Phase 2 Primary healthcare providers substitute for each other

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1 When does phase 2 start?

Phase 2 starts when the first midwives become ill. This absenteeism will initially be compensated by others at their own practice. If this is no longer possible, supporting colleagues from other local/regional practices will be called in. The work substitution in other local practices is done at a KNOV locum rate at the applicable fee.
Of course, the anticipation of phase 3 can be started at an earlier stage. The preparations must take place at the latest at the start of the first cases of illness among midwives. The plan itself and the implementation of the plan vary per region, which is why it is good to anticipate this.

2 Why should you be anticipating phase 3?

In phase three, midwife care is centralised. This can include prenatal, natal or postnatal care combined, but also just natal care, for example. For more information, refer to the Natal Care Phase 3 plan. The starting point is that primary care is provided in primary healthcare and secondary care in secondary healthcare. Location indications (B/D) vary per region and will have to be agreed upon. To set up this phase quickly and clearly, there is a need for anticipating measures in phase 2, ensuring that all stakeholders are on the same page and know clearly why and how phase 3 is used.

3 Which stakeholders are involved?

- Practice owners
- Obstetricians
- Hospital Executive Board
- Healthcare insurers
- Maternity care organisations
- Regional acute care (ROAZ)

4 Which elements should be taken into consideration?

4.1 Communication

In this phase, it is crucial to clarify the lines of communication between stakeholders. Midwives in primary healthcare are very suitable to take on this vital role. Communication needs to be handled at different levels.

4.2 Alliance Coordinator (VSV in the Netherlands, Midwifery Alliance)

- Practice owners inform the alliance coordinator that continuity problems are expected. This is when the absenteeism is increasing and can no longer be compensated by members of their own practice.
  Discuss your concerns with the gynaecologists, let them know that you have an idea to centralise care to counter any expected problems.
- Discuss the reasons for centralising care. Share your ideas and issues with others.

- Create a group chat (WhatsApp, Messenger) with primary healthcare coordinators, the obstetrics coordinator and the childbirth and maternity care managers. Discuss the types of care that could be provided at the centre.
- Inform maternity care providers about scenarios about when it is desirable to centralise care. Ask them to also contribute to this topic. Let the maternity care organisations come together here. Leave the coordination of the creation of delivery teams to the maternity care organisations.
- Find out which of the directors on the Executive Board is responsible for childbirth care. Try to keep the lines of communication with childbirth care managers as short as possible. Know who to approach when you notice the acute situation arise and have to switch to phase 3. Link this back to the ROAZ regional coordinator.
- Know who the contact person of the preferred regional healthcare insurer is. Provide direct communication lines (phone/email address). Link this back to the regional coordinator.
- Invite the ROAZ to the childbirth care escalation team, using a single point of contact. This is most likely the regional coordinator at this time. Know who to approach for information about acute care problems. The ROAZ does not have a controlling role but ensures that acute care can still be delivered. Try to gather information about the situation from the alliance coordinators. Start handing out scenarios that are required in case of a shortage of ambulance care capacity/midwives/hospital capacity. Also, ask if you can be kept actively informed about any capacity problems.

Your regional coordinator, through the KNOV, can help you with your communication with the Executive Board of the hospital and the healthcare insurer's healthcare purchaser.

4.3 Location

- Start thinking about a location, preferably in the hospital or possibly close to the hospital.
- In the hospital, this can be a separate wing.
- The location should be expandable to more rooms in case of further capacity problems

4.4 Help

- Project management can help in establishing the organisation from scratch and coordinating with healthcare providers and healthcare insurers. The KNOV knows which project managers have experience in this area.
- Use all existing structures and expand on these. Do not build from scratch if that is not absolutely necessary.
- A delivery centre can be built quickly, but you need to count on 24-36 hours of set-up time.

4.5 Finance and responsibility

Opening a birthing centre means you will need to incur certain costs. Keep an eye on who is responsible for what. We are the primary healthcare's quick problem solvers, and sometimes we take on responsibilities when we are not responsible. Also, remember that hospitals and obstetricians may not be able to switch as quickly, because the structure/system in which they work is really different. This is often a bit slower because multiple levels are involved. Be mindful of each other’s situation.

- Keep a close eye on whose interests are at play. No capacity at the hospital is the hospital's problem. You can offer your insights, but let the hospital be the owner of the problem.
- In case of a capacity problem for ambulance care, this is the responsibility of the ambulance care service.
- In case of a capacity problem in primary healthcare (and the situation at the birthing rooms/hospital is still stable), you could postpone the creation of an external birthing centre by using delivery teams in cases when a home birth is no longer an option. Do this in consultation with the hospital.

4.6 Implementation

Implementation starts when the ambulance care has indicated that there are capacity problems, the hospital has stated the same, or the region is no longer able to keep the midwife practices open and to have a professional midwife on duty for each practice. This is the time to initiate phase 3. Which steps do you take?

- The regional coordinator determines whether to initiate phase 3. They inform the KNOV and through these channels, healthcare insurers and hospitals can also be contacted. More information to follow.
- Discuss the need for the implementation of phase 3 with the obstetricians and the Alliance. Don't wait too long. It is better to start too early than too late.
- Have the obstetricians report to their manager/Executive Board and explain that if this situation persists, acute childbirth care will be at risk.
- You should also send a letter from primary healthcare to the Executive Board with your concerns about acute care. State that there is a plan (which you have already shared) to relieve the hospital and that you need to start this phase now.
- Consult with your healthcare insurer about the need to implement this plan. Make sure that it is clear who pays for what and who the principal will be.
- Inform the ROAZ that you want to carry out this plan because of the pressure on acute care. They will not say whether they agree, but they will take this into account in their deliberations. The ROAZ is responsible for acute care coordination.