

EXECUTIVE SUMMARY

The provision of quality maternity services relies on the ability of the midwifery workforce to meet their professional standards¹. Best practice therefore is contingent on the right number and mix of midwifery and other maternity staff to provide this care. The different settings in which women and their families choose to have their babies and the relationship with external Lead Maternity Carers (LMC) will also influence the number and mix of maternity staff when District Health Boards (DHBs) plan for the appropriate workforce.

In November 2009 MERAS, with the New Zealand College of Midwives, developed a discussion document on Midwifery Staffing Standards for Maternity Facilities. Subsequent feedback from MERAS and NZCOM members and consultation with DHB midwifery leaders then occurred. This subsequent edition is a second edition of that document. It has updated references but essentially continues to reinforce to the sector the need for appropriately staffed maternity facilities. In the subsequent years since the first edition of this publication the complexity of some women in maternity and the increased midwifery support they require has impacted further on the need, particularly for the secondary/ tertiary maternity facilities in New Zealand, to update their staffing levels and skill mix of midwives.

During the development of these standards there was acknowledgement of previous work undertaken by DHBNZ and recognition of continuing workforce shortages in some areas². This has eased in some areas but not in others. The main issue noted now is distribution of the workforce and retention of midwives particularly in some of the larger maternity units in New Zealand. The impact when there are shortages of midwives can lead to suboptimal staffing standards and therefore maternity services for women. DHBs are encouraged to develop contingency plans to mitigate the risk to services and implement action plans towards meeting the staffing standards which would also assist in recruitment and retention of midwives.

1 Midwives Handbook for Practice, New Zealand College of Midwives, 2014.

2 Workforce Forecast. Prepared by Health Workforce Information Programme. Nursing and Midwifery Workforce Strategy Group, DHBNZ, December 2008.

New Zealand has a unique model of maternity service provision with midwives as the main providers of maternity care. To date, little has been done in New Zealand to describe appropriate staffing and skill mix levels for maternity facilities. Overseas staffing models and acuity tools do not translate to the New Zealand maternity service. Trendcare is gradually being introduced into many of the DHBs and work has been done by the Maternity Staffing Advisory Group³ to ensure this acuity tool which is being introduced to most DHBs reflects the New Zealand maternity model of care. There is a need to capture the correct information for maternity units for them to better describe staffing trends. Even if Trendcare is proven as a useful acuity tool within the New Zealand maternity sector, MERAS will continue to promote the Staffing Standards. These Standards do more than suggest ratios they promote expectations of the caliber of the workforce required and the supportive environment required within maternity facilities to support the acute response service which maternity is.

Whilst relatively small in size, maternity services are complex in nature with a delicate balance required to ensure the number of midwives and their level of experience and confidence are available if required for the care of women admitted to the facility. A shift in one area, e.g. self-employed midwives exiting a rural area, can impact significantly on the local maternity facility staffing. Increasingly DHBs are considering how best to achieve appropriate staffing levels in maternity. MERAS considers that these standards can assist in this exercise as they consider the whole maternity service from primary to tertiary. These Standards also recognise the impact self-employed midwives can have on the staffing of the service.

³ MSAG Terms of Reference

As a result of the implementation of the Maternity Standards and the Maternity Quality and Safety Programme^{4,5} DHBs should now have a clear understanding of their current:

- Local service configuration
- Local maternity unit staff mix
- Local population demographic changes/trends
- National policies
- Local and national trends in critical or sentinel events
- Local trends in staff absence statistics
- Historical and current midwifery recruitment and retention issues
- Local LMC workforce configuration

Currently many New Zealand women, even when well, access secondary/tertiary maternity hospitals rather than community maternity units even when these are available locally. The large secondary/ tertiary units fulfil the function of an emergency response service for maternity services. Unfortunately in most instances these units are staffed with a heavy reliance on the involvement of the community midwifery workforce supplementing the staffing when the care of women becomes complex. Community Lead Maternity Carer (LMC) midwives can transfer clinical responsibility to the emergency service provided by the secondary/ tertiary unit as described in the Referral Guidelines⁶. However due to consistently insufficient staffing levels designated to maternity units in some DHBs, this cannot occur and the community workforce retain the role. This has now become the expectation in some areas rather than a review of the staffing for the maternity service. It is hoped that the work of the Maternity Staffing Advisory Group on adjustments to the acuity tool may help identify what needs to occur. In the absence of this data MERAS still needs to ensure this has been noted and is being addressed within DHBs.

4 New Zealand Maternity Standards, Ministry of Health, 2011

5 Maternity Quality and Safety Programme. www.hiirc.org.nz

6 Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines). Ministry of Health 2012

7 Maternity Facility Service Specifications, <http://www.nsfh.health.govt.nz/>

Hospital based maternity services are resourced to provide a multi-disciplinary approach to the care of mothers and infants with complex maternity care needs. This includes providing access to a range of services and specialists⁷.

Midwifery Staffing Standards for Maternity Facilities are necessary to ensure that women accessing maternity services in any DHB in New Zealand can have confidence that if it is necessary for their LMC to transfer clinical responsibility, then the core midwife accepting midwifery responsibility for providing care to the woman within this team, is appropriately skilled and resourced to do so safely.

We would like to acknowledge the Royal College of Midwives (UK) in their willingness for us to utilise and reference the Staffing Standards in Midwifery Services Guidance Paper published by them in March 2009 which provided the framework for the original document published by MERAS⁸.

GLOSSARY OF TERMS

Birthing Suites

Are within a secondary/tertiary maternity hospital and are where women labour and give birth. These can also incorporate assessment units/ areas.

Charge Midwife

An experienced midwife who is employed to provide leadership and management of a ward or service /area within a secondary/tertiary maternity hospital or a community maternity unit.

Clinical Coordinating Midwife

Co-ordinates an area on each shift in a secondary/tertiary maternity hospital e.g. the birthing suite. This is a recognised named leadership midwifery position and is supernumerary.

7 Maternity Facility Service Specifications, <http://www.nsf.health.govt.nz/>

8. Midwifery Staffing Standards Guidance Paper. The Royal College of Midwives, United Kingdom, March 2009

Community maternity unit

A midwifery led maternity facility in a community. It is staffed by midwives and accessed by lead maternity carers. Women can labour, give birth and receive postnatal care. These units do not have epidural or caesarean section facilities. The term encompasses 'primary maternity units', 'birthing centres' and other similar terms.

Core midwife

A midwife who is employed to work within either a community maternity unit or a secondary/tertiary maternity hospital to provide inpatient or community services.

Director of Midwifery/ Midwifery Leader

A midwife who is employed to provide strategic professional leadership and liaison for maternity services across the DHB. Ideally has a reporting line direct to the Chief Executive.

Health Care Assistant

Non-regulated worker who is employed to provide support services within the maternity unit; including very limited clinical tasks. The tasks which would be done by a health care assistant would be those that could also be undertaken by a member of the woman's family. Therefore monitoring health and observations are excluded but getting a sandwich from the kitchen or assisting with a baby bath would be included. This title describes and includes terms used for other non regulated workers in maternity such as hospital aids who have no clinical role.

Lead Maternity Care

This term describes the provision of continuity of care throughout pregnancy, labour and birth and the postnatal period as described in Subpart DA within the Section 88 Maternity Notice (2007) to a woman and her baby .

Lead Maternity Carer (LMC) Midwife

Means a midwife who has been selected by a woman to provide her with lead maternity care. In a DHB midwives employed for this purpose work within the Primary Maternity Services Specification⁹. They may be described as caseloading or Know Your Own midwives however sometimes midwives working in these roles may not provide continuity of midwifery care.

Secondary/Tertiary Maternity Hospital

A maternity facility that provides secondary and in six units in New Zealand tertiary care. These facilities are designed for women and babies with pre-existing medical conditions or who experience complications at any stage in their maternity experience and who may require the services of a midwife as well as an obstetrician/anesthetist/pediatrician. They provide an emergency response service for the population of pregnant women in a geographical area.

Maternity Facilities

Broad term encompassing all facilities that provide; inpatient, intrapartum and postnatal services to women. This includes both community maternity units and secondary/tertiary maternity hospitals.

Maternity Manager

Is a person (maybe a midwife) employed because of their experience within management roles and management qualifications to provide operational management of a maternity service.

Midwife

A health practitioner who is registered with the Midwifery Council of New Zealand and holds an annual practicing certificate.

Midwifery Educator

A midwife who is employed to facilitate/provide midwifery education and support the recertification requirements of midwives.

Supernumerary

A staff member on duty in addition to the calculated staffing matrix to enable that person to not carry a workload.

Ancillary Services

Services that are provided by unregulated domestic and administration staff to support midwives in the provision of maternity services

9 Primary Maternity Services Service Specification, Ministry of Health 2013. <http://www.nsf.health.nz/apps/nsf.nsf/pagesmh/444>

INTRODUCTION

This paper has been produced by MERAS to set out Midwifery Staffing Standards for Maternity Facilities. MERAS has involved the New Zealand College of Midwives (NZCOM) in the development of this paper as it is important when considering Midwifery Staffing Standards for Maternity Facilities that the professional standards of practice¹⁰ are not compromised/ rationed.

The Standards outlined in this paper reflect and support previous work undertaken by various working groups that have looked at midwifery workforce requirements and sustainability^{11, 12, 13} and have been reviewed in 2014.

These Standards provide a staffing framework for DHBs. It is acknowledged that some DHBs already meet the standards but for others, these standards provide an opportunity to develop strategies and action plans to enable progress towards achieving them in alignment with the requirements of the New Zealand Maternity Standards¹⁴, particularly Standard 3 which addresses workforce.

Fundamental to these standards is the knowledge that maternity is an acute service. Whilst mostly working with well women and their babies, the service requires the ability to 'flex up' for any emergency response it must be able and ready to provide. Such service provision requires on call arrangements as well as adequate resourcing and ongoing professional development for employed midwives to enhance confidence and professional practice. All of the above enhances high quality, safe maternity care.

10 Midwives Handbook for Practice, New Zealand College of Midwives, 2014

11 Future Workforce Priority Plan, DHBNZ, 2007

12 Midwifery Workforce Strategy, Nursing and Midwifery Strategy Group, DHBNZ, 2006

13 Maternity Staffing Advisory Group (REFERENCE REQUIRED)

14 New Zealand Maternity Standards, Ministry of Health, 2011. www.moh.govt.nz

CONTEXT

The cornerstone of maternity care in NZ is that each woman requiring maternity care can choose a Lead Maternity Carer (LMC) who is responsible for provision of continuity of primary maternity care throughout her maternity experience¹⁵. The objectives of primary maternity services are to:

- Ensure women have a Lead Maternity Carer (LMC) if they are planning to give birth.
- Give each woman, her partner, and her whanau/family, every opportunity to have a fulfilling outcome to the woman's pregnancy and childbirth by facilitating the provision of primary maternity services that are safe, informed by evidence and that are based on partnership, information, and choice.
- Recognise that pregnancy and childbirth are a normal life-stage for most women; and that community maternity units are the most appropriate maternity facility for women with low-risk pregnancies who have chosen not to have a homebirth.
- Provide the woman with continuity of care through her LMC who is responsible for assessment of her needs, planning of her care with her and the care of her baby; and
- Facilitate the provision of appropriate additional care for those women and babies who need it.

Nationally New Zealand has six tertiary, 18 secondary maternity hospitals and 52 community maternity units.

In addition to primary birthing and postnatal care, community maternity units also provide services such as 'transition care' for premature infants so that they can be closer to their family; or longer stay beds for women or babies with special needs¹⁶.

Hospital based maternity services are resourced to provide a multi-disciplinary approach to the care of mothers and infants with complex maternity care needs. This includes providing access to a range of

¹⁵ Maternity Services Service Specifications, Tier 1, Ministry of Health, 2014.

<http://www.nsf.health.govt.nz/apps/nsf.nsf.pagesmh/444>

¹⁶ Maternity Facility Service Specifications, MOH, 2006.

general hospital services and specialists. Maternity wards are often deemed to be the most appropriate place for a pregnancy woman to be even when in hospital for a non-maternity related problem (such as broken leg). It is advocated that in such situations the woman is admitted to the area of the hospital which can address her primary reason for admission with input from any other services eg in the case of a broken leg this would be a surgical area with input from maternity services.

Within a secondary/tertiary maternity hospital if a woman requires the care of the obstetric team, a member of this team is always a midwife. It may be a self employed or a core midwife who has taken on this role in discussion with the woman and the Lead Maternity Carer (LMC). These standards aim to support the collegiality and integration that is required for such a system to work effectively.

It is also important for MERAS to reflect the views of New Zealand women about their expectations of the maternity service and international research that has addressed issues of consumer satisfaction. Consumer satisfaction surveys conducted by the New Zealand Ministry of Health also reflect the satisfaction women have when provided with one on one care during pregnancy, labour and birth¹⁷.

The New Zealand maternity system has as its objective that all women will be able to access at least 1:1 care when required, e.g. labour and birth^{18, 19}. Evidence both nationally and internationally is increasingly demonstrating the importance of particularly midwifery continuity of care on the safety and improved maternity outcomes for women^{20, 21}. It is important that the role of the core midwife within such a framework is well described, well supported and understood by all parties.

17 Maternity Services Consumer Satisfaction Survey, MOH, 2011

18 Section 88 Maternity Notice pursuant to the NZ Public Health and Disability Act 2000, July 2007

19 Maternity Facility Specifications, MOH, 2007

20 Comparative study of maternity systems. Report prepared for the Ministry of health, November 2012. <http://www.health.govt.nz/system/files/documents/publications/comparative-study-of-maternity-systems-nov13.pdf>

21 Midwife led versus other models for child bearing women . Sandall J, Soltani H, Gates S, Shennan A, Devane D. Cochrane Collaboration online 2013 <http://summaries.cochrane.org>

THE MIDWIFERY WORKFORCE WITHIN NEW ZEALAND MATERNITY FACILITIES

Midwives employed to provide care in either a community maternity unit or a secondary/tertiary maternity hospital are called core midwives by the profession in New Zealand as they hold the core understanding of how that maternity service operates. Core midwives who work in a secondary/tertiary maternity hospital provide an essential role in caring for women with complex needs. . They form part of the multidisciplinary team which can also include the LMC midwife. Together they all assist women to adapt to unexpected adverse events in their pregnancy or with an unwell newborn.

Core midwives are required to maintain currency and competency across the scope of practice and work within the midwifery profession's standards. Employers expect core midwives to take personal responsibility for their own professional development but equally are required to support their employees to meet their professional requirements.

Determining the number of midwives that are required in secondary/ tertiary maternity hospitals and community maternity units is dependent on: service design, the types of buildings, facilities and resources, infrastructure available, local geographical and demographic influences, as well as models of service provision and individual midwives' capacity and capability.

New Zealand midwives can choose where they wish to work and whether to be self employed or employed. Midwives are the main workforce in maternity. It is essential for DHB's to understand the ratio of core to self employed midwives in their area to achieve the balance required for service provision and to then match that to the birthing population, including where women live and subsequently birth²².

22 report on mapping the rural midwifery workforce in New Zealand for 2008. Hendry, C. NZCOM Journal 41 (pp. 12-19) NEED TO UPDATE THIS. SEE MMPO

MIDWIFERY RECRUITMENT AND RETENTION

Within New Zealand it is essential to focus on supporting the development of a Maori and Pacific midwifery workforce and to ensure these midwives are supported in their role^{23, 24}. MERAS is strongly supportive of initiatives to support the midwifery workforce: the Midwifery First Year of Practice programme; the Rural Recruitment and Retention Service; and the voluntary bonding of midwives into hard to staff areas.

Whilst these initiatives in supporting the workforce are important, it is the conditions of employment for midwives which will encourage them to remain employed. Good employment practices by DHBs will result in retention of their midwifery workforce^{25, 26}. These Staffing Standards aim to support such practices and provide guidance to managers and midwives.

Midwives will consider alternative work environments if they are unable to practice to their professional standards across their scope of practice due to workforce shortages/ acuity of women and skill mix issues in the maternity units where it becomes difficult to provide care or their work environment is unsupportive.

MERAS acknowledges that other workforces impact and influence midwifery staffing levels. It is important to recognise that adequate medical specialist staffing levels form a central component of secondary/tertiary maternity hospitals. It is well known that where secondary/tertiary maternity hospitals do not have strong midwifery leadership and/ or adequate obstetric staff coverage there can be a negative impact on the recruitment and retention of the midwifery workforce, both core and LMC. It is also recognised that if ancillary staff are unavailable to support midwives with service provision e.g. housekeeping, cleaning and data entry, the core midwifery workforce's ability to provide the care the maternity clients require is adversely impacted upon.

23 New Zealand Midwifery Workforce Analysis, DHBNZ, August 2009

24 Turanga Kaupapa, Nga Maia, Midwives Handbook for Practice, New Zealand College of Midwives, 2008

25 NHS Reforms and the working lives of midwives and physiotherapists Cambridge Centre for Business Research Working Paper No. 344, June 2007

26 Workforce risks and opportunities. Working time practices in nursing and midwifery. Centre for workforce intelligence. University of Manchester. 2011

MIDWIFERY STAFFING STANDARDS FOR MATERNITY FACILITIES

1. All women, regardless of where or how they are labouring and birthing, require at least one to one midwifery care.
2. Midwifery staffing must be set at levels to support 24 hour seven day care.
3. The birthing suite and/or maternity service in a secondary/tertiary maternity hospital provide an acute, emergency response service operating 24 hours a day seven days a week. The midwife coordinating this service shall be supernumerary and in a recognised, named leadership midwifery position.
4. Maternity Facilities are staffed by core midwives who provide support for the care of women in collaboration with the woman's Lead Maternity Carer and/or the obstetric service.
5. Midwives are not employed to undertake administrative and hotel support staff tasks. All maternity units should employ sufficient ancillary staff to support the work of midwives.
6. Employed midwife caseloads reflect urban (1 midwife: 45-50 women) and rural (1:35-40) environments, and complex needs (max 40 women)
7. Maternity units have mechanisms in place to support midwives to progress through the Quality and Leadership Programme (QLP)²⁷
8. Midwifery professional leadership roles are established and supported in District Health Boards.

²⁷ District Health Boards Quality and Leadership Programme for Midwives covered by MERAS and NZNO employment agreements (INSERT DATE IF KNOWN)

APPLICATION OF THE STANDARDS

MERAS acknowledges that meeting these Standards may provide challenges for some maternity facilities. Since the first publication there has been resistance to consider these Standards as a framework for:

- adequate staffing,
- recruitment and retention of midwives,
- appropriate skill mix to ensure women receive care from an employed midwife who has the experience and skills to be working in a secondary/ tertiary unit that reflects the complexity of the women being cared for
- supporting employed midwives to provide care to a professional standard by having sufficient full time equivalents.

There are some fundamental principles that must be addressed in order that these standards can be met in the medium term:

- Employing Registered Nurses instead of Midwives is a contingency that has been used by maternity facilities in a time of workforce shortage. The contemporary nursing workforce is no longer educationally prepared to work in obstetrics and therefore is not a long term solution to maternity unit staffing.
- Increasing numbers of midwifery graduates are now joining the workforce annually and the workforce shortage that was present when the first edition of this booklet was published, no longer exists nationally. DHBs can confidently work towards employing a full establishment of midwives in their maternity facilities.
- Using a non-regulated workforce instead of midwives is unacceptable²⁸. If healthcare assistants are expected to undertake clinical assessment including systemic observations; this creates a risk for essential clinical information to be overlooked by the responsible midwife and can lead to a delay in timely care. The role of the health care assistant should not exceed that of a responsible family member, with their primary functions being administration, hotel services and maintaining the environment, e.g. cleaning, stocking etc.

- The Midwifery First Year of Practice Programme (MFYP) is highly successful at retaining graduate midwives in the profession and MERAS supports the ongoing funding and support of this programme. This includes the flexibility the graduates have in relation to where they decide to work- either employed or self employed. Ensuring support is available to midwives to support their ongoing development as midwives and in recognition of the workplace stressors that midwives encounter. This can be achieved through encouraging midwives to become part of the Quality and Leadership programme (QLP)
- The recognition of workforce concerns in rural New Zealand and the programmes supporting a rural midwifery workforce are endorsed by MERAS²⁹
- MERAS supports the governments voluntary bonding scheme for midwife graduates in difficult to staff areas³⁰.
- DHBs must have a clear understanding of their own maternity workforce, population, case mix, demographics, clinical outcomes and admission indications and be able to develop strategies for workforce requirements.
- MERAS supports DHB's local initiatives to improve retention of midwives in 'hard to staff' areas

29 Evaluation Report: Health Literacy Medication Project – Measurement and Evaluation August 2013

30 Voluntary bonding scheme, MOH, 2009

STANDARD 1

All women, regardless of where or how they are labouring and birthing, require at least one to one midwifery care.

Criteria

One to one midwifery care and the need for continuous support in labour and birth:

- Is well supported by evidence³¹.
- Reflects the maternity model of care in New Zealand^{32, 33}.
- Ensures New Zealand women get a maternity service which has them at the centre of care.
- Supports and acknowledges the professional role that both the Lead Maternity Carer (LMC) midwife and the core midwife have with women in labour.
- Supports the role of core midwives to provide 1:1 care of labouring and birthing women who have no LMC.
- Recognises that the presence of the midwife provides care and support within situations where the woman may receive care from a number of other health professionals not previously known to her and as a result experience increased fears, anxieties and confusion.
- Acknowledges the midwifery profession's approach to childbirth as a physiological and psychosocial process.
- Will optimise the woman's experience of childbirth and help her to prepare for motherhood and nurturing the baby with the best possible physical and mental health.^{34, 35}

31 Hodnett, E., Gates, S., Hofmeyr, J., & Sakala, C. (2013). Continuous support for women during childbirth (Review). Cochrane database of systematic reviews, Issue 7. Art. No.: CD003766. doi: 10.1002/14651858.CD003766.pub5
National Collaborating Centre for Women's and Children's Health. (2007). Intrapartum care: care of healthy women and their babies during childbirth. London: National Institute for Health and Clinical Excellence.

32 Section 88 Maternity Notice pursuant to the NZ Public Health and Disability Act 2007

33 Maternity Services Service Specification, Tier 1, Ministry of Health, 2014. <http://www.nsf.health.govt.nz/apps/nsfl.nsf/pages/mh/444>

34 Maternity Report, Ministry of Health

35 Maternity Clinical Indicator Report, 2009, 2010, 2011. Ministry of Health www.health.govt.nz

STANDARD 2

Midwifery staffing and skill mix must be set at levels to support 24 hour seven day care.

It is acknowledged that:

- Midwifery staffing and skill mix positively impacts on the woman's experience of childbirth and help her to prepare for motherhood and nurturing the baby with the best possible physical and mental health.^{36, 37}
- Community maternity units need to ensure there are always midwives available to attend any emergency.
- There is no differentiation of midwifery staffing between day and night shifts in a maternity facility other than when elective caesarean sections and inductions are scheduled in a secondary/ tertiary maternity hospital when there may need to be more staff available.
- Recognition needs to be given to the support that is provided by core midwives to women who have complex pregnancies either because of obstetric/ previous health concerns. These women often require extended periods of input from core midwives and extended lengths of stay with multiple agency involvement and coordination to ensure good care and protection for the newborn on discharge.

Criteria

All maternity facilities must be staffed to the following staffing standards to provide 24 hour/7 day a week services:

³⁶ Midwifery care for women with complicated births. International Confederation of Midwives, Prague council meeting, 2014

³⁷ Report on MMPO Midwives. Care activities and outcomes. New Zealand College of Midwives, 2004

Antenatal

Women receiving inpatient antenatal care have a level of care from a midwife that reflects the complex nature of their admission.

- Women admitted to hospital antenatally or as an emergency require 1:1 midwifery care initially until stable. These women may not be accompanied by their LMC midwife so require this 1:1 midwifery care from a core midwife.
- A ratio of 1:2 midwifery care is recommended to look after women, not in labour, who attend the birthing suite/ Women's Assessment Unit e.g. for assessment.
- A midwifery ratio of 1:4 is recommended for antenatal inpatients with pregnancy complications or complex women with high social/mental health needs, requiring multiple agency facilitation. The increased requirement for maternal and fetal monitoring and /observation and the unpredicted nature of obstetric emergencies make a low ratio essential.
- A midwifery ratio of 1:3 is recommended for unstable antenatal inpatients, e.g. unstable diabetics, unwell women with multiple pregnancies

Labour and Birth

The core midwife with the most appropriate skills within a secondary/ tertiary maternity hospital must be available to accept transfer of midwifery clinical responsibility from an LMC midwife if /when indicated as per the Referral Guidelines³⁸. Ratios of staffing for these occasions must be incorporated into the staffing/ skill mix of a unit.

- A ratio of at least 1:1 midwifery care for all labouring women (as per standard 1)

Postnatal

Due to rooming in of the newborn with its mother, there is an acknowledgement that the number of beds does not equate to the number of clients/patients on a postnatal ward, "e.g. a bed is not merely a bed".

³⁸ Guidelines for consultation with obstetric and related specialist medical services (Referral Guidelines). MOH, 2011. To be used in conjunction with Section 88, 2007 and the Maternity Facility Service Specifications 2012

Postnatal areas must be staffed by sufficient midwives to ensure:

- women receiving inpatient postnatal care have a level of care from a midwife that reflects the straightforward but also at times the complex nature of some women's and baby's maternity experience.
- Women who have had complex births require care from a midwife which also recognises the enhanced level of support she requires due to having had surgery/intervention.
- Women starting to breastfeed are given adequate support. A newly birthed mother may need a midwife to spend a minimum of half an hour with her during each breastfeed.
- A ratio of 1:1-2 when a woman or her baby are more complex after birth e.g. immediately post caesarean (first 6-12 hours) or recovering from obstetric/medical conditions which have seriously affected the woman's/baby's health, e.g. high dependency unit or neonatal intensive care unit discharges .
- A ratio of 1:5 postnatal midwifery care is recommended where women are low risk and recovering well from birth.
- A ratio of 1:4 when a mother is unwell requiring ongoing medical/surgical intervention and she has a well baby of ≥ 37 weeks rooming in
- A ratio of 1:3 when the mother is unwell requiring ongoing medical/surgical intervention and with a baby ≤ 37 rooming in which also requires frequent monitoring and care.
- A ratio of 1:5-8 midwifery staffing is recommended for a community maternity unit where all labouring women are accompanied by an LMC and where women and their babies are generally of lower dependency postnatally.

Note: Community maternity units rely on an adequate number of LMC midwives in order to operate on these minimal core staffing levels. Where the number of LMCs is low, or the Units provide other additional services, core midwife ratios may need to be adjusted up to reflect the local situation.

STANDARD 3

The birthing suite and/or maternity service in a secondary/tertiary maternity hospital provide an acute, emergency response service operating 24 hours a day seven days a week. The midwife coordinating this service shall be supernumerary and in a recognised, named leadership midwifery position.

Criteria

The midwife who co-ordinates the birthing suite and/or maternity service in a secondary/tertiary maternity hospital needs to be an experienced practitioner who is supernumerary within the staffing matrix because:

- These services have a high workload with often rapidly changing levels of complexity and acuity. The midwife who has the oversight of the unit must be able to focus on coordinating care and patient flow and cannot be distracted by carrying a clinical load herself.
- Being a midwife in a recognised named leadership midwifery position e.g. Clinical Coordinating Midwife means she has the skill and experience necessary to undertake the role.
- Within this role she can also provide clinical leadership and advice across the DHB service.
- Within such a role she can support experienced midwives to preceptor less experienced midwives.
- Midwives will not be expected to provide medical cover in the absence of obstetric medical staff

STANDARD 4

Community maternity units are staffed by core midwives who provide care for women and babies in collaboration with the woman's Lead Maternity Carer.

Criteria

- Community maternity units ensure that a midwife is available 24/7 to provide care for women and their babies
- Community maternity units may accept women for a longer stay when the baby requires transitional care or the woman or baby have additional care needs, but not requiring secondary care. The community maternity units must ensure that there is sufficient staff to meet these additional needs when they occur.

STANDARD 5

Midwives primary role is the delivery of midwifery care. Maternity units should employ sufficient ancillary staff to ensure the efficient running of maternity services³⁹.

Criteria

- Ensure a staff mix that supports midwives to primarily focus on caring for mothers and babies
- Non-clinical duties should wherever possible be assigned to support staff
- It is inefficient use of the midwifery resource to routinely undertake stocking, cleaning and non-clinical administration tasks

³⁹ Midwifery Staffing Standards Guidance Paper. The Royal College of Midwives, United Kingdom, March 2009

STANDARD 6

Employed midwives who provide continuity of care in the same as that provided by Lead Maternity Carers need to have full time caseloads that reflect NZCOM recommendations for case load numbers:

Urban (1:45-50 women), rural (1:35-40) environments and women with complex needs (1:-40)

Criteria

Employed Lead Maternity Carer midwives or their backup, give continuity of care; antenatally, throughout labour and birth and postnatally and as such they must:

- Provide care that reflects the professional standards and is consistent with the requirements of Section 88⁴⁰.
- Have caseload ratios that reflect that LMC midwives provide twenty-four hours on-call cover for women.
- Have access to and recognition of the importance of transport and telecommunication support within their employment agreement.
- Develop working practices in collaboration with their employer that supports continuity of care and meeting the expectations of women, whilst recognising that work volumes fluctuate. Staffing arrangements should be agreed that include regular rostered time off, cover for both annual leave and for participation in their annual practising certificate⁴¹ education requirements and arrangements for support when adverse events occur.
- Be able to have considerable influence in their choice of practice partner. This includes compatibility of midwifery philosophy.

⁴⁰ Midwives Handbook for Practice, New Zealand College of Midwives, 2008

⁴¹ Recertification Programme: Competence based practising certificates for midwives, Policy statement Midwifery Council of New Zealand, May 2008

STANDARD 7

Maternity Facilities have mechanisms in place to support midwives to progress through the Quality and Leadership Programme (QLP)⁴²

Criteria

DHBs will acknowledge the opportunities the Midwifery Quality and Leadership Programme (QLP) provides by:

- Providing a framework for employed midwives and midwifery employers to meet their respective responsibilities in a manner which models partnership between employer and employee. The QLP is based on the standards of the profession which apply to all midwives regardless of practice setting or employment status.
- Recognising the QLP is a structured framework which supports and assists midwives to further develop knowledge and skills necessary to provide safe and effective care for women and their babies.
- Acknowledging that midwives develop a range of transferable clinical and personal skills which can be used throughout a midwife's career in a variety of practice settings.
- Encouraging and valuing professionalism in midwifery practice within DHBs.
- Providing a mechanism through which a DHB can value, recognise and encourage the professional development of midwives.
- Helping to identify and prepare midwives for leadership roles.
- Providing a framework for midwives to contribute to DHB quality activities.
- Promoting and supporting midwives to apply for recognition in QLP Domains.
- Ensuring there is access to relevant academic and research opportunities for midwives.

⁴² District Health Boards Quality and Leadership Programme for Midwives covered by MERAS and NZNO employment agreements, INSERT DATE IF KNOWN

STANDARD 8

Midwifery professional leadership roles are established and supported in DHBs⁴³

Criteria

DHBs demonstrate their commitment to:

- Establishing and supporting professional midwifery leadership by midwives who are respected members of the midwifery profession.
- Ensuring there is a strategic professional voice for midwifery with an overview of the maternity service at the corporate level⁴⁴.
- Ensuring the midwifery leadership roles are not only accountable to the DHB but also to the midwifery profession.
- Ensuring the position descriptions for these roles are nationally consistent and reflects professional standards.
- Within maternity services, separating the operational business/ staff management roles from professional leadership. This move will clarify the responsibilities and enable a clear focus on the education and professional development required for each role.
- Placing the strategic midwifery leadership role at the DHB Executive team level with the authority and budget to be able to implement decisions in relation to the development, maintenance and retention of the midwifery workforce.
- Ensuring strategic midwifery leadership steers the midwifery workforce towards collaborative and seamless primary, secondary and tertiary midwifery services.
- Ensuring there is clinical midwifery leadership within the secondary/tertiary maternity hospitals and community maternity units of the DHB.
- * Ensure that there are opportunities for midwives to be employed as Maternity Managers
- Develop position descriptions to ensure these roles are nationally consistent.

⁴³ Midwifery Leadership and Professional Development Stocktake. Report to the Nursing and Midwifery Workforce Strategy Group, DHBNZ, May 2009

⁴⁴ Safer Births. Supporting maternity services to improve safety. The Kings Fund, 2009

- Develop comprehensive plans for identifying and growing Maori midwifery leaders.
- Growing midwifery leaders through supporting midwives to participate in the leadership domain of the Quality and Leadership Programme.
- Providing access to relevant academic and research opportunities for midwifery leaders.

CONCLUSION

MERAS first developed these staffing standards in 2009 and reviewed them in 2010 as part of its commitment to ensure adequate midwifery staffing levels are recognised as an important indicator of clinical governance and quality care. In 2014 MERAS reviewed this document and the vision remains as important now as it did in 2009.

Whilst it remains the responsibility of local managers to build a secure business case for their staffing levels and midwifery skill mix, by understanding local needs and dynamic service requirements, MERAS continues to be willing to work with DHBs in developing a business case to meet the staffing requirements that will meet these standards.

MERAS recommends that these Midwifery Staffing Standards for Maternity Facilities continue to be a focal point for DHBs to work with their midwifery leaders and workforce to develop contingencies to achieve the standards.