



Government of **Western Australia**
Department of **Health**

Midwifery Continuity of Carer Model Toolkit

© Department of Health, State of Western Australia (2016).

Copyright to this material produced by the Western Australian Department of Health belongs to the State of Western Australia, under the provisions of the Copyright Act 1968 (Commonwealth Australia). Apart from any fair dealing for personal, academic, research or non-commercial use, no part may be reproduced without written permission of the Health Networks, Western Australian Department of Health. The Department of Health is under no obligation to grant this permission. Please acknowledge the WA Department of Health when reproducing or quoting material from this source.

Copyright NSW Health: Reproduced with the kind permission of the NSW Ministry of Health

Acknowledgement

Produced by and adapted with permission from: The Nursing & Midwifery Office NSW Ministry of Health.

SHPN (NM) 120279 ISBN 978-1-74187-828-8

Citation

Western Australian Department of Health. Midwifery continuity of carer model toolkit. Health Networks Directorate, Western Australian Department of Health; 2016.

Important Disclaimer:

All information and content in this Material is provided in good faith by the WA Department of Health, and is based on sources believed to be reliable and accurate at the time of development. The State of Western Australia, the WA Department of Health and their respective officers, employees and agents, do not accept legal liability or responsibility for the Material, or any consequences arising from its use

Contents

Introduction	3
Understanding the broad context	4
Understanding Midwifery Continuity of Carer models	5
Definitions	5
Core principles of Midwifery Continuity of Carer models	6
Understanding the local context	7
Key steps	8
Identify an executive sponsor	8
Identify a project leader	8
Project plan	8
Form a multidisciplinary steering group	9
Map the woman's journey	10
Risk assessment	10
Writing a business case	10
Operational plan	11
Communication strategy and publicity	12
Recruitment	12
Education and professional development	14
Model sustainability	15
Clinical supervision	15
Include as strategy and evidence	15
Succession planning	16
Regular meetings	16
Evaluation	17
Existing midwifery continuity of carer models	18
References	19
Web links	20
Appendix 1: Template for Terms of Reference	22
Appendix 2: Risk assessment (AS/NZS ISO31000:2009)	25
Appendix 3: Template for business case	28
Appendix 4: Example of operational plan	31

Introduction

This Toolkit has been written to assist managers and clinicians working in Western Australia (WA) Department of Health maternity services to develop and implement Midwifery Continuity of Carer (MCoC) models. The aim is to improve and enrich maternity care provided to women and families in WA. MCoC models focus on the needs of the woman and her family and places her at the centre of her care.

The core principles of woman centred care:¹

- Care is focussed on the woman's individual unique needs, expectations and aspirations, rather than the needs of the institutions or professions involved
- Care recognises the woman's right to self-determination in terms of choice, control, and continuity of care from a known care giver or known caregivers
- Care encompasses the needs of the baby, the woman's family, her significant others and community, as identified and negotiated by the woman herself
- Care follows the woman across the interface between institutions and the community, through all phases of pregnancy, birth and the postnatal period. It therefore involves collaboration with other health professionals when necessary Care is holistic in terms of addressing the woman's social, emotional, physical, psychological, spiritual and cultural needs and expectations.

Local and Australian Government reports ¹, have identified the need to develop midwifery and medical programs, which focus on providing continuity of care/r. Maternity services need to establish MCoC models which are: locally focussed, enhance access, increase equity to maternity care and improve recruitment and retention of the midwifery workforce.²

As indicated in the WA Health *Improving Maternity Services: Working Together Across Western Australia – a Policy Framework*, the aim is to develop, deliver and provide maternal and newborn services that are safe, integrated, effective, and responsive to the individual needs of women and their babies in their community.³ Additionally, the *National Maternity Services Plan*² identifies the provision of continuous care by a known carer across the maternity pathway demonstrates a beneficial impact on outcomes. This is supported by international evidence which demonstrates the improved clinical outcomes for women and their newborns when their maternity care is provided by a known midwife⁴ in collaboration with other maternity care providers such as obstetricians, neonatologists, general practitioners (GPs) and allied health professionals.

A MCoC model provides a woman with a primary midwife and a backup midwife for the antenatal, intrapartum and postnatal periods. These models of care involve each midwife undertaking a caseload of women.

It is also well recognised that these MCoC models enable midwives the opportunity to work to their full scope of practice and to develop meaningful professional relationships with the women they care for and support⁵. Such factors have been recognised as important in successful recruitment and retention of midwives⁶.

Managers and clinicians who have undertaken the development and implementation of these innovative models have found there are many processes and strategic steps needed to establish a successful and sustainable model⁷.

This toolkit has been written to support maternity services as they undertake the development and implementation of their MCoC model. It also provides necessary information to enable successful and ongoing sustainability of the model. It contains helpful information about the core principles of MCoC, key steps to include in an implementation plan, lessons learnt and appendices that include useful templates and documents.

Understanding the broad context

It is important to be aware of and understand the WA industrial and policy frameworks in which the model will be designed and implemented. The key documents are outlined below.

WA Health supports the use of the [National Midwifery Guidelines for Consultation and Referral \(2013\)](#). These Guidelines provide an evidence-based framework for collaboration between midwives and doctors aimed at improving the quality and safety of care for women and their newborn. The Guidelines also aim to inform decision-making by midwives on the care, consultation and referral of women /newborns for higher level care:

- at booking
- during pregnancy and the antenatal period
- during labour and birth
- during the postnatal period

The *WA Health Midwifery Annualised Salary Agreement (MASA)* is adapted for each local service/model, in consultation with WA Health Industrial Relations Service.

The MASA specifies the arrangements that will apply to midwives employed to work within a continuity of carer model of midwifery care, including caseload programs providing care across the full continuum. The MASA is pursuant to Clause 8 – Agreement Flexibility and Clause 26 – Flexibility in Hours and Rostering of the Registered Nurses, Midwives and Enrolled Mental Health Nurses – Australian Nursing Federation – WA Health Industrial Agreement. The MASA does not replace the industrial agreement provided that to the extent of any inconsistency, the MASA will override the industrial agreement.

Understanding Midwifery Continuity of Carer models



When developing a MCoC model it is important to understand the definitions and core principles of this type of service delivery. The following definitions and core principles can be applied to suit the local context.

MCoC models, involve midwifery care being provided by the same midwife or by a small group of midwives for a woman. The woman is able to develop a meaningful relationship with the midwife/small group of midwives throughout pregnancy and the childbirth continuum. This care begins in early pregnancy, continues through pregnancy, labour and birth, to the end of the postnatal period.

Definitions

Caseload Midwife is a term that describes a midwife who has an agreed number of women (caseload) per year for whom she is the primary midwifery caregiver. As well as being the primary midwife for an agreed number of women each year, each midwife will also be a second or back up midwife for women who have another midwife as their primary caregiver. Midwives working in caseload practice are available over a 24 hour period for an agreed number of days/week, the minimum of which will be 16 times per 28 day cycle (as per the MASA). The midwife will require a paging and/or mobile phone system so that the women are able to contact her.

The **Primary Midwife** is the first point of contact for the woman through pregnancy, labour and birth and postnatal period. The primary midwife works in partnership with the woman, identifying her individual needs and ensuring that she has access to safe and supportive services. As part of this role the midwife ensures all investigations, consultations and referrals occur at an appropriate time while collaborating with other health professionals in accordance with the individual woman's circumstances and health needs.

The **Support Midwife** (or midwives) is the second point of contact for the woman when her primary midwife is not available. This may be due to a variety of reasons including when the primary midwife is not rostered to work, has worked her maximum clinical hours for that day or is on annual leave, study leave or personal leave.

Midwifery Group Practice (MGP) is where a number of midwives working in caseload practice organise themselves into a group or an agreed working arrangement. There is no ideal number of midwives in a group practice. Midwives may organise themselves in partnerships or small groups within a larger MGP, or a service may have a number of small MGPs. Regardless of the approach taken, maximising continuity of carer should be the underpinning principle. The group

will organise and agree their working arrangements to support one another and to ensure that care is able to be provided for caseload women taking into account days off, annual leave etc.

An **Annual Caseload** is the number of women per year for which a caseload midwife provides primary care. Each caseload midwife is the primary midwife for her 'own' women and provides back up for her midwife partner's women. The annual caseload takes into account:

- whether the midwife works full time or part time
- the complexity of care required by the woman (e.g. medical, psychosocial, co-morbidities)
- the distance travelled by the midwife to provide this care
- provision of total or partial postnatal care.

Whilst the caseload may range between 35 and 40 women per year for a midwife working full time it is important to calculate this accurately to ensure the sustainability of the MGP.

Core principles of Midwifery Continuity of Carer models



Midwives have an agreed midwifery philosophy of care, vision for the model and ways of working together, for example:

- The majority of midwifery care is provided by a primary midwife.
- The primary midwife provides care from early in pregnancy (usually booking visit) through labour and birth and postnatally.
- A support midwife/s is available whom the woman has met on more than one occasion during her pregnancy.
- One-to-one care for labour and birth is provided by the primary or back up midwife.
- The primary health care approach facilitates a well mother and baby to transfer home, with appropriate midwifery support. This may include a home visit on the day of birth.
- The interdisciplinary collaborative approach facilitates midwifery care to continue to be provided by the primary midwife even when complications arise.
- MCoC models utilise the same clinical guidelines, protocols and decision-making frameworks as the rest of the maternity service to ensure consistency and continuity of care and best practice.
- MCoC is valuable and safe for women with varying levels of risk in their pregnancy. In fact, women with complex pregnancies may particularly benefit from receiving continuity of midwifery carer in collaboration with other health professionals. A model can be specifically designed to meet the needs of priority groups in the local community (e.g. teenage pregnancies, obese women, women with increased psychosocial needs).

- The conclusion of the midwifery relationship is timely and facilitates the woman's transition into primary health services (for example, child and family health services and GP).

It is essential that any model being designed is woman-centred, sustainable, and meets the needs of the midwives and the service. The following points have been identified as central to promoting sustainability of a MCoC model:

- the woman and her needs should be central to the model
- the need to maintain professional relationships with women, avoiding the development of co-dependency with the women in their care
- clear reporting lines and escalation processes to line managers and obstetricians
- a balance of experience among the midwives
- regular formal and informal communication is crucial
- transparency
- flexibility
- generosity of spirit between individuals
- being aware of others
- trust between and amongst individuals
- the developing of a shared philosophy – values clarification exercises early on in the development of the MCoC can be useful
- succession planning.

Midwives have identified key factors for achieving optimal work experiences within MCoC models. These are not only about successful relationships with the women they care for, but also the relationships they have with their peers, medical colleagues and managers⁷. Key factors include:

- the ability for midwives to develop meaningful professional relationships with women through continuity of carer
- supportive relationships at work and at home
- positive working relationships and occupational autonomy involves midwives being able to organise their working lives with maximum flexibility through negotiation. This includes:
 - positive and supportive relationships with midwifery colleagues in MCoC models
 - collaborative relationships with medical colleagues and midwifery peers at the hospital
 - managers who facilitate professional development, interpersonal confidence and skills, assistance with debriefing and reflection
 - professional and clinical support/guidance.

Understanding the local context

There are many considerations and challenges in developing and implementing change in maternity care provision. It is important to understand that all maternity services are different and will require different approaches to develop and implement a MCoC model that best suits the needs of the service or facility. These changes require collaboration and effective communication between all stakeholders; clinicians (midwives, doctors, nurses and allied health professionals), managers and consumers/community.

Each MCoC model will vary as it is influenced by the needs of the local women, the community's expectations of the service, the role delineation of the facility, who the

collaborating practitioners are and the geography of the catchment area. The next section of the toolkit discusses the key steps required to set up a MCoC.

Key steps

This section provides an overview of the key process steps to enable public maternity services to implement MCoC. The timeframe for the development and implementation of the MCoC model will vary depending on the needs of the individual services and the community. The order of these key steps will also be prioritised differently by each maternity service and will overlap. Additionally, it is important that a project plan be developed that incorporates these key steps and their timeframes.

Identify an executive sponsor

An executive sponsor is essential to enable the initial development and subsequent implementation of the MCoC model. The executive sponsor will be supportive of the model creation and have the authority and influence within their role, to promote the development and establishment of the model.

Identify a project leader

The project leader will lead and manage the day-to-day requirements of the project plan. It may be possible that a current employee of the health service will be able to undertake this position within their current role. However, it may be necessary to appoint to this position for a defined period of time. The project leader will benefit from:

- passion and enthusiasm for the project
- knowledge and understanding of MCoC models and how they work
- being an effective communicator
- previous experience in developing a project plan
- knowledge of change management
- knowledge and understanding of the clinical context including the:
 - role delineation of the service
 - physical environment of the facility
 - the community setting
 - the demographics of the population
 - the skill mix and experience of all clinical staff and
 - the professional and clinical support available.

Project plan

The project plan describes the objectives of the project, assigns tasks with deadlines, and charts progress in reaching goals and milestones. The project plan needs to include:

- description of the project
 - proposed service model
 - service objectives
 - key stakeholders and their roles
- identification of critical tasks
- assignment of tasks (although it may not be possible to assign all tasks at the beginning)
- development of a time line (a Gantt chart may be useful for this)
- accountability and reporting requirements of project lead.

Form a multidisciplinary steering group

To move the project forward it is necessary to establish a multidisciplinary steering group or working party. This process ensures effective consultation, collaboration and governance for the new service.

Key stakeholders

These include:

- those who influence the current service provision e.g. midwifery managers, service managers, hospital executive
- service providers e.g. midwives, clinical midwifery consultants (CMCs), obstetricians, general practitioners (GPs), paediatricians, child and family health nurses and other members of the multidisciplinary team
- those most affected by the proposed service change e.g. consumers
- any other stakeholders affected by the model e.g. ambulance service if a homebirth service is proposed.

Consultation with a diverse range of stakeholders, who are truly representative, will ensure all views are articulated, heard and considered. It is helpful to include stakeholders who may not be supportive of the model as unresolved issues have the potential to limit the success in the long term. Identifying complex or contentious issues from the beginning enables the solutions to be built into the model as it develops. Further stakeholders may be identified during the mapping process.

Local champions

Local champions are often already identifiable, due to their individual passion and enthusiasm. This will help to drive the project forward. It is particularly useful to find a local medical champion. Having champions from midwifery, obstetrics and/or general practice will not only broaden the focus of the meetings but will potentially promote collaboration. It is advantageous to engage these champions as members of the Steering Group as this will often reinforce the authority of decisions made.

Suggested membership of steering group

In identifying membership, it is important to ensure that key stakeholders and decision-makers are represented. The following roles are considered pivotal:

- senior managers responsible for maternity services (e.g. director of nursing/midwifery, health service manager or divisional manager)
- midwifery manager/s
- midwives
- CMC
- GPs/obstetrician
- paediatrician
- consumers

Terms of Reference

The first task of the Steering Group is to develop Terms of Reference. This will enable clarity of purpose and business rules for the group to maintain momentum and accountability. The

Steering Group should aim to meet regularly (initially at least monthly). Agendas should be forwarded to members prior to meetings and minutes and action logs circulated following meetings. This will promote effective communication and collaboration amongst the membership.

[Appendix 1](#) includes a template to develop the terms of reference.

Map the woman's journey

Process mapping is a great tool to use early in the development phase of the MCoC model and will assist in identifying every step of the woman's journey and its relationship to the service. It is also important to include the baby's journey in this process, so that clear pathways are developed and the risk of separation of mother and baby, should the baby require additional care, is minimised.

It is useful to map the current journey and then the proposed journey with the MCoC model, to define the changes needed to implement the new model of care.

Mapping can be done very effectively with a whiteboard or with post it notes on a large wall. It is a great way for people to explore the changes that will need to be undertaken and engage them in the process.

Risk assessment

[Clinical Risk Management Guidelines for the Western Australian Health System](#)⁸:

[WA Health Risk Management](#):

A risk assessment should be undertaken to:

- assess the potential risks and threats of the implementation of the new MCoC model
- identify the existing controls that are in place to minimise and/or negate these risks
- develop further strategies to minimise the identified risks and threats to the service.

[Appendix 2](#) provides guidance for the steps in undertaking a risk assessment. This is intended to be a guide only and further information and assistance is available and should be sought prior to undertaking a risk assessment.

Writing a business case

A business case is usually required for any service re-design and needs to be endorsed by the hospital and/or health service executive. The business case must clearly articulate the purpose and design of the model and how it will be resourced. The proposal must always be appropriate to the individual population and environmental context.

The use of both state and national policy can assist with supporting the drivers underpinning the proposed changes. Documents which may be referenced include: the *(2011)*;² *Improving Maternity Services: Working Together Across Western Australia(2007)*³ and the *National Guidance on Collaborative Maternity Care*.⁹ A business case template has been included in [Appendix 3](#).

It may also be helpful to consider the following points:

- Consistency and coherency between different sections are more important than fitting the plan to a set format.

- Visual appearance is important:
 - ensure the title is clear, relevant and not lengthy
 - use a legible font size
 - insert relevant headers and footers
 - ensure language is inclusive and culturally appropriate.
- Checklist
 - Is the formatting correct?
 - Is the document clear?
 - Is the issue clearly identified and defined?
 - Has the strategic direction of the area health service and WA Health?
 - Has there been wide consultation?
 - Has an appropriate implementation plan been included?
 - Have clearly defined performance measures and outcomes been identified?
 - Does the case address existing or potential access or service provision?
 - Is the proposal able to be sustained?
 - Is there a documented plan which clearly outlines who is accountable for monitoring of the effectiveness of the proposal if approved?

Operational plan

The operational plan should describe how the model will function and outline its day-to-day workings.

When writing the operational plan the following points could be considered:

- how the new model will impact on other parts of the maternity service and the broader hospital and community health services?
- how women will be recruited at commencement of the model
- which women will have access to the model
- how and when women will book into the model
- where and when the midwives will provide antenatal care
- how midwives will have access to networked hospital computer data bases
- availability of vehicles for home visits
- working arrangements for back-up, on-call and annual leave cover
- clearly defining processes for clinical handover
- identification of line management
- how the midwives will communicate with:
 - consumers
 - each other
 - line manager
 - obstetricians and/or GPs
 - paediatricians
 - other midwives in the maternity service
 - child and family health services.
- how the midwives and doctors will collaborate
- escalation processes
- management of conflict
- clear articulation of clinical responsibility/accountability for inpatient care by MCoC midwives

- how education, case and peer referral will be undertaken within the model
- how evaluation will be undertaken.

(Please note: this is not an exhaustive list). Remember these documents may be drafted simultaneously as one may inform the other. For example, identifying equipment needs in the operational plan will assist in calculating the operational costs in the business plan.

Communication strategy and publicity

The development of a communication and consultation strategy will ensure senior management; clinical staff (both within the service and external to the service) and the community are kept informed at all stages of development and implementation. It is essential to start this at the beginning of the development of the MCoC and to continue with it throughout the implementation phases of the model.

Examples of strategies to utilise in the communication plan are:

- regular dissemination of information and provision of updates at staff meetings
- use of hospital and/or health service websites
- display of posters within the hospital and in the local community, such as ultrasound departments and GP surgeries and Child and Family Health services
- distribution of flyers within the local community
- having the MCoC model added as an agenda items at key stakeholder meetings
- promotion of community discussion via local radio and newspapers
- gaining invitation to local consumer groups to discuss the model.

A few points to remember about effective communication:

- vary the methods – face to face (formal meetings as well as corridor chats) posters, information bulletins, (don't forget the back of the toilet door)
- be transparent; tell as much as possible
- try not to have secrets
- start communicating early and update people frequently
- take every opportunity to talk up the message
- don't be afraid of dissent (it will always be there) allow it to be aired, clarify issues wherever possible, challenge thinking when needed
- work with "early adopters", allowing the "late adopters" to watch on the sidelines, coming on board when they are ready. However, don't forget to keep them in the loop with regular updates
- be clear about the message and stick to it (over and over and over and) e.g. "Midwifery continuity of carer models are about access and choice for women. Women want this model and so do lots of midwives"
- try not to respond in haste, "think twice, speak once" is a useful adage
- don't assume people understand what is being talked about – the message needs to be reconfigured for different audiences
- take the necessary time with people to talk through the issues; some will need more time than others, it's worth the investment.

Recruitment

[WA Public Sector Standards in Human Resource Management](#)¹⁰

A key step to the development of the MCoC model is recruitment and long-term retention of the midwives. When developing the implementation plan timeline, recruitment of the midwives needs to be included. The amount of time to enable successful recruitment must be taken into consideration early in the implementation phase. Good recruitment processes underpin a strong workforce. Specific time dependent factors are:

- Drafting a thoughtful, well written position description is the first step to successful recruitment.
 - Clearly describe the work to be undertaken by the midwives, the expected scope of practice as well as the expectations and obligations of both the service and the midwife. This process will assist in determining the essential criteria and interview questions.
 - Define the essential criteria needed by midwives to work in the MCoC model.
 - What are the expectations of ongoing Continuing Professional Development for the MCoC model? For example continuing professional development is a requirement of all midwives and is included in every position description. However, midwives working in a stand-alone or publicly-funded homebirth model may be required to undertake additional obstetric emergency support training.
 - A willingness to work in a team and good communication skills are essential for all midwives, but a keen and detailed understanding of this would be expected from midwives applying to work in a midwifery group practice.
- Executive approval of job description.
- Management of applications.
- Short listing and interviewing of applicants.
- Appointment of successful applicants:
 - orientation
 - provision of any specific additional education if required, e.g. perineal suturing or cannulation skills.

As with any employment in WA Health, recruitment of midwives to a MCoC model is undertaken in accordance with WA Health recruitment policy.

It may be considered that only experienced midwives are suitably skilled to work in MCoC models. However, less experienced midwives should be considered equally for recruitment into continuity models recognising that they may need additional support as they transition into this model of care - an important strategy for succession planning. The support can be provided internally from other midwives in the model, as well as externally from other staff in the maternity service, and should be individualised, planned and documented. These needs can be identified through the recruitment process, so that both the service and the midwife clearly understand their expectations and responsibilities at the commencement of employment.

Managing long-term sick leave, maternity leave and long service leave can be challenging in this kind of model. It's a good idea to think about how this will be managed when the model is being designed and the issue of sustainable staffing is being considered. For example, some midwives may like to move in and out of the model over set periods (perhaps 6 – 12 months). Facilitating this kind of rotation will ensure the model can continue to be adequately staffed at short notice. An acknowledgement by the maternity service at the outset that creative solutions are sometimes required at short notice will facilitate a smoother transition when it is needed.

Education and professional development



An important factor in regard to sustainability of the model is education and professional development.

The midwives who are to work in the MCoC model are required to be competent and skilled across the continuum of pregnancy, labour and birth and postnatal care. If the maternity service has relied on midwives being skilled in one aspect of care, such as labour and birth or postnatal care it will be important to support their attainment of the appropriate knowledge and skills to care for women and babies from antenatal booking to postnatal discharge (in hospital or at home).

Many different avenues of education and professional development support are readily accessible at an area health service level, which may also have links to other WA Health resources. Additional resources are available through national organisations such as the [Nursing & Midwifery Board of Australia](#)¹¹ (NMBA) and the [Australian College of Midwives](#) (ACM), and the [Statewide Obstetric Support Unit](#) (SOSU) with additional education being available via the [Women and Newborn Health Service education hub](#)¹²

NMBA resources include:

- [National Competency Standards for the Midwife](#)
- [Codes of Ethics and Professional Conduct](#)
- [A midwife's guide to professional boundaries](#)
- [National framework for the development of decision-making tools for nursing and midwifery practice](#)
- [Registration standards e.g. Recency of practice](#)

ACM resources include:

- [Midwifery Practice Review](#)
- [MidPlus](#)
- [National Midwifery Guidelines for Consultation and Referral 2013](#)
- [Professional development workshops and on-line resources](#)

Peer review

Midwives who work in MCoC models will need midwifery and obstetric peer review to support their clinical practice and to enable them to be reflective practitioners. Often maternity services provide meetings that provide this support for obstetric staff and managers, but not for the midwives. It is important the midwives either become involved in the current peer referral

forums, or they are supported to undertake their own with support from their manager and an obstetrician.

Additional professional development for MCoC midwives

Additional education and training may be beneficial for midwives working in more isolated models, e.g. stand-alone maternity services, or public homebirth models. An example of such training is the [Advanced Life Support in Obstetrics](#) course which is a theoretical and practical course designed to assist health professionals develop and maintain the knowledge and practical skills to manage emergencies that may arise in maternity care. This course is facilitated by a not-for-profit organisation and a cost is associated with registration and the provision of the manual.

Similar courses are available such as In-Time, Rural Health West Obstetric workshops, K2 Fetal Surveillance, Waterbirth competency.

Model sustainability

One of the key factors in the success of any model is sustainability. When designing the model, it's essential to be mindful of strategies to promote and enhance sustainability. The following sections may assist.

Clinical supervision

Clinical supervision is a “support mechanism for practicing professionals within which they can share clinical, organisational, developmental and emotional experiences with another professional in a secure confidential environment in order to enhance knowledge and skills.”¹³

Professional supervision originated in the mental health environment. It's a formal arrangement for professionals to work regularly with someone who is experienced in counselling and supervision. It is a process to maintain adequate standards of professionalism and a method of consultancy to widen the horizons of an experienced practitioner. It provides a means of passing on skills, attitudes and knowledge to newer members of a profession. It ensures that clients receive adequate support whilst a trainee is training.

Include as strategy and evidence

Midwives working in a MCoC model are an identified priority group for clinical supervision as part of their work is to perform the psycho-social screening for women booking to the model.

There are specific aspects of working in MCoC models that can increase stress and tension in a midwife's work life and where clinical supervision can become a proactive strategy for sustainability within the model. These aspects include on-call working hours, being a highly visible group within the greater team and the relationship development with the women which can create anxiety, tensions, possible co-dependence or possible strained relations if the relationship is difficult. The relationship can also create anxiety when there is an adverse outcome and the group and the woman share the circumstances

Clinical supervision should be an integral component of MCoC models and has been demonstrated to have positive results as a reflective approach to practice, as a recruitment and retention strategy and as a means to enhanced quality of clinical care through increased awareness and empathy amongst clinicians.

Supervision should be available on a regular basis. It can be very effective in a group arrangement for the midwives working together through issues and should be facilitated by someone formally trained who is not a line manager to the midwives. Supervision should also be conducted in a space that ensures privacy and all participants need to be reassured of the confidentiality of information shared to enable free and open disclosure.

Succession planning

Succession planning is essential to the sustainability of any MCoC model. The best strategy to achieve this is by providing experiences for student and novice midwives to practice within MCoC models in a supported environment. MCoC models provide the perfect learning environment for all midwifery students.

For Bachelor of Midwifery students, their supernumerary status facilitates their placement within MCoC models for a portion of the clinical component. Challenges exist in providing adequate opportunities for the students being educated through postgraduate programs. Flexibility is the key to ensuring that they have the opportunity to experience continuity of care firsthand. The MCoC models provide a perfect vehicle through which undergraduate; graduate diploma and masters (pre-registration) students can recruit their follow-through experiences.

For the novice midwife the opportunity to work within a MCoC model in the transition to practice period has many benefits. It allows the novice midwife to integrate and embed the acquired knowledge and skills into her practice in a holistic way, whilst being supported by experienced midwives.

Regular meetings

A significant difference for midwives who work in MCoC models to current mainstream practices is that they are often working in isolation due to their irregular work patterns. This is due to the ad-hoc nature of the job and that often only two midwives will be working together in a MGP of eight midwives on any given day. Isolation can stem from MCoC peers and other colleagues in the hospital or community. The importance of regular meetings is therefore paramount to ensure that they maintain links with each other and the organisation as a whole. Weekly meetings are the most effective and need to be included in the midwives' roster. The meetings need to have a clear management structure and include an agenda and minute taking.

Regular MGP meetings can provide the midwives with a forum to:

- meet with their manager for general service updates
- management of any issues (including conflict resolution)
- provide each other with peer support
- manage the day-to-day workings of the model
- organise back-up and annual leave
- intake and allocation of referrals
- discussion of care plans for women with identified risks
- undertake mandatory education sessions
- provide opportunity for clinical supervision.

Evaluation

Evaluation of the MCoC model is an essential aspect of the implementation and the ongoing sustainability of the model. Without evaluation it is impossible to assess if the model has been successful and is meeting the stated aims and objectives. It is also important to include the midwives in this process. It will enable them to take ownership of the model and understand firsthand how well the model is performing. The weekly meetings are a great time to discuss the evaluation methods and coordinate responsibilities for these ongoing evaluation requirements.

The design of the evaluation will be guided by the outcomes defined in the project plan and/or business case. Most services focus on four areas for their evaluation: the clinical outcomes of mother and baby, the woman's satisfaction with the model, the midwives satisfaction and the financial outcomes of the model.

Clinical outcomes for mother and baby can be collected, for the most part, through the Stork database. Outcomes could include:

Mother

- gravida and parity
- gestation at booking
- antenatal complications/admissions
- onset of labour
- mode of birth
- immersion in water for labour and/or birth
- intrapartum complications
- pain relief used
- perineal trauma
- blood loss
- postnatal complications
- Vaginal Birth After Caesarian (VBAC) success rates
- satisfaction with care

Women's satisfaction with the model can be ascertained via a postnatal survey or questionnaire. It may be useful to record numbers of letters and cards of thanks as well as tracking any complaints.

Baby

- Apgar scores
- birth weight
- gestation
- admission to nursery or Neonatal Intensive Care Unit (NICU)
- breastfeeding on discharge

Outcomes not available via Stork include:

- continuity of antenatal care (number of midwives seen)
- primary midwife during labour
- primary midwife at birth
- support midwife at birth

- number of women receiving postnatal care at home up to 2-4 weeks
- Clinical Incident Management System (CIMS) data to track any incidents.

Midwives' satisfaction

Midwives' satisfaction with the model can be ascertained in a variety of ways. Formal methods of determining satisfaction are by tracking retention rates, recruitment into the model, sick leave, questionnaires and feedback gained in annual performance appraisals. Informal methods include meeting with the midwives regularly to discuss their day-to-day issues working in a MCoC model. This relationship with the midwives enables the manager to monitor any changes in morale and issues which may need an urgent response.

Financial outcomes

- length of stay
- readmission
- decreased intervention rates.

Existing midwifery continuity of carer models

A list of the operational MCoC models is provided below and is current at time of publication. Please note that there are many other models under development.

- Community Midwifery Program (CMP)
- Broome Hospital
- Bunbury Hospital
- Armadale Hospital
- King Edward Memorial Hospital

The following services also have a publicly-funded homebirth service:

- CMP
- Bunbury Hospital

References

1. Homer CSE, Brodie P, Leap N, (Eds). Midwifery continuity of care: a practical guide. Sydney: Churchill Livingstone/Elsevier; 2008.
2. Australian Health Ministers' Conference. National Maternity Services Plan (online). Canberra, ACT: Commonwealth of Australia; 2011 (cited September 2015). Available from:
<http://www.health.gov.au/internet/main/publishing.nsf/Content/maternityservicesplan>.
3. Western Australian Department of Health. Improving maternity services: working together across Western Australia. Perth: Health Policy and Clinical Reform; 2007.
4. Hatem M, Sandall J, Devane D, Soltani H, Gates SM. Midwife-led versus other models of care for childbearing women (Review). Cochrane Database of Systematic Reviews 2008(4).
5. Kirkham MJ. The midwife-mother relationship. London: Macmillan Press Ltd; 2000.
6. Sullivan K, Lock L, Homer CSE. Factors that contribute to midwives staying in midwifery: A study in one area health service in New South Wales, Australia. Midwifery 2011;27(3):331-5.
7. Leap N, Dahlen H, Brodie P, Tracy S, Thorpe J. Relationships-the glue that holds it together: midwifery continuity of care and sustainability. In: Davis I, Daellenbach R, Kensington K, editors. Sustainability, Midwifery and Birth. New York: Routledge; 2011.
8. Western Australian Department of Health. Clinical Risk Management Guidelines for the Western Australian Health System Information Series No. 8. Perth: Western Australian Department of Health.
9. National Health and Medical Research Council. National Guidance on Collaborative Maternity Care. (online) 2010 (cited September 2015). Available from:
www.nhmrc.gov.au/files_nhmrc/publications/attachments/CP124.pdf.
10. Government of Western Australia. Public Sector Standards in Human Resource Management. Perth: Government of Western Australia; 2011.
11. Nursing and Midwifery Board of Australia. Regulating Australia's nurses and midwives (online); 2015 (cited September 2015). Available from:
<http://www.nursingmidwiferyboard.gov.au/>.
12. Western Australian Department of Health. Department of Nursing and Midwifery Education and Research (DNAMER) (online) (cited September 2015). Available from:
<http://www.kemh.health.wa.gov.au/services/dnamer/>.
13. Lyth G. Clinical supervision: a concept analysis. Journal of Advanced Nursing 2000;31(3):722-9.
14. Australian College of Midwives. National midwifery guidelines for consultation and referral. Canberra: Australian College of Midwives; 2013.

Web links

Page:

- 3 National Midwifery Guidelines for Consultation and Referral (2013)
<http://issuu.com/austcollegemidwives/docs/guidelines2013/1>
- 12 Clinical Risk Management Guidelines for the Western Australian Health System
http://ww2.health.wa.gov.au/~/_/media/Files/Corporate/general%20documents/Quality/PDF/Clinical_risk_man_guidelines_wa.ashx
- 12 WA Health Risk Management
http://ww2.health.wa.gov.au/Articles/A_E/Clinical-risk-management
- 15 WA Public Sector Standards in Human Resource Management
<https://publicsector.wa.gov.au/publications-resources/instructions-standards-and-circulars/public-sector-standards-human-resource-management>
- 16 Nursing & Midwifery Board of Australia
<http://www.nursingmidwiferyboard.gov.au/>
- 16 Australian College of Midwives
<http://www.midwives.org.au/scripts/cgiip.exe/WService=MIDW/ccms.r>
- 16 Statewide Obstetric Support Unit
<http://www.kemh.health.wa.gov.au/services/SOSU/>
- 16 Women and Newborn Health Service education hub
<http://www.kemh.health.wa.gov.au/services/dnamer/>
- 16 National Competency Standards for the Midwife
<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>
- 16 Codes of Ethics and Professional Conduct
<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>
- 16 A midwife's guide to professional boundaries
<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>
- 16 National framework for the development of decision-making tools for nursing and midwifery practice
<http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Frameworks.aspx>
- 16 Registration standards e.g. Recency of practice
<https://www.ahpra.gov.au/Registration/Registration-Standards/Recency-of-practice.aspx>
- 16 Midwifery Practice Review
<http://www.midwives.org.au/scripts/cgiip.exe/WService=MIDW/ccms.r?pageid=10040>
- 16 MidPlus
<http://www.midwives.org.au/scripts/cgiip.exe/WService=MIDW/ccms.r?PageID=10051>
- 16 National Midwifery Guidelines for Consultation and Referral 2013
<http://issuu.com/austcollegemidwives/docs/guidelines2013/1>
- 16 Professional development workshops and on-line resources
<http://www.midwives.org.au/scripts/cgiip.exe/WService=MIDW/ccms.r>
- 17 Advanced Life Support in Obstetrics
<http://www.also.net.au/>

- 28 Severity Assessment Code (SAC) matrix
<http://www.rph.wa.gov.au/~media/Files/Corporate/general%20documents/patient%20safety/PDF/WA-Health-Severity-Assessment-Codes-2015.ashx>
- 28 WA Health Mobile Telephone Policy and Guidelines
http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12813
- 44 WA Health Motor Vehicle Fleet Policy
http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=12571
- 45 Policy for Publicly Funded Home Births
http://www.health.wa.gov.au/CircularsNew/circular.cfm?Circ_ID=13045
- 46 Centering Pregnancy©
<http://centeringhealthcare.org/pages/centering-model/pregnancy-overview.php>

Appendix 1: Template for Terms of Reference

(Insert the name of the group)

Terms of Reference

Name

The group shall be known as *(insert the name of the group)*

Purpose

The purpose of the *(insert the name of the group)* is *(insert the purpose of the group)*.

Accountability

The *(insert the name of the group)* is accountable to the *(insert Chief Executive of relevant Health Service)*, WA Department of Health.

Responsibilities

The *(insert the name of the group)* will have the following responsibilities:

- *(Insert an example of the responsibility)*
- *(Insert an example of the responsibility)*
- *(Insert an example of the responsibility)*

Chair

The *(insert the name of the group)* Chair will be *(insert name of chair)*

The *(insert the name of the group)* Chair will be responsible for keeping the *(insert name of supervisory group, e.g. name of hospital management group)* informed about the *(insert the name of the group)*'s activities and progress.

Membership

The *(insert the name of the group)* will include members from some or all of the following key stakeholders:

- *(Insert the name of stakeholder)*
- *(Insert the name of stakeholder)*
- *(Insert the name of stakeholder)*

The *(insert the name of the group)* may nominate persons to temporary membership of the group when and as required. Members may nominate a proxy in their absence as long as the proxy is fully briefed on the *(insert the name of the group)* matters.

Operating procedures

7.1 Meetings

Meeting frequency is at the discretion of the *(insert the name of the group)*, but initially *(insert initial meeting frequency)*.

7.2 Quorum

50 per cent of the members constitute a quorum.

7.3 Agenda

Standing agenda items include:

- a) apologies
- b) minutes of last meeting
- c) review of action items
- d) general business

Guiding principles

The *(insert the name of the group)* will adhere to the following:

- Members of the *(insert the name of the group)* that are present as organisational representatives will present the views of their organisation and not personal views
- Members will complete agreed actions within agreed timeframes, including documentation review
- A declaration of conflict of interest is required where a member has competing professional or personal interests. In this instance the member will, on advice of the Chair, either refrain from voting/ participating in consensus decision making or retire from the room for the duration of the item
- Discussion and issues remain confidential where identified by the *(insert the name of the group)* It is each member's responsibility to canvas views and provide feedback to its constituency as appropriate and as directed by the Working Group
- Resolution of dissenting issues shall be achieved by a vote of members present and the Chair shall have the casting vote
- The *(insert the name of the group)*, through or at the direction of the Chair, is able to co-opt/ seek expert advice on an as needs basis
- The *(insert the name of the group)* is time limited and will disband on completion of its purpose.

Records

The Secretariat shall issue agendas and supporting material at least three days in advance and prepare a record of outcomes from each meeting.

The secretariat shall keep files of the following:

1. agendas, meeting records and papers circulated with these documents
2. correspondence, papers tabled at meetings and papers circulated other than with agendas.

These files are the property of the WA Department of Health and must be preserved in accordance with the *State Records Act 2000* and the *Freedom of Information Act 1992*. The *Health Services (Quality Improvement) Act 1994* may also apply to the documents.

Adoption and amendment of Terms of Reference

The Terms of Reference shall be reviewed (*insert frequency*) by the (*insert the name of the group*) if the Group continues past their defined term. Terms of Reference may also be reviewed at the request of (*insert name of other group that may ask for review*). Terms of Reference amendments shall be approved by the (*insert name of the approving group, eg name of hospital management group*).

Version control:

No.	Date	Nature of change(s)
1		
2		
3		
4		

Appendix 2: Risk assessment (AS/NZS ISO31000:2009)

How to undertake gap analysis and assess the risks associated with changes to clinical work processes in maternity services.

Risk assessment

The following guide outlines the process used to identify and assess the risks associated with changes to a clinical work process within a hospital or Health Service. This is intended to be a guide only and further information and assistance is available and should be sought prior to undertaking a risk assessment.

The risk assessment process has already been utilised by a number of facilities where service delivery change has been proposed to meet the changing needs of women, midwives and health services.

The process has proven to be valuable in not only assessing risk but also in providing a forum in which facilitated, open communication between clinicians can occur and issues raised can be constructively addressed. The process encourages collaboration of clinicians to ensure the design of new models of care is efficient and safe.

The risk assessment process allows the team to:

1. describe how the proposed changes affect existing services in relation to who does what, where, when and how.
2. assess the risks associated with those changes
3. make recommendations for systems and procedures that need to be in place to support the changes to ensure that the project is successful.

What is risk assessment?

Risk assessment is a systematic process that assists in the identification of risks to a process and prioritises risk in relation to its consequence and likelihood. A risk assessment is proactive in its approach, attempting to predict the impact of risk before it takes place.

How to conduct a risk assessment?

A risk assessment is best conducted within a team environment. This ensures there are multiple viewpoints available for consideration of the risk in its context. The team dynamic ensures participation of stakeholders, encourages open communication and ensures that workload is shared. Team members also bring different experiences of working within the same process to the risk assessment which facilitates risk identification. All of these factors encourage ownership of the process.

Establishing context

Establishing the context is often the most difficult part. The context needs to be established in order to set the boundaries of the risk assessment. In facilitating a risk assessment it is essential that you are clear on what it is that you are assessing. For example, when considering the risks associated with changing a maternity service the context is the entire process, starting with the referral of woman to a service and concluding at its end point – discharge of mother and child. Along the way there will be points where the service interacts with external agencies

– the impact of your service change on these agencies needs to be included in the risk assessment process. i.e. ambulance, tertiary facilities, Newborn Emergency Transport Service (NETS).

All of the above needs to be documented and distributed to the team prior to the first meeting. In addition you will want to provide an overview to key stakeholders such as hospital executive, clinical directors and the hospitals risk manager.

As facilitator of the process it would also be beneficial to provide the team with a list outlining the proposed changes to the service. These become the basis of the risk assessment. The best way to identify the proposed changes is to use a process map.

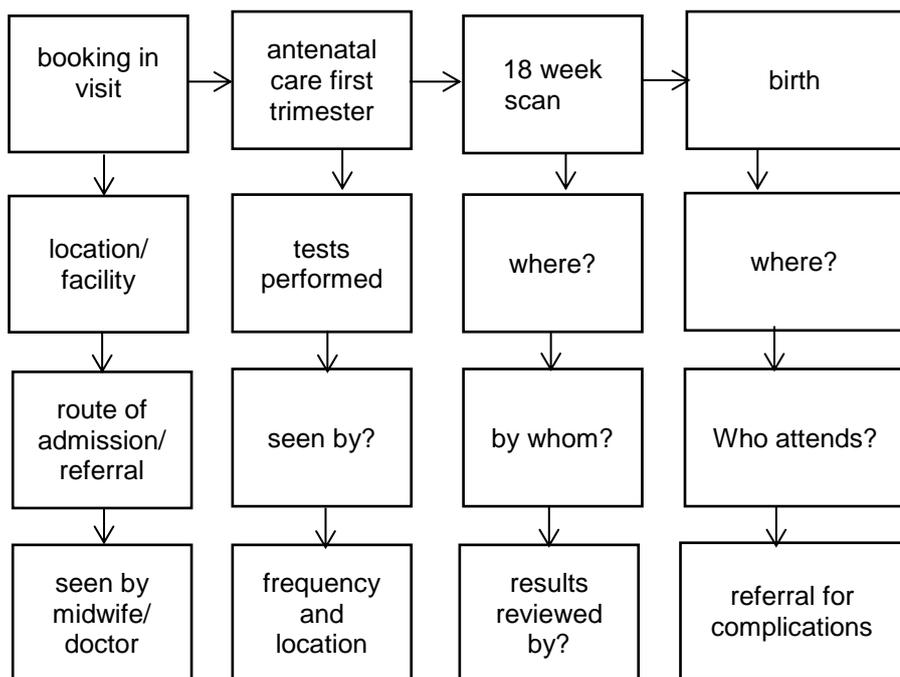
Step 1: Process map the work flow

Before you can understand the risks associated with the way a service is delivered you must first understand how the service will actually change. One method to do this is to process map the existing service (how things are currently done) and then to process map the new service (how it will change).

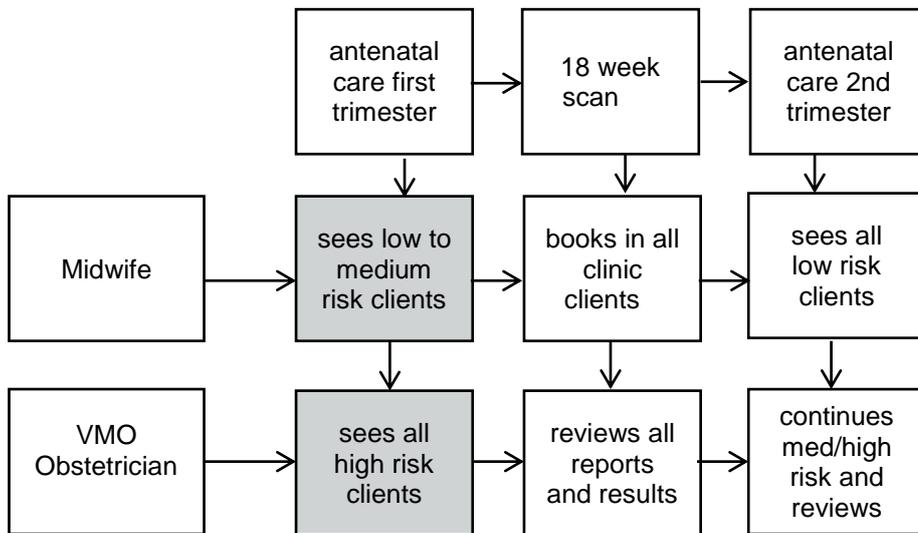
The difference between the two processes is the “gap” and it is this that will be risk assessed. The intent of the gap analysis is to identify what processes are changing and the potential impact upon service continuity and patient safety. By changing a service there is an opportunity to design out current problems in the system however, in doing so you may inadvertently design some new problems into the system. For example, in a low risk model there will be a need to consider, transfer of women who develop complications in labour to a tertiary hospital. This change will impact upon both the ambulance service and the tertiary hospital which introduces additional risk factors that may not have previously been considered.

How to construct a process map

There are many models to map work processes. Below is a simple version which looks at the macro steps and then records the sub processes or conditions of the step.



Another method is to create a two dimensional matrix that assigns responsibility for each step of the process:



You can then track and highlight the changes.

Step 2: Identifying risks

Once you have identified and documented the changes you can then begin to analyse the potential threats associated with that change.

Step 3: Risk rank the threat using the severity assessment code

Determine the maximum reasonable consequence of the threat. Then determine the likelihood of that occurring. Then use the matrix to assign the threat a risk rank. This version asks you to record consequence (C) and likelihood (L) as well as the risk (R) rank. To facilitate this you can amend the [Severity Assessment Code \(SAC\) matrix](#) to label the consequences A through to E and the likelihood 1 through to 8.

Step 4: Identify Priority risks and priority controls

1. After identifying all threats they can be sorted into priority order based on the risk rank.
2. Next list all the possible additional controls that have been assigned to high risks.
3. Use this table to create the summary of critical controls in the executive summary.

Appendix 3: Template for business case

Business case for

(insert project title)

Presented to

(insert name and position)

Presented by

(insert name, position) (insert date)

(Insert name of Health Service and/or facility)

1. Executive Summary

Include a clear and concise outline of the whole proposal, including the purpose and rationale for proceeding.

Provides a useful 'big picture' overview

Should be brief (one to two pages maximum) and include:

- short account of current position, issues / problems and the need for change
- broad scope of the proposal
- a brief outline of the method of analysis used to identify and assess options for addressing the issues / problems
- a short description of the recommended approach or solution, including expected benefits and any known drawbacks
- a cost summary.

2. Project definition problem / opportunity being addressed

Describe the current situation, outline strategic issues and give rationale (your business case could be addressing a problem that needs solving or an opportunity which has arisen).

Project objectives / outcomes

How will the proposal support the Health Service's core interests and priorities? (i.e. provide better service to clients, assist by providing better supporting systems, etc). What strategies will be employed to achieve the objectives? What training and post implementation support will be needed?

Demonstrate that discussion and consultation with affected parties has taken place. Provide views of all key stakeholders i.e. community, clients, staff etc in brief in this section – provide full information of studies, meetings held, etc in appendices.

Include SWOT analysis:

- strengths
- weaknesses
- opportunities
- threats

3. Implementation plan

- Set out the proposed timeframe and milestones.
- Set out the project management framework and other strategies. Include management plan – i.e. who is responsible and accountable for what area of the project etc, key stakeholders and their roles, training required, staffing issues, change management required, procurement strategies etc.

4. External funding arrangements (if applicable)

If part or all of the funding will be sourced from the private sector, must include an acquisition and financing plan for the project

5. Assessment of options

- List and describe options considered for addressing the problem outlined in Section 2, Project Definition.
- What will differentiate this service from alternatives (if applicable)?
- List any existing projects or services (internal or external) that can be significantly affected by this project and a contact officer for the other processes.

6. Conformity with legislation, policies and strategies

Relate the feasible options for the project back to relevant agency and government legislation, policies, standards and strategies (ie individual service plans, Asset Strategic Plan, Health Service Strategic Plan)

Consideration must be given to the changes to the work environment which will result from the model change. It is a requirement of the Work, Health and Safety (WHS) Act that staff are consulted if changes occur to their working environment including premises where staff work, systems or methods of work or the plant or substances used for work. If this applies to your business case, these issues must be addressed.

7. Financial analysis

a. Cost benefit and cost effectiveness analysis

Assess the impact and net benefits of the chosen option in comparison with other possible approaches. It may be helpful to seek input from the hospital finance department to assist with the financial aspects of the business case.

Include resources required for the project and their source including who is responsible for what and who are the beneficiaries and what staff impacts may occur. Show benefits gained as realisable (cash), quantifiable (resources) and tangible (improved quality). A financial profile should be included to cover items such as:

- staffing – salary base rates, leave, workers comp, superannuation, overtime and other on costs
- motor vehicle purchase (preferable) or lease rates and other travel costs
- equipment required e.g. computer, printer, phone/s desks, stationery & consumables, advertising, postage, uniforms / clothing
- support services costs – cleaning, maintenance and servicing, security, human resources, payroll, finance other support services

- rental / leasing of floor space (capital charging for Health Service floor space)
- fuel, light and power costs.

b. Asset purchases – leasing versus buying

Cost centre managers should undertake a cost of leasing versus outright purchase, when ordering assets of significant value to determine if the health service is getting value for money. (If applicable see attached addendum)

8. Risk analysis and risk management

Compare the risks and impacts of implementing a particular feasible option with the risks and impacts of not implementing it. What are the flow-on effects of not proceeding?

9. Critical success factors

Include a brief summary of factors, which are critical to the success of the project, and therefore of which the Health Service needs to be aware of.

10. Quality and evaluation mechanisms

- Include any quality issues or mechanisms that need to be associated with the project, also describe evaluation strategies that will apply to the project.
- Appendices (if required).
- This is the place to include any feasibility studies, details of any research, detailed economic and financial analyses, explanatory notes etc.

Appendix 4: Example of operational plan

***(Insert service name)* Maternity Service Midwifery Group Practice (MGP)**

Operational Plan

This operational plan aims to provide all staff within *(insert name of hospital or health service)* information that will assist in the understanding of the new midwifery continuity of carer model – Midwifery Group Practice (MGP) at *(insert name of hospital or health service)*. The model will offer midwifery care for women with normal risk, through the continuum of care i.e. antenatal, intrapartum and postnatal care. The model will be an additional option of care for women and will operate parallel to the existing care offered to women at *(insert name of hospital or health service)*. This plan describes the services and the implications within the health service area.

This document addresses the most commonly asked questions. Should there be any further questions, please contact *(Insert name of contact person and their contact details)*.

Overview of Midwifery Group Practice

Use this section to outline the overarching concepts of your new model. For example:

Midwifery Group Practice (MGP) is a primary health, midwifery continuity of care model that offers normal risk women an option of continuity of midwifery care. MGP midwives will be responsible for a caseload of 40 women per year based on 1.0 FTE (i.e. 4 women per month over/for 10 months with no caseload during planned leave) and part-time midwives on a pro-rata basis.

The MGP will aim to provide 24 hour continuity of clinical care across the continuum. A known midwife within the MGP will provide the majority of antenatal care and education, care during labour and birth and post-partum home support and care (for at least 14 days) to all women within their caseload.

The midwives will be rostered to 24hr on-call shifts with a second designated midwife on-call each day for back up and support. The MGP midwife will work a maximum of 12 consecutive hours (can be combination of antenatal and postnatal visits, and intrapartum care). Each MGP midwife will have a dedicated work mobile phone and an MGP woman will directly contact her midwife as needed. The midwives working within this model will be required to have a minimum of 9 designated and a maximum of 12 days off a month. Women receiving MGP care will still be able to access all other services offered to women booked at (*insert name of relevant hospital or health service*), e.g. Social Work, Diabetes Clinics. All midwives providing MGP care will continue to utilise the *Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral*¹. The ACM Guidelines describe the parameters for identifying normal risk pregnancy and supports midwives to make appropriate consultation and referral to other clinicians and allied health staff if risk factors arise in pregnancy, labour and the postnatal period. Acceptance into the model will be based on the local eligibility criteria. Midwifery care may continue even when referral to care by a secondary or tertiary level health care provider is necessary i.e. the midwife continues to provide midwifery care and support to the woman in collaboration with other health care providers.

At all times the MGP midwives will be practicing under the policy and procedure guidelines set out in the local Unit and endorsed Policies and Procedures. The systems and processes established within the unit will be utilised by all carers including the MGP midwives.

Proposed changes from current maternity service

Outline what the key changes are from your current service. For example:

- offer midwifery continuity of care model
- changed work conditions including annualised salary, flexible work arrangements, on-call
- transition from hospital to home 2 to 6 hours after birth if mother and baby well
- when risk is identified and the woman is referred to a medical practitioner the individual situation of the woman will be evaluated and documented agreement will be made about the responsibility for the provision of continuing maternity care.

Midwifery Group Practice Objectives

What are the objectives of your MGP? For example:

- To provide care and facilities that are aligned with each woman's needs to ensure the right care is delivered to women by the right health professionals in the right setting and in a timely fashion.
- To provide a philosophy of care that focuses on pregnancy, labour and birth, and postnatal as a normal life event.
- To provide a safe service with quality maternal and neonatal outcomes based on best practice.
- To promote women's satisfaction during pregnancy and childbirth by enabling their participation in decision making relating to their care.
- To provide evidence-based midwifery care.
- To provide continuity of care by a known midwife within a designated group.
- To implement an affordable and sustainable model of maternity care within the current budget.

Evaluation

You may want to add in here any specific data items as outlined in the project plan. Include details in the appendix along with copies of any questionnaires, surveys or audit tools.

There will be a process evaluation of the model including specific outcomes for the women at six months after implementation and then ongoing. Predetermined MGP Key Performance Indicators will be monitored on an annual basis and more frequently where there are identified adverse outcomes or identified concerns about outcomes or processes ([Appendix 3](#)).

Antenatal period

Booking-in

Detail here the local arrangements for co-ordination of booking appointment and how this will interact with the MGP.

Women access Maternity Services by GP referral via (*detail process steps...*)

- 1.
- 2.

Booking-in first visit

Outline booking process including any specific processes of the hospital.

Notes Referral

Outline any processes for the referral of clinical notes including the booking history.

Midwifery Triage

Detail how will women be allocated into the MGP; ideally this should be prior to the first booking appointment. For example:

An MGP allocation meeting will be conducted weekly. Women who are eligible for the model will be allocated to a midwife based on parity, and expected date of birth (EDB) month - to the MGP midwife/s that has a vacancy for the month. The allocation process should ensure an equal distribution of workload amongst the midwives. The midwife will contact the women allocated to her caseload and make a mutually agreeable booking appointment date.

The National Women Held Pregnancy Record (NWHPR) OD 00605/15 will be identified with the MGP midwife's name and work mobile telephone number. The NWHPR will also have relevant Birthing Suite and Maternity Unit contact numbers attached. Each site should determine their schedule of antenatal visits for both primipara and multipara.

Subsequent antenatal visits will be discussed by the MGP midwife with the woman. It is useful for the MGP to have a database in which they can record women accessing the model and other relevant data for audit and evaluation processes. The midwife will enter each woman's information in the MGP database (i.e. woman's name, Medicare Reference Number (MRN), parity, EDB, suburb and MGP midwife's name.) The database will be maintained by the MGP midwives and will facilitate tracking of the women and will provide data to contribute to the process evaluation of the model.

Antenatal consultation and referral (as per the National Australian College of Midwives guidelines for consultation and referral)

Outline processes for midwives to consult and refer with medical staff. For example:

When risk factors are identified and depending on the risk factor and severity (Code B or C of the *National Midwifery Guidelines for Consultation and Referral*), ongoing care with MGP will be decided on an individual basis with the woman, MGP midwife and relevant obstetric doctor. The possible outcomes would be either transfer of care to obstetrician, collaborative care or tertiary centre care. Collaborative care will be between the woman, the MGP midwife and the relevant obstetric doctor with a documented management care plan that also outlines lines of responsibility for care.

Obstetric consultation/discussion will occur between 40+7 and 40+10 weeks gestation regarding the assessment for induction of labour, management and birth.

Should the MGP woman require assessment during pregnancy outside her scheduled antenatal visit, she is to contact her MGP midwife. The MGP midwife may arrange for the woman to be assessed in the Birthing Suite (BS). The MGP midwife will usually meet the woman in the BS for assessment and the MGP midwife will organise an obstetric consultation for MGP women if medical management is required. Any antenatal care episode provided in the BS will be recorded in the woman's medical record.

Phone consultation is to be done in accordance with the local maternity services telephone consultation guidelines and the MGP midwife will document discussion on the phone call sheet. The midwife will ensure that she/he has the phone call sheet available at all times (kept in diary/home) which will be filed in the woman's notes at the earliest convenience.

There may be occasions where the MGP midwives will need to reschedule planned antenatal visits. This may be if she has worked for 12 consecutive hours or has been called in for intrapartum care. If the MGP midwife can't reschedule visits, she/he will need to contact their MGP partner/2nd on-call midwife to see the women or reschedule the women's visits.

Provision will be made to ensure the support midwife has met the other women by 37 weeks. The MGP midwife can make arrangements to facilitate the woman meeting the other MGP midwives in the group. A monthly meeting and information session is one strategy that provides an opportunity for the women to meet the other midwives in the MGP as well as meet other women and their partners who are due around the same time.

Antenatal admissions

Outline the arrangements for a woman's care should she need to be admitted antenatally. For example:

If the woman requires admission during her pregnancy the ward staff will be responsible for the provision of daily care. However, there will be ongoing communication between the ward staff and the MGP midwife to ensure the MGP midwife is informed about the woman's progress and ongoing management plan.

For women who have had an antenatal admission the discharge documentation is to include a management plan indicating handover to the ongoing lead carer, the next planned antenatal visit and future schedule of visits. If the woman on the MGP program is discharged prior to the date/time planned, the ward midwife is to contact the MGP midwife to inform her of this change. Ongoing collaborative care will be between the woman, the MGP midwife and the appropriate obstetric doctor with a clear, documented management care plan.

If the woman commences labour during her in-patient stay, the ward midwife is to contact the MGP midwife and advise her/him.

Preparation for labour and birth, and parenthood

Outline provision for antenatal education for women within the MGP. For example:

All women participating in MGP models will be able to access local health service childbirth and parenting education programs. Other external courses may be offered as appropriate.

Add usual psychosocial and Stork special child health process and Operational Directives.

Post-dates pregnancies

Detail the agreed management plan for women over 41 weeks gestation. For example:

From 41 weeks gestation, MGP women will receive collaborative care with the MGP midwives and the appropriate obstetric doctor. A clear management plan will be developed and documented. The MGP midwife is to attend to the usual care of women at this gestation.

Induction of labour for post-dates pregnancy

Detail the arrangements for care of a woman requiring a post-dates induction of labour. For example:

The MGP midwife will conduct antenatal outpatient induction of labour (IOL) assessment and consult senior medical staff for the development and documentation of a management plan. The MGP midwife will retain the midwifery carer role in consultation with the obstetric doctor/team

Cervical ripening induction of labour

The MGP midwife will conduct the pre-induction admission and final pre-induction assessment, including Cardiotocography CTG. She will perform the vaginal assessment, assist with the chosen method and post-induction CTG if required in accordance with guidelines. The MGP midwife will hand over care to the BS midwife until notified that she is in established labour. The clinical handover from MGP to the BS midwife will include a documented plan, negotiated between the midwives which outline the indications for the MGP midwife to be notified to return.

Artificial rupture of membrane syntocinon induction of labour

The MGP midwife will attend the BS for the induction assessment and the induction in collaboration with the relevant obstetric medical officer.

Elective lower segment caesarean section operation

Detail the arrangements for care of a woman requiring an elective lower segment caesarian section operation (LSCS) operation. For example:

The MGP will be available for the woman's care on the day of the LSCS operation. If the woman comes in the night before, the ward staff will be responsible for the woman's admission unless the MGP has negotiated otherwise. There is to be ongoing communication between the MGP midwife and ward staff.

Intrapartum care

Detail the process and arrangements for care of a labouring woman. For example:

When the woman commences labour the woman will contact her MGP midwife (via work phone).

Close consultation between the woman and the MGP midwife will be maintained by phone until arrangements have been made to meet in the BS. The MGP midwife will document all discussions on the phone inquiry sheet. The midwife will also inform the BS of the pending arrival time for the woman and self. The MGP midwife will conduct the woman's assessment unless her condition warrants earlier assessment by BS staff.

Should an MGP woman arrive at the hospital requiring assistance and has not contacted her MGP midwife, the BS staff are to contact the MGP midwife and inform her of the woman's presentation. If the primary MGP midwife is unavailable/not contactable the second on call midwife will be contacted.

A list of MGP midwives and work mobile and home phone numbers will be kept in the BS.

The BS and MGP midwives will work as a team assisting each other as required. Ongoing communication will occur between the MGP midwives and ward shift coordinator as indicated.

The MGP midwife can provide care for a maximum of 12 consecutive working hours after which she will hand over the lead carer role to the next midwife on-call. If birth is expected within a reasonable timeframe, the primary MGP midwife may choose to remain, in a support role only. If the primary MGP midwife has already worked most of her 12 consecutive hours when called

to attend a woman in the BS she may negotiate with the second on call to undertake care immediately. The BS will routinely provide the second midwife for hospital births.

The MGP midwife will be responsible for ensuring she/he takes meal breaks and liaises with the maternity ward shift coordinator or midwifery colleagues when assistance is required.

If the primary midwife's 12 consecutive hours is complete soon after birth and the woman requires minimal postnatal care, it is reasonable to expect the primary midwife to negotiate the postnatal care/discharge home from BS, if activity allows, rather than calling the 2nd on call midwife.

All midwives providing MGP care will continue to utilise the *Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral* in accordance with the local hospital policy/guideline.¹⁴ When a variance from normal arises during labour it is the midwife's responsibility to communicate promptly with midwifery and / or obstetric colleagues and document the management and review plan.

Postnatal care

Detail the process and arrangements for a woman's postnatal care. For example:

Discussion regarding the expected postnatal pathway begins when the woman "books in" to the MGP. The expectation is that a woman will transfer home within 2-6 hours provided her condition remains uncomplicated and her baby is well. Midwives should provide appropriate support to women at home, especially within the first 24 hours. This may include a postnatal visit on the day of birth to monitor maternal and infant well-being, allay anxiety for the woman and her family and support feeding.

Discharge planning will be undertaken by the MGP midwife with the woman. MGP postnatal home support and/or phone visiting is available for at least 14 days.

Beyond four to six hours: transfer to ward

Postnatal ward midwives will assume the lead midwife role during the MGP woman's in-patient period. However it is expected that the MGP midwife will visit and provide care whenever possible. The MGP midwife should communicate the timing of her anticipated visit to the ward as soon as it is known. The MGP midwife will seek out the woman's allocated carer when visiting/phoning the woman to discuss any outstanding support, information or care she/he can provide for the woman. When a MGP midwife visits and provides care, she will document the outcome of visit on the usual hospital records and communicate this verbally to the allocated carer.

Babies requiring admission to the Neonatal Unit will be cared for by nursery staff. The MGP midwife and nursery staff will communicate regularly regarding the baby's progress.

Transfers to a maternity services facility for higher level care

Detail processes for when a woman and/or baby requires transfer from the hospital. For example:

Maternal

If an MGP woman requires transfer to a tertiary or higher level of care, an escort, if required will be negotiated between the MGP midwife and the relevant inpatient area and will be based upon

MGP availability and workload. The tertiary referral centre will assume full responsibility for ongoing care.

Neonate

Transfer of neonates to a tertiary centre will be as per local policy. Escort if required will be negotiated between the MGP midwife and the relevant inpatient area and will be based upon MGP availability and workload.

Readmissions

Neonatal

Babies requiring readmission to the Special Care Nursery (SCN) will be cared for by nursery staff. The MGP midwife and nursery staff will communicate regularly regarding the baby's progress.

Maternal

Women requiring re-admission to the postnatal ward will be cared for by ward staff. The MGP midwife and ward staff will communicate regularly on the woman's progress.

Referral to Child Health Services

Referral to Child Health Services will be attended by MGP midwives for MGP women. This will also include where a high priority referral is required.

When discharging the woman from MGP, the MGP midwife will complete Stork and the MGP database.

Management structure

Detail the management structure that the MGP will work within. Outline reporting pathways and line management responsibilities. For example:

The MGP model promotes an autonomous approach of working for the midwives. They are responsible for the organisation of their individual workload to meet the needs of the women through the continuum. They also need to develop effective relationships within the MGP to ensure adequate communication between one another and a commitment to shared responsibility for on-call arrangements.

The MGP midwives have a reporting line through the management structure of the (insert hospital name) Maternity Service as is usual for all midwives in the Maternity Unit. The usual process of request for leave, notification of personal leave will apply. If there are professional / performance issues identified these will also be addressed by the maternity services manager in the first instance.

The maternity services manager will also be responsible for monitoring the education requirements of the midwives, the hours worked by each midwife and the mobile phone accounts.

Clinical referral

Detail the processes for formal and informal clinical referral and reflection. For example:

MGP will conduct a regular meeting every week with the expectation that all MGP midwives attend unless on annual leave, with a woman in labour or has been working on the night preceding. The meeting consists of case referral and reflection, peer referral, group meeting, allocation of women and midwives for care and an education session. The meeting/s will be supported by the maternity services manager and/or CMC as required.

Each midwife will receive a copy of the *Australian College of Midwives National Midwifery Guidelines for Consultation and Referral* for reference when allocating risk categories. Adverse outcomes are subject to the usual reporting and referral mechanisms.

Each MGP midwife will undertake her own yearly reflection on practice as part of the performance review process. As part of this process each midwife will access her own personal practice statistics through Stork and subject them to critical self-analysis.

Professional development

Detail how the midwives will access education and training and other opportunities for professional development. For example:

As per the National Registration and Accreditation Scheme each midwife will maintain their ongoing professional development requirements. All midwives are encouraged and supported to continue their professional development by developing a professional development plan based on the ACM Self-assessment tool. Midwives working in this model are encouraged to attain the Australian College of Midwives- Midwifery Practice Review- 'MPR' within 12 months of commencing in the model.

As with all midwives opportunities to attain and maintain clinical skills will be provided to ensure MGP midwives maintain competency. Essential education requirements for midwives will be as per the health service policy e.g. MGP midwives will participate in education programs as required by the organisation.

Clinical supervision

Detail opportunities for the midwives to access clinical supervision. For example:

The MGP midwives will be provided with clinical supervision for one hour every month. This will occur at one of the scheduled meetings and there will be a commitment made by each midwife to attend. A supervisor will be allocated to MGP who will provide this supervision each month.

Annualised salary

Detail how the midwives will work within the. For example:

The MGP midwives will be employed under the Midwifery Annualised Salary Agreement (MASA). In return for this salary and flexible working arrangements the midwives will provide continuity of care to 40 women / FTE / year.

Each MGP midwife will receive and sign off on a copy of the MASA.

Each MGP midwife will keep a log sheet of hours worked. While short term imbalance in hours may be anticipated, the expectation inherent in the salary agreement is that balance of hours will be maintained over the longer term. Long term imbalance in hours will be subject to referral and management by the maternity services manager

On-call

Detail the on-call arrangements for the MGP. For example:

The MGP midwife will be on 24 hour call, during their rostered 'days on', for their own caseload of women. When not on duty or on-call, the MGP midwife will divert her mobile phone to the next MGP midwife on-call for that group practice.

During 'days on', the MGP midwife will attend booking-in, antenatal and intrapartum care and postnatal visits as required for her caseload of women.

In accordance with the MASA MGP midwives will work a maximum of 12 consecutive hours. If and when it becomes clear that intrapartum care and/or pre-arranged visits are likely to exceed this 12 hour limit, the midwife will arrange hand over of intrapartum care as indicated to the MGP midwife on-call and where possible re-organise scheduled visits. Scheduled visits that cannot be rearranged for another time will be provided by the next available MGP midwife on call.

If for any reason the MGP midwife cannot be contacted on her mobile phone (for example, flat battery or switched off, non-reception area) the MGP midwife's home number can be used by staff but is not to be given to women.

Rosters

Detail arrangements and processes for the MGP roster. For example:

MGP midwives work flexible work arrangements to meet the needs of the women. Therefore, they are not rostered to shifts but provide care when required by the women. However, there will be a roster plan developed to ensure that all full time midwives are allocated to nine days off each month and there is an even distribution of midwives responsible for weekend on-call. This roster process will be developed by the MGP midwives and submitted to the maternity services manager.

A master roster will be issued including rotating weekends on roster. The roster is updated with annual and long service leave.

Annual Leave

Detail how the MGP will manage their annual leave. For example:

The MGP midwife will be required to book annual leave with the maternity services manager at least 6 months in advance. The midwife will not allocate or accept women into her caseload whose EDB falls within her approved holiday period (+ 7 days either side if taking more than 2 weeks). The midwife will need to re-distribute antenatal and postnatal visits between the other group midwives prior to commencing leave.

Should an MGP woman birth while the primary MGP is on annual leave, the partner and/or on-call MGP midwife will attend the birth and report back to the primary midwife upon her return.

Sick leave

Detail how the MGP will manage their short term and long term sick leave. For example:

Short term

In the event of short term illness the MGP midwife may where possible re-schedule her appointments and visits and arrange phone diversion to on-call MGP midwife to provide cover for intrapartum care. A sick leave form is only required where any part of the unwell midwife's workload is undertaken by another.

Long term

The usual arrangements for formalising long term sick leave will apply. Care for the caseload of women affected by their primary midwife's leave will be re-distributed amongst the remaining group midwives. Re-distribution needs to consider each midwife's current caseload to minimise risk of excessive work load.

If necessary and where it does not compromise safe staffing in the maternity unit, it may be possible to allocate suitably skilled midwives to provide interim leave relief. If this is not possible the women may need to be re-allocated to standard care. The decision needs to be based on reasonable workload for midwives and safety for women. This process will be coordinated by the maternity services manager.

Midwifery group practice office telephone number

Detail arrangements for MGP office space, IT and telephone. For example:

MGP will be provided with office space (desk/computer/phone) at *(insert name of location)*. The office contact number for MGP will be *(insert phone number)*; and the message bank on this phone will be cleared by MGP daily.

Voicemail will advise the caller that no urgent matters are to be left on this line and advise of alternate number provided.

Clinic rooms

Detail arrangements for where the midwives can carry out antenatal clinics, antenatal education and any other clinical care. For example:

MGP will utilise clinic rooms in the antenatal clinic or established outreach clinics in the community.

Home visiting

Detail arrangements for antenatal, early labour and postnatal home visiting. For example:

Home visiting will be undertaken using the area health service guidelines, including completion of a home visit risk assessment prior to the first home visit.

Include for homebirth, that each midwife should attend the woman's house at least once antenatally to familiarise herself with the location and also the set-up space within the house for homebirth equipment.

Consider how to record home births and home visits as patient activity.

Mobile phones

Detail arrangements for the midwives to have access to mobile telephones. For example:

Each MGP midwife will be provided with a work mobile phone for direct communication between the midwife and the women and between the midwife and the hospital. The work mobile phone will be with the MGP midwives at all times when on-call. The MGP midwife will need to comply with the area health services guideline for [WA Health Mobile Telephone Policy and Guidelines](#). Midwives residing in areas without mobile reception will need to divert the mobile phone to their home number for the necessary period of time. The midwives will also be responsible for ensuring that each woman has an alternate number to contact and this would usually be the (insert appropriate contact number, e.g. the name of the hospital and birth unit) number.

Motor vehicles

Detail the arrangements and processes for midwives to either access hospital pool/fleet cars or use their own. For example:

As the MGP midwives will be continuing the care in the community after discharge from hospital there will be considerations for vehicle use. The MGP midwife will use the cars allocated to maternity when available or an alternate hospital fleet car. Where neither of these options are possible or practicable the MGP midwife will use his/her own car.

All work use of the midwife's private car will be recorded in the area health service approved log book with reasons for using own car. All personal car usage documented on the log book will be signed off monthly by the maternity services manager and reimbursed according to business rates as per [WA Health Motor Vehicle Fleet Policy](#). The MGP midwife will need to demonstrate the comprehensive insurance status of her/his private vehicle and a valid driver's licence.

Medical records

Detail the type of medical record that the midwives will use, for example woman held records, electronic records, hospital medical record etc. Outline processes for filing, handling and storage of information.

Equipment

Detail the equipment that the midwives will be provided and where they can access stock for example blood bottles, needles, syringes and paper. This may include but not be limited to: hand held fetal dopplers, sphygmomanometers, stethoscopes, O2 cylinders and neonatal resuscitation equipment. For example:

The MGP will be provided with, or have available, all the required equipment to ensure that antenatal care can be provided in community locations and postnatal care in the home. It is anticipated that the MGP will require some additional equipment to achieve this.

MGP will be provided with a standardised "kit" with all equipment required for community based postnatal care. As most of the equipment is the same as current stock items used within the unit this should be a cost neutral exercise. Additional equipment such as portable baby weighing scales and kit bags will be required. The MGP midwives will be responsible for the maintenance and restocking of this equipment.

All MGP midwives will be issued with a diary to facilitate management of antenatal appointments and postnatal care visits.

MGP midwives will use all the usual stationery/stock items that are available in the Maternity Unit.

Homebirth equipment is as per *WA Health* [Policy for Publicly Funded Home Births](#)

Commonly asked questions

Q: What will I do if the woman is in labour and the MGP midwife is not in the birth suite?

A: The core midwives can provide the care the woman requires immediately and make efforts to contact the MGP midwife or second on call. We all have a duty of care to the women in our care and therefore cannot put them at risk by not providing the care required.

Q: Will I need to assist the MGP in the birth suite?

A: Yes, as the MGP midwives will also assist the core midwives. Both groups will provide assistance as in receiving the baby at birth, assisting for meal breaks, emergency assistance etc.

Q: Who cleans up after the birth?

A: The midwife caring for the woman cleans up after the birth where possible. Remembering that we are working in a team and we can all offer assistance where possible with whatever possible. If the MGP midwife has just completed 12 hrs the core midwife may offer to assist with cleaning, likewise the MGP midwife may offer to assist with cleaning and other care to facilitate the core midwives workload.

Q: Who does the postnatal check?

A: MGP midwives will provide immediate postnatal care in Birth Suite. Ward midwives will assume the lead midwife role during the MGP woman's in-patient period. The MGP midwife will seek out the woman's allocated carer when visiting the woman to discuss any outstanding support, or care she can provide for the woman. This may sometimes include the postnatal check. The MGP midwife will document the outcome of visit and any care attended and will communicate this verbally to the woman's allocated carer before leaving the ward.

Q: Will the MGP midwives be using the usual stationery and forms?

A: Yes, the MGP midwives will use all the usual stationery, forms; adhere to the same protocols, policies and guidelines that the rest of the unit use.

Q: What if an MGP woman phones the birth suite in the middle of the night, and can't get on to her midwife?

A: Check whether it is an emergency situation. If it is, respond as per protocol. If it is not an emergency the birth suite will attempt to contact the MGP midwife on her mobile and her home landline number. If unsuccessful the birth suite will take the woman's phone number and reassure her that a second midwife will shortly make contact. The second MGP midwife on call is to be contacted and will make early contact with the woman.

Q: What if the woman telephones in the middle of the night during the pregnancy complaining of pregnancy related issue. Do I call the MGP midwife?

A: If the issue can be addressed over the phone and the woman does not require assessment the core midwife can deal with it over the phone. If during the discussion you decide the woman

requires assessment in the birth suite during the night the MGP midwife should then be contacted. If the assessment can wait until the morning a call could be made to the MGP midwife in the morning advising her of the woman's needs.

Q: If a woman telephones in the middle of the night with a breastfeeding issue should I call her MGP midwife?

A: In this case it is appropriate that the core midwife addresses the issues that the woman has over the phone.

Q: Can a MGP midwife choose to practice differently to the core midwives?

A: The MGP midwives will be working in a different manner in that the organisation of their hours and their activities will be different. However, they will work under the same protocols, guidelines and policies of the service.

Q: What do I do if I have concerns about clinical care or any issues with MGP?

A: If you have any concerns with the model or the clinical practice/ care of the MGP midwives you can discuss this with the individual concerned, or if you prefer you can speak to the Midwifery Manager of the unit. It is important to remember that the MGP midwives are still part of the team and the process that you would normally follow in such matters will still be the same. As this is a very new way for most of us to work we do invite open discussion and constructive feedback.

Q: In some models there has been an "us and them" attitude. Will this happen here?

A: In developing the MGP model, this possibility was taken into account. It is important to always remember that we are working as a team to provide care for the women and babies in our care regardless of where we work.

Q: Can any of us be MGP midwives?

A: Yes. Interested midwives will be provided with clinical support to obtain necessary skills should vacancies occur. There may be some consideration of rotation to MGP once the model is well established.

Q: What about burnout for MGP midwives?

A: Some midwives working in similar models have experienced burnout. In developing the MGP model, the midwives have been encouraged to be mindful of caring for themselves, and are required to preserve their rostered days off. The hours worked and the workload of the MGP midwives will be frequently assessed and strategies provided to minimise the possibility of burnout. The MGP midwives will be provided with clinical supervision for one hour every month.

Q: Will the [Centering Pregnancy](#)© model continue to be offered? (if applicable)

A: Yes. The CenteringPregnancy© model will continue to be offered to appropriate women at the time of booking in. Group antenatal care may also be possible within the MGP model.



This document can be made available in alternative formats on request for a person with a disability.

© Department of Health 2016

Copyright to this material is vested in the State of Western Australia unless otherwise indicated. Apart from any fair dealing for the purposes of private study, research, criticism or review, as permitted under the provisions of the *Copyright Act 1968*, no part may be reproduced or re-used for any purposes whatsoever without written permission of the State of Western Australia.