MERAS
Midwifery Employee
Representation & Advisory Services

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

Midwifery retention and recruitment

Retention and recruitment of midwives is a recurring issue for many of the District Health Boards (DHBs). Short term solutions are put into place that mediate the issue for a short time but the issue re-occurs regularly. A long term strategy is required to support ongoing retention and recruitment of midwives to ensure sufficient midwives to provide maternity care throughout NZ.

Hospital (employed) and Community LMC midwives are a co-dependent workforce, when one workforce is under pressure it has a direct impact on the other workforce so it is important to always ensure that both workforces are fully supported.

The New Zealand College of Midwives and MERAS has developed the following draft strategy to support recruitment and retention of employed midwives as an essential part of the maternity workforce.

Vision: All maternity services are fully staffed by Registered Midwives working to their full scope of practice and accountability.

We have set the following five objectives to help reach this goal.

1. A model of service delivery that enables, values and supports employed midwives to work to the breadth of their scope of practice and remunerates them accordingly
2. Maternity units staffed by midwives to the MERAS staffing standards
3. Ensure support for graduate midwives who choose to work in DHBs following graduation to support their retention in the profession
4. Support for women to birth in the appropriate facility for their needs and staff that facility appropriately
5. Support midwives working as Lead Maternity Carer's to ensure they are able to provide care within their primary role

The underlying principle for this strategy are that the objectives are generic and can be applied to all DHBs but targeted engagement and local solutions for local problems will be necessary. The strategy provides an overall direction and tools/ideas for improving recruitment, retention and responsiveness. A template (appendix A) has been developed to aid DHBs when considering their maternity service to identify issues that may be barriers and enablers to optimal midwifery staffing.

1. **Objective one: A model of service delivery that enables, values and supports employed midwives to work to the breadth of their scope of practice and remunerates them accordingly**

i. Recognition of midwifery as a distinct and separate profession from nursing
ii. A Midwifery leadership structure with the appropriate responsibilities, decision making, autonomy and communication lines to the executive leadership team
iii. Remuneration that recognises the midwifery scope of practice and clinical responsibilities and is not linked to nursing pay scales.
iv. Sufficient clerical and non-clinical support so that midwives can focus on providing midwifery care
v. Staffing levels reflect maternity as a 24/7 acute service and birthing suite as the 'ED of maternity'
vi. Development of designated senior midwifery roles in secondary and tertiary units to recognise the complexities of care provided and to support the workforce in the provision of acute complex care and service coordination.
vii. Efficient referral processes with other members of the multidisciplinary team and hospital services that respect midwifery clinical decision making
viii. Educational opportunities that enable midwives to develop and enhance their secondary and tertiary skills
ix. Midwives have opportunities through staff forums, working parties or committees to raise issues and contribute to the development of the maternity service.
x. Midwives have opportunities to develop leadership skills and participate in QLP.

2. **Objective two: Staff to the MERAS staffing standards**

I. Use MERAS Midwifery staffing standards as the template for midwifery staffing within maternity facilities.
II. Rostering practises that are flexible and recognise both the needs of the service and the needs of midwives.
III. Aim for maternity units to have a 100% midwifery workforce by 2025 with a planned approach to increasing midwifery staffing and replacing nurses within maternity services
IV. Rapid and immediate response to midwifery vacancies

3. **Objective three: Ensure support for student and graduate midwives (employed and LMC) to assist their retention within the profession**

I. Increase clinical teaching presence in the DHB maternity service for undergraduate student midwives.
II. Provide a joint academic/clinical position within each DHB or secondary/ tertiary unit for a midwife
III. Ensure all maternity services are welcoming to student midwives
IV. Ensure student midwives are able to access the experiences they require
V. Support the MFYP programme for graduate midwives
VI. Ensure a well-structured orientation programme is in place at maternity units and works with the Midwifery First Year of Practice programme to meet the employed graduate's needs.
VII. Support graduate midwives who enter LMC practice on graduation by ensuring that the DHB offers collegial and practical midwifery support from experienced core midwives when the LMCs are accessing the DHB facilities

4. Objective four: Support women to birth in the appropriate facility for their needs and staff that facility appropriately

I. Promote and support healthy well women to give birth in primary units to reduce the number of women unnecessarily accessing acute services and enable staff to focus their services on women who have complex obstetric care requirements[1].
II. Support the development, maintenance, appropriate staffing and funding for primary units
III. Ensure safe, seamless and supported transfer pathways for women needing secondary/tertiary referral/care
IV. Promote and support the use of primary units to women, families, midwives and other health professionals
V. Support obstetric outreach/virtual health clinics for rural areas for women with complex obstetric needs
VI. Support early postnatal transfer to primary units once acute episode of care is completed
VII. Ensure facilities provided by non DHB providers (but still funded by DHBs) have access to supportive structures and resources
VIII. Have appropriate processes in place that allow review or debriefing of obstetric interventions.

5.0 Objective five: Support midwives working as Lead Maternity Carer's to provide care within their primary role.

Support midwives to work as LMCs in each region to ensure there are sufficient to meet the needs of the community. A lack of LMC midwives impacts negatively on the workload for the employed hospital midwifery workforce. This can be achieved by:

I. Ensuring enough core midwives are employed to enable transfer to secondary care services or handover of clinical responsibility
II. Kind and welcoming units (zero tolerance policies for bullying etc.)
III. Support LMC's if/when they choose to provide complex care
IV. Appoint an LMC liaison midwife
V. Develop systems that enable collaborative care between LMC, core midwives and specialist staff
VI. Support obstetric outreach/virtual health clinics in the community/rural areas for women with complex obstetric needs
VII. Provide extra support and incentives for rural midwives
VIII. Offer of short term contracts to fill shifts in the hospitals for LMC midwives with low or building caseloads (if the unit has midwifery vacancies)
IX. Provide support to midwives working as LMC's and providing support to vulnerable families or those with complex needs

[1] There is strong evidence of safety and benefit for women and their families when they labour and give birth in a primary unit. The results are increased normal birth rates, a reduction in unnecessary interventions, increased satisfaction with service, a reduction in costs for the DHB and a potential for a reduced workload in the secondary/tertiary units. In addition they provide another employment opportunity for midwives.

Appendix A

Midwifery Staffing Strategy Template

This template has been designed to provide a useful way of discussing and focusing attention on midwifery staffing at a DHB and the factors relevant to that DHB.

Using the themes of Recruitment, Retention and Responsiveness provides a useful framework and reference point.

RECRUITMENT

FACTOR	POINTS FOR CONSIDERATION	RATIONALE
Advertising	Where is the DHB advertising for midwives (DHB job search, NZCOM website, Midwifery News) Do the adverts clearly show what opportunities are available for midwives working at that DHB (rotation, 12/8 hr shifts, etc)	Some DHBs have not had good advertising! Hard for midwives to know the DHB has vacancies if they don't advertise Some adverts can be too generic and don't promote the specific benefits of working as a midwife at that DHB
New Graduate Programme	How many new graduate midwives can be supported. Is there a well structured new graduate orientation programme in place which complements (rather than replicates) the MFYP? Consider the provision of accommodation for the MFYP year in hard to staff areas	New graduates are more likely to be attracted to DHBs that offer a comprehensive orientation programme with a good reputation. In some urban areas the cost of housing or rentals can be expensive. If DHBs are able to offer some cheap accommodation this could attract some new graduate midwives to that DHB
How many midwives are there working on 'casual' contracts *(a number of different terms are used to define 'casual' these can include bureau or part-time no fixed hours. The term*	There can be a larger pool than really needed of midwives on casual contracts. Look at factors that have encouraged midwives to seek casual rather than permanent contracts. Have one on one interviews with these midwives find out why they went on 'casual' and what would encourage them to convert to a permanent contract	Often factors such as failure to meet roster requests, declined annual leave and not meeting roster preferences have caused midwives to convert from permanent to casual contracts. This can become a downward spiral if this starts to have a negative impact on the rosters of permanent staff (more MWs go casual)

'casual' is used in the MERAS DHB MECA)	Identify number of midwives needed on casual contracts to support the service	Address issues that are causing midwives to choose 'casual' instead of permanent positions Some midwives are needed on 'casual' or very part-time hours to cover sick leave or other acute service needs. Those midwives do need to be given some working hours each week/ month or they are likely to seek work elsewhere
Is there an excess of local LMC midwives?	Some LMC midwives may be interested in working at the DHB part-time if there are more LMCs in the community than required	An excess of LMCs in the local community can be an indicator signaling there may be factors within the workplace as to why midwives are not choosing to work at the DHB. Discussions at access holders meetings may identify 'perceptions' LMCs have about working at the DHB.
Is there potential for part-time midwives to increase their FTE by even 0.1FTE per fortnight	How many part-time midwives regularly work more than their contracted FTE. Talk to those midwives and find out if they are interested in increasing their FTE or factors that deter them from doing this.	In units where rostering is an issue, midwives will often have a lower FTE then choose which additional shifts they work.
What is the minimum FTE midwives can be employed to	Is the minimum FTE a barrier to a permanent position? What flexibility is there for midwives returning from maternity leave or needing to reduce hours for a period of time	Midwives with young children prefer a lower permanent FTE so it is easier to accommodate school holidays etc Midwives returning from maternity leave may want a lower FTE initially then gradually increase. There are times midwives want to reduce hours to care for family or elderly parents
Is there potential to 'grow your own' midwives	Are there opportunities for the DHB to support local women to do their midwifery training (bonding scheme)	Living locally could increase the chance of the midwife remaining within that community on graduation. The right package could support more women to complete their midwifery training

RETENTION

FACTOR	POINTS FOR CONSIDERATION	RATIONALE
What are the advantages of being a permanent employee?	When the number of vacancies and midwives on casual contracts increase, midwives on permanent staff may end up being rostered more nights, having AL requests and roster requests declined. Whereas midwives on casual choose when and what shifts they work and can take leave whenever they want. DHB needs to turn this situation around so that midwives see some benefit in being on permanent staff	Units start to roster to accommodate the needs of the casual staff (many don't want nights) which results in more nights for permanent staff. Downward spiral can occur with more midwives going onto casual because of poor rostering
Rostering	Need to demonstrate that permanent midwives are valued. Listen to ideas of staff around rostering. Does not have to be 'one size fits all'. Meet all roster requests Offer option of 12 or 8 hour shifts. Accommodate shift preferences. Consider 'set shift' patterns where this may provide 1 or 2 staff across the 7 days. At the most only roster the expected number of night shifts (50% for 12 hr shifts, 1/3 for 8 hour shifts). Centralised rostering has had a negative impact in units where it has been introduced	The MERAS staffing survey 2016 showed the factors that midwives considered important and would enable some to increase their FTE A number of DHBs need to demonstrate a more flexible approach to rostering. There are a number of midwives with a preference for night duty (and many others who would prefer to do less nights) yet not all Units allow this. Often when staffing shortages arise permanent staff are rostered more nights because some have gone onto casual to avoid night shifts.
Available shifts	Have a system in place which allows permanent staff to view the roster first this enables: Shift swaps Part-time staff a chance to pick up extra shifts before casual staff. Casual staff not able to pick up available shifts until the roster has been out for 2 weeks With fair rostering for permanent staff	This gives a preference to permanent staff. If midwives on casual contracts find there is less choice around what shifts they work and when, with more night shifts being the only option they are more likely to opt for a part-time permanent contract which gives them an improved roster pattern and earlier access to available shifts.

Annual leave requests	Is there a system in place so midwives can easily see weeks available for AL Do all midwives understand the process for booking AL (esp if it is an electronic system) Is it clear how much FTE can be on leave at one time. Do AL requests get approved promptly (within 5 working days) Does AL get cancelled or unreasonably declined Is there a fair process for allocation of AL during school holiday and Christmas/ New Year periods?	In some units midwives experience a number of barriers to getting AL. There may be long wait periods for approval, difficulty in finding weeks that are available and AL requests declined. These situations can cause midwives to convert to casual contracts or resign
Workload	Is the staffing to acuity appropriate? Does it reflect the 24/7 and ED nature of maternity? Do the staffing levels reflect the MERAS staffing standards. Impact of secondary care handovers on staffing needs. Does the staffing allow the shift coordinator to have a reduced workload. Do the Midwife managers/ leaders assist clinically when very busy Is there a good understanding of the differing roles of LMC midwives v core midwifery services? Is each working to their full scope? Are there organizational wide policies impacting on workload Are there primary units available and could use of these be increased to reduce workload on secondary/ tertiary unit?	In many larger units midwives have reduced their FTE due to workload fatigue. Some units still have a reduced FTE overnight DHBs are funded to provide secondary care. This needs to be reflected in staffing. After hours midwives are often expected to coordinate and carry a full caseload Midwives appreciate their managers helping when busy and view the manager as understanding the workload issues better. Understanding core v LMC roles ensures the right midwife provides care and care is not overly medicalized There can be organizational initiatives that creep into maternity that have little relevance for maternity. The postnatal transfer policies and contracting out of primary units by some DHBs limit when women are able to transfer to primary units and increases workload for base hospital

Sick leave	What are the sick leave rates. Is known long term sick leave covered with a 'fixed term contract'	High sick leave rates often signal a problem with workload or poor rostering
Feeling valued	What does the Unit do to make midwives feel valued? Are busy shifts acknowledged with thanks or other acknowledgements from management Are midwives offered longer meal breaks on quieter shifts Are midwives views sought on changes in the workplace? Are midwives concerns listened to and addressed? Do midwife managers help clinically on busy shifts What are the opportunities for employed midwives and LMC midwives to contribute to the decision making within the maternity unit (working parties, committees etc)	Midwives often comment about not feeling valued. When managers are asked they often seem to find it difficult to define how they demonstrate that they 'value' their staff. Small gestures go a long way Too often midwives feel their ideas are received negatively or ignored. Having visible midwife managers who assist clinically when busy is valued and midwives feel they then understand their workload Very few DHBs have forums that enable employed midwives and LMCs to work together with the Midwifery Leader or manager to shape the direction of the maternity service. Where this is in place and working well it has a positive impact.
Study days/ conference leave	How easy is it for midwives to attend study days or conferences? Is the application process too onerous? Do study days get cancelled to accommodate staffing shortages? Are there study days available to support the develop of secondary care skills for midwives that would encourage midwives to progress to the Complex Care Course Can the Midwifery Leader influence the way the complex care course is structured?	In some units the application process for external study days or conferences is too onerous Cancellation of study days causes frustration. Seems to be some concern about the way the complex care course is structured. Is this deterring midwives from applying? Could greater weight be given to current clinical experience?

Support for QLP	Are midwives supported to apply for QLP. Are there unreasonable expectations on those midwives who have achieved 'leadership'? Are midwives supported in their resource roles or with projects	Some DHBs are good at promoting and encouraging midwives to do QLP. There are often expectations that midwives with QLP 'leadership' will coordinate, work with students and do a number of other things without thanks or acknowledgement simply because they have QLP leadership.
Career development	What training/ support does the DHB have in place to support midwives in career progression so that they have the skills to apply for more senior positions Are there more opportunities to develop horizontal leadership (delegation of tasks from manager)	Some DHBs now have good programmes in place to support career development. Others do not. It is then disappointing for midwives to see senior roles being given to external applicants Delegating or sharing the 'tasks' that are required in a ward assist in the development of a cohesive team and assists midwives feeling they are part of the decision making. It also develops leadership skills, supports QLP and enables the CM to take AL knowing the unit will continue to function well.

RESPONSIVENESS

FACTOR	POINTS FOR CONSIDERATION	RATIONALE
How promptly does the DHB respond to known reductions in FTE from retirement, maternity leave or long term sick leave	Often DHBs wait until a staff member has left before they advertise. A more prompt response would reduce the period of staffing shortfall. For smaller units the loss of one staff member can be a significant % of the budgeted FTE	Improved predicting and planning for these exits could occur in many Units.

How quickly does the Unit respond to downward trends in staffing or recruitment	Why are staff leaving or reducing hours? Talk those staff leaving and staff remaining, what are their concerns and how can these be addressed. Offer exit interviews with a HR advisor Check that the DHB is advertising	Midwives are often reluctant to be too explicit about why they are leaving a Unit in case they want to return at a later date. Listen to the staff remaining. Managers can be quite slow to respond to a downward trend or reluctant to acknowledge that a particular factor/ policy is the cause (poor rostering) In some cases adverts have been discontinued
How does the DHB respond when maternity is occupancy low	Does the DHB try to move staff out of maternity when occupancy is low?	The DHB needs to recognize that maternity is an acute service that can experience admissions at any time of the day or night. It needs to be staffed accordingly as an emergency response service. Midwives are not able to work in non-maternity areas as it is not in their scope of practice When the acuity and occupancy is usually high, any 'down time' can be used to provide staff have the ability to catch up on administrative work and other quality improvement tasks that can be neglected when units are busy