The New Zealand Nurses Organisation (Inc)

Submission to
District Health Boards New Zealand

on the

Midwifery Workforce Strategy Discussion Document

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Contact: Susanne Trim
Professional Nursing Advisor
susannet@nzno.org.nz
Telephone (03) 366 0186

Introduction

The New Zealand Nurses' Organisation Inc. (NZNO) represents 39,000 health workers on a range of employment related and professional issues across the public, private and community sectors. The majority of our members are registered, enrolled and student nurses, and midwives. NZNO has 900 midwife members, the majority of whom work as employed midwives. According to NZHIS (2006) figures there are 1227 core midwives working in a range of maternity facilities. It has been estimated that 93% of women come into contact with a core midwife at some time throughout the childbirth experience (Campbell 2000). NZNO has an active midwifery network and midwife delegate support system in major maternity hospitals.

NZNO welcomes the opportunity to comment on the Midwifery Workforce Strategy discussion document. NZNO appreciates that the District Health Board New Zealand (DHBNZ) granted it an extension to 28 August for this submission.

Section 2.2.4 Complex Pregnancies

Question 1: With increasing specialisation as pregnancies and birth becoming more complex, what impact should this have on midwifery education and on involvement of other health professions in service delivery?

Response: The consultation document clearly outlines the changes to the birthing population and increasing complexity and risk. This has implications for both undergraduate and post-Registration midwifery education.
Although the undergraduate programme focus is rightly on normal pregnancy and birth, a thorough grounding in emerging maternal conditions such as diabetes, and interventions frequently used, for example epidurals and peri-operative surgical core is required within the curriculum and competence in these areas demonstrated prior to registration. NZNO will be submitting to this effect in its submission on the Midwifery Council of New Zealand's (MCNZ) undergraduate education review. Clinical and technical care of women with diabetes and common interventions such as those described should be competencies demonstrated and maintained by all midwives. Interdisciplinary team teaching strategies could enhance the programme and model interdisciplinary maternity service provision.

Post Registration education for midwives employed in secondary and tertiary maternity services would be delivered on two levels:

i. In-house education delivery supported by the service provider and complemented by short courses run by external providers. This would be targeted at the specialty service needs and be aligned to a service professional development plan for employees. The Entry to Practice Programme funded by the Clinical Training Agency (CTA) would be a part of this strategy.
ii. Post-graduate midwifery programmes with complex maternity core as a component of the programme. The complex maternity practice papers within the programme could be supported by CTA funding. It is likely that only one post graduate programme with complex maternity practice could be sustained within New Zealand. NZNO will be submitting to this effect in its submission on the Midwifery Council of New Zealand's (MCNZ) undergraduate education review. Clinical and technical care of women with diabetes and common interventions such as those described should be competencies demonstrated and maintained by all midwives.

Question 2: Should midwives continue to be able to provide high levels of technical care? If so, how should the profession and the sector support midwives to develop and maintain competencies related to complex pregnancies and births?

Response: All midwives should be able to provide the technical cares commonly used, for example, the management of epidurals, although rarely used technologies would become the domain of core midwives working in the secondary and tertiary units. Their competencies would be maintained by experienced and in-house education and skills simulation, supported by interdisciplinary education.
There is a case to support the employment of those who hold registrations of both a midwifery and a nursing qualification into secondary and tertiary services. This enriched skill mix would support care provision of women with complex needs. Alternatively the future workforce for maternity services may include a mix of midwives and nurses, each providing their separate discipline's expertise, for sound patient outcomes. It must be noted however, that the undergraduate programme for Registered Nurses (RN) has limited clinical exposure to maternity services.

Section 2.2.6 Consumer Choice and Expectation

Question 3: To what extent should 'best practice' guide access to use of technology in pregnancy?

Response: The concept of choice by the woman, supported by information provided by the lead maternity carer (LMC), has largely determined maternity provision over the last decade. Public health provision in all other services is determined by need and best practice guidance. NZNO believes it timely to debate the balance between consumer choice and best practice guidelines within maternity service provision. More "technology" does not necessarily result in better outcomes for mother and/or baby, and it puts on unnecessary strain on service provision and budgets. NZNO supports evidence-based practice.

Question 4: Can publicly funded maternity services continue to offer breadth of choice to women. If so, what impact will this have on the workforce configurations in the future?

Response: Normal birthing in low technology primary units should be supported. Public health funding should be targeted on a needs and evidence based approach. Intervention should be based on clinical need.

Question 5: What implications does consumer choice and expectation have for midwifery education and for the future configuration of the midwifery and maternity workforce?

Response: Any shift to restrict choice will require a cultural shift for New Zealanders. A public education strategy would be required. In addition, health professionals would require information in regard to any policy shift. They may need additional training in negotiation and conflict management strategies.

Section 2.3 Health Sector Response to Changing Population Health Needs

Question 6: What strategies should the sector adopt to preserve the positive responses to changes in demand for maternity services?

Response: NZNO is concerned that changes to Section 88 Primary Maternity Notice are developed by the Ministry of Health, the New Zealand Medical Association and the New

Zealand College of Midwives without involvement of DHBNZ representatives. This results in proposals without consideration of the flow-on impact of change in the primary sector on the DHB maternity services. The current proposals to change the Notice are an example of this. NZNO proposes that DHBNZ should be party to all Section 88 Maternity Notice deliberations and this will preserve positive responses to changes in demand.

Section 3.0: Dynamics of the Current Midwifery Workforce:

Section 3.2 Defining the Midwifery Workforce

Question 7: Should the separation of the midwifery workforce into core and caseload continue?

Response: Yes. Core midwives support the LMC Model. The choice for midwives of either being a core or case loading midwife assists in lifestyle choice, professional choice and thus retention of the midwifery workforce.

Question 8: Would it be possible to have a more generic midwifery role that incorporates both roles?

Response: NZNO midwives do not believe this generic role is possible.

Section 3.4.2 Workforce Growth

Question 9: How should the Midwifery caseload be determined?

Response: NZNO supports the recommendation of 50-60 cases per annum for LMC's. NZNO undertook significant analysis of midwife/caseload ratios in maternity service facilities in 2004 and developed guidelines which are appended for your reference.

Section 3.4.5 Midwifery Practice Contexts

Question 10: Are LMC midwives being used appropriately? Are there some activities that could be taken on by others, such as core midwives?

Response: Core midwives support the LMC model, provide the care for women with complex needs and are the midwifery providers of last resort. The current proposals to change Section 88 Primary Maternity Notice have significant implications for core midwifery practice. Already there is a perception that LMC's defer some of their responsibilities to core midwives, unnecessarily.
An example is significant breast feeding education and support when women are in post natal wards. The proposed changes to the Notice do not define "urgent situations" (Section 5.1.3) which will be transferred to secondary services and thus many DHB provider midwives fear that their service will become a "dumping" ground for LMC's not willing to respond to evening or weekend calls. Clear definitions and transfer protocols need to be stipulated in the Notice.

Question 11: Is the core/caseload midwife an appropriate distinction? Is there a place for midwives who do both?

Response: NZNO midwives believe that this is an appropriate distinction.

Section 3.4.6 Hours of Work

Question 12: How sustainable is LMC midwifery if the midwife remains available 24/7? Is there another way of working that could reduce burnout and encourage others to take on this role?

Response: Reports would suggest that a collaborative LMC model would be more sustainable, encouraging recruitment and retention of LMC's, however this will impact on the continuity of carer model. An appropriate work/personal life balance is required to sustain the LMC workforce and is supported by NZNO.

Question 13: Who should take responsibility for the maintenance of the rural midwifery workforce, most of whom are self-employed?

Response: The issues facing rural midwives are not isolated and apply to all rural health practitioners. The increased costs facing rural midwives have been addressed in part by changes to the Section 88 Maternity Notice fee schedule.

A proactive policy to enable replacement/relief for professional development and annual leave cover is required. This could be managed by the Rural Health Centre and be incentivised by Ministry of Health funding.

It could be possible for rural midwives to be supported in their practice by qualified midwives who do not wish to practice as LMC's to assist with post natal visiting, however for this to happen the MCNZ would need to allow the issue of practising certificates with a condition on them that these midwives practise only post natal care. To date, the MCNZ has rejected such proposals by NZNO.

Question 14: What is the appropriate ratio of core to caseload midwives?

Response: This is difficult to predict.

Question 15: If there were sufficient caseload midwives could core midwifery roles be reduced?

Response: No. The increasing complexity in the maternity populations will determine the appropriate core midwife numbers and role. Section 88 Maternity Notice provisions will also have an impact on the numbers and role of the core midwife.

Section 3.4.7 Ethnicity of Midwives

Question 16: With a predominantly 'Eurocentric' midwifery workforce at present, what strategies should be implemented to increase the ethnic diversity of this workforce?

Response: Exciting interest within the school leaver population by means of promotion packages promulgated to careers advisers would be one strategy.

Another could be international recruitment strategies for Asian midwives, however the MCNZ requirements for registration by overseas midwives may be seen as a disincentive.

Question 17: Thinking about the birthing population ethnic diversity and district variation, should the sector adopt strategies to promote a better match between the distribution of the midwifery workforce and population/ service need? What might these strategies be?

Response: A Ministry of Health incentive programme to attract midwives to rural and South Auckland areas could be considered.

Section 3.5.1 Workforce Supply

Question 18: What processes should be developed to more effectively manage workforce supply, given that midwifery is a small workforce?

Response:
NZNO sees three key areas of supply:

i. School leaver (see Q16 response)
ii. Overseas midwives (see Q16 response)
iii. RN's who may have an interest in midwifery practice.

Some DHB employers may assist these RN's to register as midwives under a scholarship and/or bonding scheme.

Question 19: Midwifery education preparation has implications for supporting models of practice. What input should the health sector have in determining the competencies of newly graduated midwives?

Response:
Providers need input into:

- MCNZ undergraduate education review and an ongoing feedback loop on graduate competency profiles and service requirements
- Employers are to be represented on school of midwifery advisory groups
- The MCNZ and education sector need to be responsive to industry need and feedback.

Providers need to determine the experience and outcomes of the CTA supported entry to practice programme for midwives, and assist in supporting mentors to work with new graduates.

Section 3.5.2 Retention of Midwives

Question 20: Is there a place for a second level carer within maternity services?

Response:

- Unregulated caregivers to provide support such as stocking, environmental support, meal support etc.
- Registered Nurses may provide an important part of the skill mix in the future in tertiary and possibly secondary maternity facilities.
- In the past there was a second level regulated workforce, the Registered Obstetric Nurse (RON), however this role has been phased out with only about 30 currently employed nationally. NZNO's position on RON's is appended for your reference.
- Responses from NZNO members during this consultation would indicate that there is no support for a second level carer within maternity services other than a Registered Nurse.

Question 21: Is there a place for unregulated workers in the maternity workforce? Is there a place for maternity assistants? Is so what role would they play?

See response to Question 20

Question 22: Is there a role for a 'specialist' midwives and what would their relationship be with other members of the health service team?

Response:
In the past NZNO has advocated the position of an advanced practice or specialist midwife. This view has been criticised by the NZCOM. It is of interest to note that Ireland has an advanced midwifery practice position. This consultation document does not explicate a potential specialist role. It is possible to envisage midwives specialising with particular patient populations, for example diabetic or drug addicted women. The service need should determine this.

Section 3.6.2 Competency Maintenance

Question 23: What is an appropriate balance between employer and individual responsibility for competency maintenance activities?

Response: The introduction of the MCNZ recertification programme has resulted in an upsurge in debate around this issue. The recertification programme is complex, time consuming and costly. Anecdotal evidence indicates to NZNO that the programme has and will drive midwives out of the workforce although the latest MCNZ newsletter states that there is no evidence to support this claim. NZNO members remain concerned.
The provisions applying to professional development and competencies requirements within the NZNO/DHBNZ MECA are supported. Competence maintenance is both an individual and employer responsibility.

Question 24: What role should DHB's have in providing opportunities for self-employed midwives to upskill?

Response: In-service education programmes could be open to self-employed midwives at a minimal cost.

Section 3.6.4 Post Graduate Midwifery Education

Question 25: How should post-registration education for midwives be funded?

Response: Post-graduate studies will continue to be funded by Ministry of Education funding, however there may be provision for added support through CTA funding or Ministry of Health scholarships for targeted courses. DHB's could support individuals by reimbursement of registration fees on successful completion of papers.

Question 26: What is the appropriate balance between health practitioner, employer and education sector based funding?

Response: New models of funding through CTA and the Ministry could be explored to address particular priorities however post graduate education will always be a mix of Ministry of Education funding, employer support for study leave and full or partial reimbursement of fees and individual practitioner contribution.

Conclusion

NZNO thanks the DHBNZ for the opportunity to contribute to this important workforce strategy.

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Appendix One

Inpatient Safe Staffing Ratio's for Maternity Services

NZNO guidelines
18 August 2004

The establishment of safe staffing levels for Inpatient Maternity Services is complex. There are primary (normal), secondary and tertiary services and within these services may be antenatal, postnatal and delivery, or combined ante- and post-natal units. The midwifery care needs for both mother and baby need to be considered in determining appropriate staffing levels. Women with complex medical or post-operative care needs have added acuity. Women presenting with poor obstetric histories or who have had no antenatal care require a higher ratio.

In May/June 2004, NZNO surveyed its members on proposed staffing ratios for maternity services. Proposed levels were put forward for comment. Extensive feedback was received. The staffing levels identified below are those recommended by NZNO. Night shift was identified as a particular shift of concern with very low staffing levels while mothers and babies need the same level of care. At times, the high acuity levels will mean that these ratios are inadequate and that in the clinical judgement of a midwife there is a need for additional staff. Where "midwifery co-ordinator" is specified, this is supernumerary to the ratios identified. The midwifery co-ordinator assists, leads, co-ordinates mentors and liaises. Clerical support throughout office hours is implied.

Couplets refers to mother and baby.

PRIMARY / NORMAL BIRTHING UNIT			
Antenatal	**Delivery**	**Postnatal**	**Combined**
1:5	1:1 established labour & delivery	1:4 (couplets)	1:5 or 1:4 if more than one feeding problem

SECONDARY MATERNITY UNIT			
Antenatal	**Delivery**	**Postnatal**	**Combined**
1:4-5 Midwifery co-ordinator	1:1 established labour & delivery Midwifery co-ordinator	1:4 (couplets) if mix of first time mothers, post-Caesarean, multiple births etc 1:5 (couplets) if experienced mothers 1:6 postnatal women only Midwifery co-ordinator	1:4-5 Midwifery co-ordinator
TERTIARY MATERNITY UNITS			
Antenatal	**Delivery**	**Postnatal**	**Combined**
1:1 or 2:1 for those with acutely life threatening situations 1:2 for those in early labour 1:4 Midwifery co-ordinator	1:1 established labour & delivery Midwifery co-ordinator	1:4 (couplets) but 1:3 (couplets) if high Caesarian rates, women acutely ill, multiple births, premature infants 1:1 specialling may be required. Midwifery co-ordinator	

Prepared for the DHB MECA team
Susanne Trim
NZNO Midwifery Reference Network

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Appendix Two

NZNO POSITION STATEMENT

Registered Obstetric Nurses

4 August 2004

The New Zealand Nurses' Organisation Inc. (NZNO) and the Registered Obstetric Nurses Section (NZNO) welcome the Nursing Council of New Zealand announcement on scopes of practice for Registered Obstetric Nurses.

The NZNO position on Registered Obstetric Nurses:

1. NZNO supports the Nursing Council decision that the scope of practice for Registered Obstetric Nurses is that of a Registered Nurse.

2. NZNO supports the continued regulation of Registered Obstetric Nurses by the Nursing Council. NZNO will not support any attempt to transfer the regulation of Registered Obstetric Nurses to the Midwifery Council of New Zealand.

3. NZNO supports the continuation of employment of Registered Obstetric Nurses in antenatal, postnatal and neonatal areas. Further, NZNO supports the continued practice of Registered Obstetric Nurses in the provision of intra-partum assistance to the midwife/medical practitioner when required.

4. NZNO recognizes that Registered Obstetric Nurses work in a collegial and co-operative relationship with midwives, providing nursing support to the lead maternity care (LMC) model of practice.

5. NZNO and the Registered Obstetric Nurses Section (NZNO) have an expectation to be consulted and included in any ongoing work in relation to the Registered Obstetric Nurse scope of practice.