (Green Book) will be completed.

The MGP Midwife will either do a home visit or phone call prior to discharge from MHC. Phone calls may be attended if home visit not required. If client is coming to hospital for an appointment, the MGP midwife will arrange to meet them in the Pregnancy Care Clinic for the MHC Visit. If women require extended visits, consider arranging for them to occur at the health service as this requires less midwifery work time.

Discharge

Early discharge to home will be encouraged and supported by a known midwife.

A woman may be discharged home from hospital post a vaginal birth when:

- Vital signs are stable and appropriate
- Pain is controlled with oral analgesia
- Discharge planning is completed.
- All relevant documentation is complete.
- The woman feels safe and wishes to return home.

A woman can be discharged home from hospital post a caesarean birth when:

- Vital signs are stable and appropriate
- Pain is controlled with oral analgesia
- Surgical wound is clean and dry
- Patient's medication assessment is completed and medication list (if appropriate) prepared
- Discharge planning is completed
- All relevant documentation is complete before discharge
- The woman feels safe and wishes to return home.

A discharge summary/letter to the woman's healthcare provider is to be completed and sent on discharge (Obstetric Discharge Summary BOS).

The MGP midwife will phone M&CH re birth and postnatal progress. Referrals to Mt Alexander MHCN

Services are done via Connecting Care and the ward clerk actions this referral. Macedon Ranges MCHN Services require referrals to be faxed. This is completed by midwives.
The discharge will be completed on BOS and the medical record will be sent to HIS for completion and filing.

Unbooked women

Women who present to Castlemaine who are **NOT** booked for pregnancy or birth care at Castlemaine will initially be cared for by UCC staff. An assessment of needs will be completed initially, and contact made with the staff midwife and on call GPO on shift to determine management.

Women who present to CH for CTG (booked to birth elsewhere), Anti-D (booked to birth elsewhere) or domiciliary care (have birthed elsewhere) will be cared for by the staff midwives. Care will be escalated as required to the referring health service or GPO on call depending on the clinical indication. Consultation may be required with the MGP midwives if workload precludes staff midwives for completing this work.

Managing Increasing Demand

As demand for the model increases the caseload will need to be reviewed to ensure compliance with *Nurses & Midwives (Victorian Public Health Sector) (Single Interest Employers) Enterprise Agreement 2016-2020*. **6 monthly review** for the first **two** years will enable a clear understanding of the demand, staff wellbeing, caseload (actual vs projected) and cost. This will be the responsibility of the MGP Co-ordinator.

Midwifery Professional Expectations

There is an expectation that midwives working in the MGP model will be advocates and role models for midwifery colleagues and the profession. This will be demonstrated through contributing to:

- Clinical governance meetings
- Case presentations for case review/M&M for women they have cared for
- Policy/guideline development and review
- Education and mentoring of staff midwives, students and new graduates

Proposed Roster

Proposed roster: 4 midwives with FTE 2.0 at CH (including 0.4 FTE at BH)
Midwifery Clinical Coordinator FTE 0.4

	Week 1	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
0.5	**Midwife 1**	OFF	OFF	C			1	1
0.5	**Midwife 2**	BH			OFF	OFF	2	2
0.5	**Midwife 3**			C	BH		OFF	OFF
0.5	**Midwife 4**			C			OFF	OFF
0.4	**Coordinator**		X	X				

	Week 2	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
0.5	**Midwife 1**	BH		C	OFF	OFF	2	2
0.5	**Midwife 2**			C			OFF	OFF
0.5	**Midwife 3**	OFF	OFF	C			1	1
0.5	**Midwife 4**			C		BH	OFF	OFF
0.4	**Coordinator**			X	X			

	Week 3	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
0.5	**Midwife 1**		BH	C			OFF	OFF
0.5	**Midwife 2**			C			OFF	OFF
0.5	**Midwife 3**	BH		C	OFF	OFF	2	2
0.5	**Midwife 4**	OFF	OFF	C			1	1
0.4	**Coordinator**		X	X				

	Week 4	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
0.5	**Midwife 1**			C			OFF	OFF
0.5	**Midwife 2**	OFF	OFF	C		BH	1	1
0.5	**Midwife 3**			C			OFF	OFF
0.5	**Midwife 4**	BH		C	OFF	OFF	2	2
0.4	**Coordinator**			X	X			

Notes:

C= Pregnancy care/MCP/Team meeting
X -= Coordinator day. Will also work on C days to attend MCP/Team meeting
1 = 1st on call
2 = 2nd 0n call

Each midwife will have 2 clear days off per week.
Allocation of women will be done via during Team meeting by Coordinator who will take into consideration FTE, EDD, Mw Annual Leave.

Each Midwife will spend 1 day per fortnight in Birth Suite at Bendigo Health

Options:

Mw who have reached their 8-12 hr workday will handover in a circular Buddy system.

MW1 diverts to MW2 diverts to MW3 diverts to MW4 diverts to MW1

Midwives will work in two teams of 2 and cover each other as second midwife should they use all their hours or a second woman presents in labour at the same time.
It would be preferable to have one from each team on call over the weekend if possible??? To continue Continuity
Mw 1 & 2 attend morning clinic
Mw 3 & 4 attend afternoon clinic
All attend MCP meetings and team meetings

Appendix 9: Regional Collaborative Partnership

Regional Partnership Proposal – Rural Birthing Service

Bendigo Health and Castlemaine Health have enjoyed a long and productive relationship supporting rural and regional health services to meet the needs of the communities across the Goldfields of central Victoria. Both services are committed to improving health outcomes for rural communities and providing innovative models of care to meet their needs.

Context

In June 2020, Castlemaine Health Board suspended the operation of the maternity service in order to enable an external review of the service. The external review was undertaken by Dr Rupert Sherwood (FRANZCOG) and Lisa Smith (Senior Midwife) with a focus on documenting a future state for Castlemaine Health that would be safe, sustainable and meet the needs of the community.

The final Operational Model of Care (OMoC) has been born out of the recommendations provided in the Sherwood/Smith report viewed and created through a lens of woman centred care. This work has been overseen by the Castlemaine Health Maternity Services Governance Group reporting to the Board of Executives who are committed to supporting the Maternity Service in remodelling care delivery in a way that is collaborative and sustainable into the future.

In line with the Castlemaine Health Strategic Plan 2020-2022 we have sought to strengthen the role of our regional partner, Bendigo Health, with respect to Maternity Care. This will be realised through formal mentoring roles with key senior staff, clinical advice and collaboration on care pathways for women as required. The following is a summary of the proposed opportunities for collaboration between the two health services to meet the recommendations of the Sherwood/Smith report and the model of care as endorsed by the CHMS Governance Group, Safer Care Victoria, ANMF (Vic Branch) and DHHS.

Clinical Governance

It is proposed that a **senior Bendigo Health Obstetrician and Midwife** participate in the clinical governance framework proposed in the Operational Model of Care (OMoC) for the Maternity Service. The purpose of this strategy is to ensure close alignment in clinical practice between the services and to provide some mentorship to the maternity service leadership team at Castlemaine. This will entail participation in the following committees:

The Maternity Care Planning Meeting (MCP)

The MCP meeting will assign all women booking into Castlemaine Health for maternity care to a model of care, taking into consideration the woman's preferred option. All women suitable for care at Castlemaine Health as per the green or amber pathway will be allocated a primary midwife. This will occur for women who choose Midwifery Group Practice or Collaborative Shared Care.

This meeting will ensure coordination, oversight and monitoring of midwifery and obstetric clinical care, and the management of risks throughout a woman's pregnancy. The MCP team will make recommendations and plan care of women booked to birth at CH and ensure communication of these recommendations to the midwifery and GPO team is clear and accessible. The MCP meeting will be co-ordinated by the clinical leads with senior Bendigo Health clinical staff participating to ensure consistency of clinical practice and to ensure a smooth transition for women between the services should this be required. This aligns with the Sherwood/Smith recommendation to ensure

"improved communication and information sharing… to facilitate specialist advice for women under CHMS care," (2020).

Commitment: Fortnightly meeting, one-hour duration (virtual or in person)

The Clinical Case Review Meeting (CCR)

The case review meeting will review ***every birth and maternity interhospital transfer*** that occurs at Castlemaine Health in line with recommendations made in the Sherwood/Smith Report (2020). This process will provide an opportunity to evaluate care, systems, infrastructure, policy, workforce and governance in providing maternity care. Opportunities for improvement / change will be captured in addition to exemplar practice that should be perpetuated. The Clinical Case Review meeting will provide a safe and collegiate environment that focuses on outcomes and professional reflective practice. This meeting will be co-ordinated by the clinical leads with a **senior Bendigo Health Obstetrician and Midwife** participating to ensure variations in practice and clinical decision making are minimised and communication between the services is enhanced.

Commitment: Monthly meeting, one-hour duration (virtual or in person)

Castlemaine Maternity Service Mortality & Morbidity Committee (M&M)

The M&M Committee is responsible for:

- Creating a patient safety learning culture within the organization.
- Ensuring a consistent approach to the management and organizational learning that occurs following an adverse patient safety event.
- Reviewing all adverse patient safety events to identify the action required to prevent, or reduce, the likely hood it will reoccur
- Ensuring the systematic review of any adverse patient safety event or near miss. Aligned with SCV policy Adverse Patient Safety Events
- Focus on quality improvement process to foster shared understandings and learnings
- Maintain a permanent record of all proceedings and report to the Board via the Maternity Services Committee
- Receive and analyse recommendations from Regional mortality and morbidity Committee

This meeting will be co-ordinated by the clinical leads with a **senior Bendigo Health Obstetrician and Midwife** participating to provide external peer review and mentorship for the clinicians working in the model of care.

Commitment: Quarterly meeting, one-hour duration (virtual or in person)

Maternity Services Committee

The Maternity Services will then be strategically governed by the Maternity Services Committee that is responsible for overseeing the implementation of the new model of care, evaluate progress and monitor clinical outcomes in order to inform the CHS Clinical Governance & Quality Committee and, by extension, the CHS Board & Executive. Castlemaine Health would appreciate either a **senior Bendigo Health Obstetrician and Midwife** presence on this committee to ensure clarity regarding

any recommendations and practice implementation that occurs as a result of overall governance strategies.

Commitment: Monthly meeting, one-hour duration (virtual or in person)

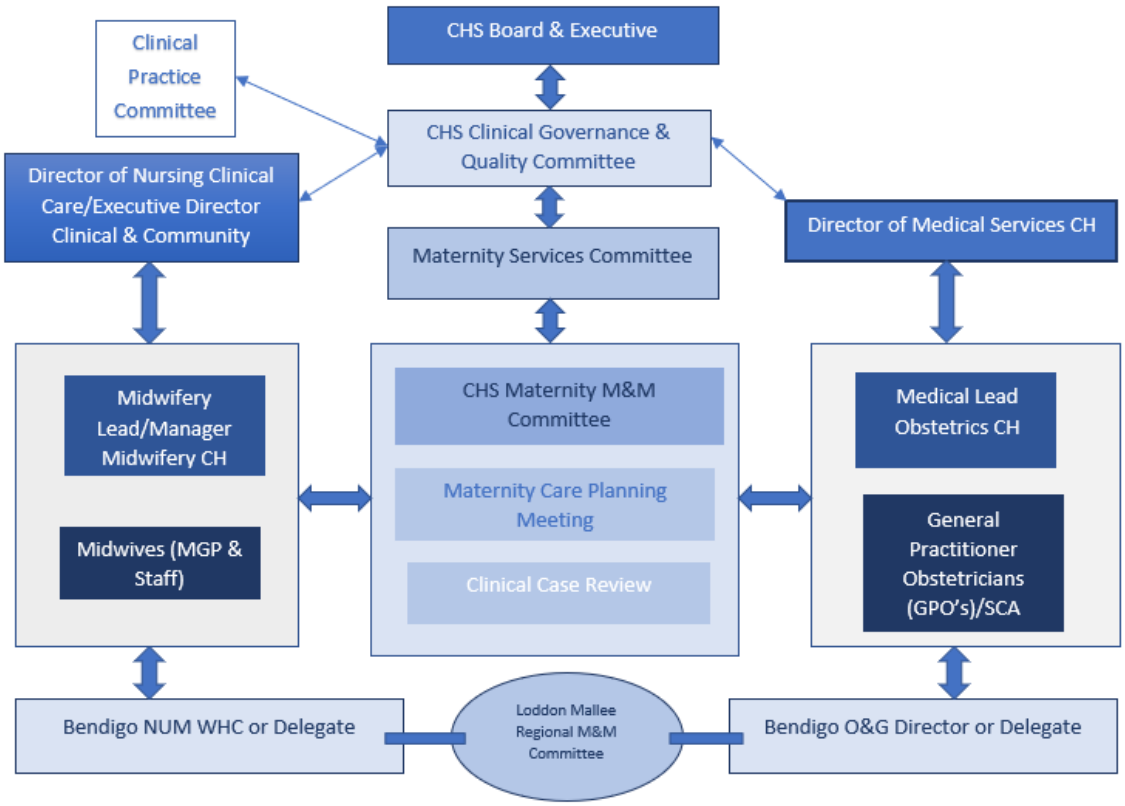
Total commitment requested:

Director O&G: 54 hours per year
Senior Midwife: 54 hours per year

Credentialing

The Director of Obstetrics and Gynaecology at Bendigo Health will provide advice and support to the DMS at Castlemaine Health with respect to clinical practice and credentialing requirements for GPO's. This will enable discipline specific input that will ensure credentialing leads to safe and effective practice.

Table 1: Clinical Governance Framework – Castlemaine Health Maternity Service



This will occur on an as needed basis and will be facilitated through ongoing communication between the two positions.

Training/education/skill maintenance

As the regional teaching facility Bendigo Health is well placed to be able to support the clinical skill maintenance and training required to support rural staff working in a low risk, low volume maternity service. The following has been recognised as key to maintaining staff and skills to deliver safe maternity care at Castlemaine Health.

Medical Staff

GP Obstetricians at Castlemaine Health are credentialed to provide maternity care having completed specialised training through the Diploma of the Royal Australian and New Zealand College of Obstetrics & Gynaecology (RANZCOG) or the Advanced Diploma of the RANZCOG. Due to the low risk, low volume nature of the maternity service at Castlemaine Health GP Obstetricians have limited access to opportunities to build and maintain skills in managing more complex labour and birth which may occur unexpectedly. To mitigate this a regional GPO workforce strategy is proposed that supports Castlemaine GPO's in meeting their credentialing requirements in addition to maintaining skills in managing labour and birth.

All GPO's are required to ***undertake 5 instrumental births and 5 vaginal births annually*** and this will be documented in their logbook. GPO's will meet annually with the Director of Medical Services and the Director of Obstetrics and Gynaecology at Bendigo to monitor progress towards this requirement. To ensure GPO's have the opportunity to meet these requirements they may need to spend time in the regional centre. The following is proposed to achieve this:

1. An agreement is established between CH & BH for related CH staff to work at BH
2. The related staff would work at BH but would be paid by CH
3. The agreement schedules could indicate the staff, hours per fortnight and period
4. CH would remain responsible for all salaries and on costs including Workcover
5. CH could be provided with a timesheet of hours worked at BH. The timesheet could be signed off by Medical Workforce or the Senior Consultant
6. The employment contract changes remain the responsibility of CH.

Midwifery Staff

Midwifery staff at Castlemaine may identify practice deficits or lack of exposure to certain practices by nature of working in a low risk low volume rural service. Bendigo Health provides an opportunity for midwives to gain valuable experience should they identify this is required in collaboration with their line manager. This would be achieved through supernumerary time (paid for by CH) at BH in the relevant clinical space. This would be available to both MGP midwives and staff midwives from Castlemaine.

In addition, Castlemaine Health is proposing an arrangement whereby midwives from Castlemaine Health Midwifery Group Practice (MGP) are enabled to work at BH in an ongoing capacity to ensure confidence and competence in the regional centres birth suites and in managing more complex labour and birth. This would equate to 0.1FTE for each MGP midwife.

Contractual Arrangements

To enable this initiative, midwives would need to be enabled to work as Registered Midwives at both facilities. This will require onboarding at both facilities with an agreed understanding of scope of practice and training and development plan (where required). This would be negotiated through an MOU between organisations whereby an honorary appointment is made at BH. There would be two elements to practice for MGP midwives at BH:

- ***Ongoing contracted hours*** (rostered) – this would be negotiated with BH and would enable a CH MGP midwife to work in Birth Suite at BH as rostered. This would constitute 0.1FTE of their contracted FTE with CH. **A midwife working in this model therefore would be contracted 0.5 FTE**

with 0.1 FTE being worked at BH and 0.4 FTE caseload at CH. This would be paid for by CH and would be in addition to ratios at BH.

- ***Induction of labour continuity*** (unrostered) – the midwife would work in Birth Suite at BH in supporting their woman through labour and birth. She would be working 'above ratios' in addition to rostered staff in Birth Suite. This will enable handover should the midwife exhaust her clinical hours and need to leave in addition to providing postnatal care following birth. The midwife would be paid by CH and transfer of the woman back to CH post birth would be strongly encouraged. As Castlemaine GPO's also have positions at Bendigo Health BH may choose to support IOL occurring on a day when these staff members are present. This will further enable continuity for the woman and for the care team.

Onboarding considerations

Onboarding at CH should be considered when onboarding at BH occurs to facilitate ease of this process. Standard onboarding processes (medication management, OH&S requirements, WWCC, Police Check, etc.) should be mapped across the organisations and reduce any duplication to enable an efficient and effective process. MGP midwives will be supported to attend **2 weeks of orientation** to Birth Suite at Bendigo Health (supernumerary, paid for by CH) which will also include one day on the postnatal ward. This will ensure they are comfortable working in this environment prior to commencing independent clinical shifts.

Roster Management

Roster management and senior liaison between services will be managed by the MGP Co-ordinator in collaboration with BH. This will ensure that MGP midwives are not trying to manage two distinct rosters and days off will occur as per EBA clause 107.

Future State

The Operational Model of Care Working Group supports this model to commence when the maternity service reopens in 2021. As part of future state considerations, the working group recommends ***consideration of extending this model of continuity to Mount Alexander Shire women who require an elective caesarean section.*** This may be implemented after initial review of the model in late 2021. In the 12 months prior to suspension of the service there ***were 11 women*** who were low risk who had elective caesareans at BH. This would indicate they would be suitable to receive pregnancy care at CH and continuity of midwifery care at birth at BH.

Reciprocal arrangements should be developed so midwives working at BH are also supported in working at CH. This will enable a deeper understanding of capability and challenges faced by level 2 maternity services.

References

AHMAC. (2011). *National Maternity Services Plan*. Retrieved from Canberra: Department of Health | National Maternity Services Plan

Forster, D., McLachlan, H., Davey, M.-A., Biro, M., Farrell, T., Gold, L., . . . Waldenström, U. (2016a). Continuity of care by a primary midwife (caseload midwifery) increases women's satisfaction with pregnancy, intrapartum and postpartum care: results from the COSMOS randomised controlled trial. *BMC Pregnancy Childbirth, 16*(28). doi:10.1186/s12884-016-0798-y

Forster, D., McLachlan, H., Davey, M.-A., Biro, M., Farrell, T., Gold, L., . . . Waldenström, U. (2016b). Continuity of care by a primary midwife (caseload midwifery) increases women's satisfaction with pregnancy, intrapartum and postpartum care: results from the COSMOS randomised controlled trial. *BMC Pregnancy and Childbirth, 16*(28). doi:10.1186/s12884-016-0798-y

Freytsis, M., Phillippi, J. C., Cox, K. J., Romano, A., & Cragin, L. (2017). The American College of Nurse-Midwives Clarity in Collaboration Project: Describing Midwifery Care in Interprofessional Collaborative Care Models. *Journal of Midwifery & Women's Health, 62*(1), 101-108. doi:10.1111/jmwh.12521

Homer, C. (2019). *Midwifery continuity of care* (Second edition.. ed.): Chatswood, N.S.W. : Elsevier.

Kildea, S., Gao, Y., Hickey, S., Kruske, S., Nelson, C., Blackman, R., . . . Roe, Y. (2019). Reducing preterm birth amongst Aboriginal and Torres Strait Islander babies: A prospective cohort study, Brisbane, Australia. *EClinicalMedicine, 12*(9), 43-51. doi:10.1016/j.eclinm.2019.06.001

McLachlan, H. L., Forster, D. A., Davey, M. A., Farrell, T., Flood, M., Shafiei, T., & Waldenstrom, U. (2016). The effect of primary midwife-led care on women's experience of childbirth: results from the COSMOS randomised controlled trial. *BJOG, 123*(3), 465-474. doi:10.1111/1471-0528.13713

McLachlan, H. L., Forster, D. A., Davey, M. A., Farrell, T., Gold, L., Biro, M. A., . . . Waldenstrom, U. (2012). Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomised controlled trial. *BJOG, 119*(12), 1483-1492. doi:10.1111/j.1471-0528.2012.03446.x

Phillippi, J. C., Holley, S. L., Thompson, J. L., Virostko, K., & Bennett, K. (2019). A Planning Checklist for Interprofessional Consultations for Women in Midwifery Care.(Medical condition overview). *Journal of Midwifery and Women's Health, 64*(1), 98. doi:10.1111/jmwh.12900

Rayment-Jones, H., Murrells, T., & Sandall, J. (2015). An investigation of the relationship between the caseload model of midwifery for socially disadvantaged women and childbirth outcomes using routine data – A retrospective, observational study. *Midwifery, 31*(4), 409-417. doi:10.1016/j.midw.2015.01.003

Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2015). Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*(9). doi:10.1002/14651858.CD004667.pub4

Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2016). Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*(4). doi:ARTN CD004667
10.1002/14651858.CD004667.pub5

Smith, D. C. (2015). Midwife-physician collaboration: a conceptual framework for interprofessional collaborative practice. *Journal of midwifery & women's health, 60*(2), 128. doi:10.1111/jmwh.12204

Viveiros, C. J., & Darling, E. K. (2018). Barriers and facilitators of accessing perinatal mental health services: The perspectives of women receiving continuity of care midwifery. *Midwifery, 65*, 8-15. doi:10.1016/j.midw.2018.06.018

Watkins, V., Nagle, C., Kent, B., & Hutchinson, A. M. (2017). Labouring Together: collaborative alliances in maternity care in Victoria, Australia-protocol of a mixed-methods study. *BMJ open, 7*(3), e014262-e014262. doi:10.1136/bmjopen-2016-014262