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| Maternal and Child Health COVID-19 response recovery |
| Guidance (April 2022) |
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# Purpose

This document is a guide for Maternal and Child Health (MCH) services to use when reviewing, developing, and designing models of care for use during periods of workforce shortfall and activity surge throughout the COVID-19 pandemic[[1]](#footnote-2). This guidance focuses on MCH services.

The guidance has been prepared in consultation with the Department of Health (Department), Municipal Association of Victoria (MAV), Safer Care Victoria (SCV), Executive MCH Coordinators Group and the Australian Nursing and Midwifery Federation (ANMF) (Vic Branch).

# Background

Due to the impact of the COVID-19 pandemic, health services in Victoria have experienced significant workforce challenges and shortages that have impacted service delivery.

In recognition of these extreme pressures, on 18 January 2022, a Pandemic Code Brown was announced across public health services in metropolitan Melbourne and regional Victoria for a period of four to six weeks.

In parallel and due to extreme pressures impacting some metropolitan maternity services and MCH services a coordinated and system-wide *Metropolitan Maternal and Child Health (MCH) COVID-19 Surge Response* was activated on Friday 28 January for an initial six-week period until Friday 11 March 2022.

The response:

* was activated to ensure that vulnerable new mothers/caregivers, infants, and families continued to receive essential health care in both maternity and MCH service settings
* enabled the temporary diversion of interested MCH nurses into Health Services to undertake the role of the midwife in delivering extended post-natal care
* enabled cross municipal support for metropolitan Local Government MCH services experiencing significant workforce shortages.

Activation of the *MCH COVID-19 Surge Response* required the uniform and temporary prioritisation of metropolitan Local Government MCH services for:

* All infants aged 0-8 weeks and their mother/primary caregiver
* All Aboriginal infants, children, and families (0-5 years)
* All infants and children over 8 weeks of age with additional needs or concerns, including families on the Enhanced MCH program or those with COVID-19.

# Recovery from Metropolitan MCH COVID-19 surge response

The *Metropolitan Maternal and Child Health (MCH) COVID-19 Surge Response* formallyconcluded on Friday 11 March 2022. However, it is understood that COVID-19 will continue to impact MCH workforces and levels of MCH service delivery throughout 2022.

As MCH services confront variations in their capacity to deliver MCH services, significant variation that is ongoing will need to be communicated to the Department and local families.

Some MCH services experiencing extreme longer term workforce pressures may continue to grapple with providing service delivery to all age groups, including metropolitan MCH services scaling up after the *Metropolitan MCH COVID-19 surge response****.*** These services may need to implement time limited altered service models and/or purchase MCH services from other organisations to ensure that local families continue to have access to the MCH services for all age groups.

Workforce strategies and alternate models of MCH service provision are outlined in this guidance to assist MCH services to manage extreme workforce pressures and continue to deliver support to all age groups in their communities. These measures can be ongoing or time limited.

## Recovery principles

In working towards and sustaining full MCH service delivery to all age groups, all MCH services should be guided by the:

* **goal of the Victorian MCH service** to promote health, wellbeing, safety, learning and developmental outcomes for children and their families, providing a holistic approach to the physical, emotional, and social factors affecting families in contemporary communities. The service is underpinned by 10 principles including universal access and when applied delivers an integrated and coordinated approach to support continuity of care through MCH service systems.
* [**Maternal and Child Health Service guidelines**](https://www.health.vic.gov.au/publications/maternal-and-child-health-service-guidelines) including the delivery of **standard face-to face- consultations to all infants and children** so that MCH services are accessible in the right place at the right time for children, mothers, and families.
* current ***Advice COVID-19 MCH and Early Parenting Centres*** for families assessed as positive of COVID-19, Low or High Risk SCOVID at [Maternal and Child Health Service](https://www.health.vic.gov.au/primary-and-community-health/maternal-and-child-health-service).
* ***Maternal and Child Health COVID-19 Contingency Planning – Staff Shortages* (Appendix 1)**guidance and accompanying spreadsheet ***MCH Prioritised Service Delivery* (Appendix 2)** which were developed to support MCH services to implement prioritised service delivery during temporary changes to MCH services due to COVID-19. The guidance provides scalable detail on the level of staffing required to undertake prioritised MCH service delivery at each age level of Key Age and Stage (KAS) consultation and can be used as a guide for services to implement a staged return to service delivery across all age groups.

## Recovery requirements

To monitor recovery and variations in service delivery across the state due to COVID-19, it is requested that metropolitan and regional MCH services continue to complete the staffing capacity spreadsheet on the MAV SharePoint site weekly, and.

1. MCH services experiencing continued extreme workforce pressures with **30 percent or more deficit** in staffing capacity and who are unable to resume service delivery to all age groups in their community for a **consecutive period of 4 or more** weeks are required to proactively contact:

* **MAV (via** [**hlees@mav.asn.au**](mailto:hlees@mav.asn.au)**)**
* **Department of Health (via** [**camilla.macdonell@health.vic.gov.au**](mailto:camilla.macdonell@health.vic.gov.au) **and mch@health.vic.gov.au)**
* **Safer Care Victoria (via** [**marcia.armstrong@safercare.vic.gov.au**](mailto:marcia.armstrong@safercare.vic.gov.au)**)**

1. For workforce pressures continuing for **6 weeks or more**, an Action Plan will need to be developed in consultation with the Department, MAV, SCV and staff to enable the implementation of agreed time limited workforce and altered MCH service models inclusive of time frames, communication strategy and risk assessment **(Example template at Appendix 3)**.

The Department will inform the ANMF (Vic Branch) during regular workforce meetings of any MCH services implementing an Action Plan.

# Workforce strategies

There are several ongoing workforce strategies that can increase MCH workforce capacity.

MCH workforce initiatives to ensure a sustainable and adequate workforce are detailed in the [Maternal and Child Health Service guidelines](https://www.health.vic.gov.au/publications/maternal-and-child-health-service-guidelines) pp. 26.

## Recruitment of staff

MCH services should consider recruitment principles to ensure there is always adequate FTE to undertake full MCH service delivery with a planned approach to accommodate demands from staff attrition, long service leave, maternity leave and extended sick leave. Ongoing positions provide incentive for staff over temporary contracted positions.

## Employer of choice

MCH services should consider all aspects of their workplace, so they can be considered an ‘employer of choice’ and utilise these levers in the recruitment and retention of staff.

## Student and graduate programs

Actively supporting MCH students and graduates through mentorship programs and providing opportunity for ongoing permanent positions, can realise sustainable additional FTE capacity.

## Offer of increased hours to casual and permanent part time staff

Offer casual or permanent part time staff to increase FTE by small amounts, for example 3.8 hours per fortnight over 10 staff = 38 hours = 0.5 FTE or 7.6 hours per fortnight over 10 staff = 76 hours = 1 FTE.

## Weekend shifts

Offer the flexibility of additional shifts on weekends to staff offering to increase hours. These additional hours on weekends may also be favourably received by the community.

# Time limited workforce initiatives

Whilst services are impacted by COVID-19 and face severe workforce shortages (> 30 per cent deficit), there are some time limited workforce models that can be explored to increase FTE to enable full MCH service delivery.

## Accommodation for staff

MCH services with severe workforce pressures may consider providing accommodation and/or costs to attract staff to travel to local areas and work on a casual basis.

## Relocation costs

MCH services with severe workforce pressures may consider providing relocation costs to potential permanent part time or full-time applicants.

## Retirement models

Registration maintained – consider advertising for retired MCH nurses to come back to the workforce for a time limited period to undertake KAS visits for older age groups such as 18 months, 2 years, and 3.5 years.

Registration on Sub register – consider advertising for those MCH nurses who are part of the COVID-19 response Aphra Sub Register to undertake work within MCH up until 21 September 2022, when the Sub register expires.

# Time limited alternate service models

Implementation of any time limited workforce and altered service models will require communication with the Department, MAV and SCV. Services experiencing pressures over 6 consecutive weeks, or more are requested to develop an agreed Action Plan.

The Action plan should detail the workforce initiatives and alternate service delivery models which the service proposes to implement, together with time frames for commencement and conclusion of the initiative/model, a communication strategy and risk assessment.

## Negotiated arrangements between local governments

The Municipal Association of Victoria (MAV) has worked with key stakeholders to develop a template that can be used between local government service providers to support the purchase of MCH hours between services. The cost of a MCH hour of service is based on the MCH unit price. LGAs interested in contracting MCH hours from other service providers, can contact Helen Lees at the MAV on [hlees@mav.asn.au](mailto:hlees@mav.asn.au)

## Hybrid model – combined telehealth and short face to face service delivery

A hybrid model of combined telehealth and short face to face service delivery may provide MCH services experiencing ongoing workforce pressures with the capacity to deliver prioritised service delivery to increasing age cohorts.

Those services with their own ‘well staff’ isolating could work from home providing the telehealth component of the consultation, with those staff available in the workplace undertaking the short face to face service delivery to deliver physical and developmental assessment. This sustains service delivery to more clients compared with not having isolating ‘well staff’ participating in service delivery.

In addition to services utilising their own staff who are isolating and otherwise well, the telehealth component of the consultation could be undertaken by a contracted supporting MCH service. The short face to face component would continue to be delivered by the local MCH service who are best placed to undertake physical and developmental assessment and build relationships with local families.

## KAS group work

For those children and families without concerns, group work to obtain universal levels of KAS visits may be undertaken. The premise to this model is to provide a group setting in which more children and families can be assessed and provided with key information in less time, compared to undertaking individual consultations. Those with additional concerns identified will need to progress to an additional consultation.

## Agreement to share MCH services between neighbouring LGAs

MCH services experiencing continued workforce pressures may be able to engage neighbouring services through a negotiated arrangement, to undertake components of MCH service delivery in addition to providing the telehealth component of a KAS or additional consultation. This may include face to face service delivery through home visits (first and any other KAS visit) lactation support and group work.

This negotiated arrangement could extend to clinical and leadership supervision and support of administration staff within a service.

## Prioritised MCH service delivery

Once all levers to increase workforce capacity have been exhausted, services with continued workforce pressures may need to implement a level of a **prioritised** MCH service delivery based on staffing capacity. This can be guided by the ***Maternal and Child Health COVID-19 Contingency Planning – Staff Shortages* (Appendix 1)**.A prioritised level of service delivery ensures the most vulnerable children and families are provided with MCH services where there are workforce pressures. Any sustained prioritisation of MCH service delivery needs to be documented and agreed in consultation with the Department, MAV and SCV.

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| To receive this document in another format phone 1300 651 160 using the National Relay Service 13 36 77 if required, or [email Maternal and Child Health and Parenting](mailto:email%20Maternal%20and%20Child%20Health%20and%20Parenting) <mch@health.vic.gov.au>.  Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne. © State of Victoria, Australia, Department of Health, April 2022.  In this document, ‘Aboriginal’ refers to both Aboriginal and Torres Strait Islander people. ‘Indigenous’ or ‘Koori/Koorie’ is retained when part of the title of a report, program or quotation. |

1. Visit https://www.dhhs.vic.gov.au/coronavirus to find general information and further resources about coronavirus (COVID-19). [↑](#footnote-ref-2)