Select Committee on Birth Trauma

Hearing – 7/09/2023

Questions on Notice

QUESTION 1 – Page 39

Dr AMANDA COHN: My follow-up question, which is either to yourself or perhaps to Dr Woods, is regarding the high-risk clinic for pregnancies that have been identified as high risk. We have heard from a number of people this morning about the trauma caused by seeing different people at every appointment, and it's been well argued that high-risk pregnancies probably would benefit the most from continuity of care. I am interested in the rationale behind the high-risk clinic being staffed in such a way that people see a different obstetrician or obstetric registrar every appointment and the barriers to someone seeing the same doctor throughout a high-risk pregnancy.

ANDREW WOODS: I can take that. Thank you for the question. I think first and foremost it's important to ensure that any model of care is woman centred, acknowledging the importance of midwifery-led care, midwifery models of care and the benefits that that has been shown to give women in pregnancy. From a risk perspective, I think we also need to acknowledge the importance of collaborative care models where the skills and expertise of different craft groups are valued, and that women have exposure to both midwifery, medical and allied health care as part of high-risk care and that that care also adopts a continuity model where there is, where possible—and I'm sure we can achieve this—a named obstetrician who a woman gets to know during the course of her pregnancy and supports the information she's provided, the choices she's supported to make and the care delivered through pregnancy, birth and afterwards.

Dr AMANDA COHN: Further to that, what are the barriers currently to being able to provide that? We've heard from a number of people today that it's not the case that there is currently continuity in this area. What are the barriers that we need to be addressing?

MARGOT MAINS: I think I need to answer that. I think that's something we need to take away from having listened, and actually explore locally what we can actually do to reflect what women are saying about seeing a number of obstetricians. I'd like to take that away, and we will be looking at it within the organisation.

ANSWER

The District has heard the concerns about how care is managed for women accessing the High Risk Antenatal Clinic and is considering how continuity of care can be improved. This includes reviewing rostering practices and the allocation of women to a lead obstetrician for coordination of care. This may entail each high risk woman being allocated an obstetrician to coordinate their care. This obstetrician would be consulted if any change in care is proposed by another practitioner.

QUESTION 2 – Page 40

The CHAIR: I've also got a follow-up question about high-risk women not going into the MGP model. I understand you're working towards changing that, but I'm just wondering, going back, what was the decision? Looking through a lot of these submissions, it suggested that the research said that high-risk people giving birth are the ones that are most likely to benefit from something like this. I'm wondering why the decision was made to focus on women who weren't identified as high risk?

MARGOT MAINS: The model was developed some time ago, and I might need to take that on notice to go back to the previous decision.

ANSWER

Goal 6, objective 6.1 of the NSW Health Connecting, listening and responding: A Blueprint for Action - Maternity Care in NSW outlines a range of continuity of care models for maternity care, including that all risk midwifery models and culturally safe continuity of care models for Aboriginal women, are available. The Blueprint, published in March 2023, aims to ensure all women in NSW receive respectful, evidence-based and equitable maternity care that improves experiences and health and wellbeing outcomes. It replaces NSW Health Policy Directive *Towards Normal Birth in NSW* (PD2010_045*).*

QUESTION 3 – page 40-41

MARIA FLYNN: I can probably answer a little bit. The full-time equivalent midwives you need to manage a case load—you need more midwives to manage a more complex case load. If we started with the women—and there's lots of moves away from calling them high risk; it's women with additional care needs, or babies with additional care needs—it requires a bigger full-time equivalent. If we focused on the high risk—albeit that would be wonderful to do—it means that we wouldn't have it for the women that actually don't need to see an obstetrician probably at all. Again, on a balance of risk, it's where you can provide most of that service. The MAPS model and continuity-of-care model can be provided in slightly different ways. We are looking at a long-term vision of providing support to medium-risk or medium-care-needs women. It requires a slightly different FTE, so as we start to gain those numbers of FTE then we will be looking at that model.

With regard to the issue around trying to encourage midwives to do it—as I said, it is the most fantastic job from a scope of practice point of view and the relationship that you build with mums and partners. We do offer flexible working, and some of those models and some of those full-time equivalents will be offered in pairs or teams, because it is a big commitment for one midwife to be on call over all of that period of time. As we work through the re-establishment of the workforce, the models we take on will be taken on based upon a risk and safety based approach for where we need to do it. That will be our endeavour, but the start has to be with the women with the reduced care needs, being the women who probably only need to see a midwife.

The CHAIR: If you could take that question on notice—just for some more detail. This might be one to take on notice as well, but you mentioned the balance of risk that was considered. Could we get a bit more information about that? From an outsider, it sounds like it would be better to focus on the high-risk women, even if that means less women go through the program in those early stages, because they're the ones with the greater risk of birth trauma and greater risk of complications. It sounds like they would benefit more than women who are potentially low risk. If you could give me a bit more information on the decision-making around that, and where the balance of risk was given to the larger group of women that could be covered by the program but who had a lower risk of complications, that would be really useful.

ANSWER

The NSW Ministry of Health developed the Continuity of Care Models: A Midwifery Toolkit (the toolkit). The toolkit assists midwifery leaders at the local level, to implement models of care that meet the local consumer needs, whilst considering local service delivery capacity and capability.

The Wollongong Hospital Midwifery Group Practice (MGP) adopted a low-risk category model when it was established in 2004. This has recently expanded to include women having a next birth after caesarean (NBAC), with each MGP midwife allocated one space per month to take an NBAC woman. Women with gestational diabetes who require less than 30 international units of insulin are also now able to access MGP.

The District is reviewing the MGP model to explore options for women in higher risk categories to access the service. This includes considerations around additional staffing requirements. Initially, this work will focus on enabling women who develop risks to stay on MGP, which will maintain continuity of care for women who become medium or high risk.

QUESTION 4– Page 41

ANDREW WOODS: May I make two comments? In relation to the high-risk continuity-of-care models, I am aware of successful and sustainable models within New South Wales, and I am happy to work with the district to understand the barriers and challenges to introducing those and what's made them sustainable. Also, in answer to your question regarding endorsed midwives and access agreements, if you'd like me to take that on notice, I'm happy to provide more information to the Committee.

The CHAIR: Yes, please.

ANSWER

Since 2015, NSW Health has had a policy directive that enables privately practicing endorsed midwives to gain access agreements with NSW public hospitals. This policy was revised and updated to the current Private Midwifery Practice policy (PD2022_018), released in June 2022. This is an active policy that supports local health districts to enable private endorsed midwives to accompany the women they are caring for when labouring and birthing in NSW hospitals.

QUESTION 5 – Page 41

Dr AMANDA COHN: You have offered to provide the successful continuity models to the local health district. Could those also be provided to us on notice?

ANDREW WOODS: Of course. Forgive me for being too local. I am happy to provide that to the Committee too.

ANSWER

Continuity of care is provided through many maternity models of care, one of which is midwifery group practice. Continuity of care models reflect local contexts and may vary in structure across local health districts, depending on geographic distances and availability of clinical staff. Sustainability of the model of care must be considered.

Examples of continuity of care models within Hunter New England Local Health District are below:

The 'Family Care' Model is a multidisciplinary model involving midwifery, medical and allied health (specifically social workers). It provides antenatal and postnatal continuity for vulnerable women with mental health, alcohol and other drug challenges, and social disadvantages. Women have a named midwife, social worker and medical officer providing most of their care as part of this model.

The 'Birra-Li' model is a multidisciplinary Aboriginal Maternal and Infant Health Service (AMIHS) model providing antenatal and postnatal continuity. This model involves midwifery, Aboriginal health practitioners/workers, medical and other staff for Aboriginal women and women whose babies will identify as Aboriginal. Women have named clinicians providing most of their care.

The high-risk antenatal clinic model has dedicated midwifery and named obstetrician input to all clinics. It has 2 multidisciplinary focussed visits, one at 16 weeks to go through the model of care, and the other at 36 weeks to discuss birth planning visits. This aims to optimise information sharing and education to support informed choice and decision making for women.

The M3 Team model is a full midwifery team-based continuity of care model, providing antenatal, intrapartum and postnatal care 24 hours, 7 days a week, and collaboration with a named obstetrician throughout antenatal and postnatal periods. This model was introduced in 2009. It has midwives coming through with an active mentorship program from within existing team members, including the high-risk clinical midwifery consultant. This model cares for approximately 24 women per month, with 6.5 full time equivalent (FTE). Most individual clinicians work full time, however part-time hours can be supported with 0.7FTE preferred.

The team run an on-call roster for continuous individual availability, improving staff sustainability. Due to the complex nature of the care provided, rotation of staff into another model after 3-4 years

is needed. This model also benefits midwifery career progression as it provides midwives an opportunity to move into senior midwifery positions and leadership succession planning.

Aboriginal maternal infant health service (AMIHS) programs are accessible for all Aboriginal and Torres Strait Islander families. The service provides individualised culturally appropriate support and education during pregnancy, after birth up to 6- 8 weeks postnatally.

In the rural and regional areas, where the barriers are more significant and a locum medical workforce is relied on to support a depleted midwifery workforce, a High Risk Maternal Foetal Medicine Outreach Clinic provides monthly fly-in-fly-out consultancy for high risk women in Moree and Narrabri.

QUESTION 6 – Page 41

The CHAIR: I have another question about a report that was mentioned when we were speaking with Better Births Illawarra. I believe that report is not public. Is there a reason that report is confidential?

MARGOT MAINS: Sorry, I was unaware that the report wasn't public, so I'll take that on notice.

The CHAIR: Can you table that report to the Committee?

MARGOT MAINS: Yes.

ANSWER

The *Final Report on the Wollongong Midwifery Group Practice: Recommendations for Expansion, April 2019* was not provided as a public document as it contains information and comments about identifiable individual members of staff. The Final Report outlines 8 recommendations, which the District previously provided to Better Births Illawarra.

The Final Report is attached, with redactions to comments made about identifiable individual staff members.

Attachment:

- Q6 TAB A - Final Report on the Wollongong Midwifery Group Practice: Recommendations for Expansion - Redacted

QUESTION 7 – Page 42

The CHAIR: In regard to the action points on that, I think there were eight recommendations, and they were made public. Can I get an understanding of where we are up to on those? That might be something to take on notice, if you or not able to provide it now.

MARGOT MAINS: Yes. I'll take that on notice too.

ANSWER

Please refer to table attached.

Attachment:

- Q7 TAB A – District response to recommendations of the *Final Report on the Wollongong Midwifery Group Practice: Recommendations for Expansion*

QUESTION 8 – Page 46

The Hon. NATASHA MACLAREN-JONES: That brings me to my next question, which is the number of midwives that you currently have in the district and, I suppose, the percentage that are CALD background or are Aboriginal as well. You might need to take that on notice.

MARIA FLYNN: I know the total number. I think we might need to take that on notice.

The Hon. NATASHA MACLAREN-JONES: If possible, could you also take on notice, looking at the budget, how much is allocated to employment of midwives within the overall budget of the midwifery services as well?

MARGOT MAINS: Of course.

ANSWER

There are currently 177 midwives across the District, in 130 full FTE midwife positions.

Of the 177 midwives, 3 midwives (1.69% of the total midwifery workforce) identify as Aboriginal and/or Torres Strait Islander, however it is important to note that not all staff choose to identify.

The District does not have information on the number of midwives from Culturally and Linguistically Diverse (CALD) backgrounds. The District is aware that there are several midwives who speak a first language other than English. It is not possible to provide the exact number as this information is self-reported and the data is not part of mandatory reporting.

In 2022-23, the District salaries and wages budget for nursing/midwifery in maternity-related services was $20.3 million. This was 57% of the total budget for maternity related services.*

**Due to midwifery recruiting challenges, some midwifery positions are filled by registered nurses to maintain service delivery. The salaries and wages budget includes any registered nurse positions in the maternity related services establishment*.

Recommendation	District response/progress
1. *Recruit a dedicated midwifery manager who has an understanding and commitment to midwifery-led continuity of care model.*	The Wollongong Hospital Midwifery Group Practice (MGP) Clinical Midwifery Specialist (CMS) works as the MGP team leader and oversees the MGP model of care. Any issues or concerns are escalated to the Birthing Unit Midwifery Unit Manager (MUM). The District acknowledges the support for a dedicated MUM for the Wollongong Hospital MGP and is reviewing options to establish this position. This includes liaising with other NSW Local Health District Maternity Services regarding their staffing models.
2. *Change the name from Midwifery Group Practice (MGP) to Midwifery Caseload Practice (MCP) to reflect a high level of continuity of care.*	Midwifery Group Practice (MGP) is the name used universally across NSW to describe this model of care and is widely understood by midwives working in health and women accessing this service. The District has concerns that changing the name could cause confusion, for example to women seeking to access the service and in terms of recruiting midwives to work in MGP, whilst not providing any real benefit to the service.
3. *Increase all women's access to the model through advertising on the Hospital's website and in the community, allow self-referral and liaise with Primary Health Care network to ensure 1st trimester referral from general practitioners.*	The Wollongong Hospital Midwifery Group Practice (MGP) is promoted as one of the models of care available for pregnant women and families in the Illawarra. Illawarra Shoalhaven Local Health District's website features information about MGP and how to apply to the program. This includes a self-referral form that can be downloaded directly from the website and emailed to the Wollongong Hospital Antenatal Service. In addition, both Wollongong Hospital and Shoalhaven Hospital Group Maternity Services have a GP liaison midwife and the District's website has detailed information about GP Antenatal Shared Care.
4. *Attract and support the midwifery caseload workforce by;* a. *placing students with the model to prepare them to transition directly to caseload practice –* b. *employing new graduates directly into the model –*	a. Midwifery students are now allocated to work within the MGP model of care. This commenced in 2023 and will be evaluated at the end of the current students' training period, with input from the students, to ensure it is meeting their needs.

c. *transitioning midwives from other areas of practice into the model with an initial reduced caseload combined with mentoring and support.*	b. A new midwifery graduate position is being created as part of the current work to expand the MGP model. The District is seeking feedback from other NSW local health district maternity services on how graduate positions are managed within their MGP services. c. As part of the current work to expand MGP, the District is liaising with existing maternity service staff about transitioning into new MGP positions. This will continue to occur as the team is increased.
5. *Increase access to publicly-funded homebirth by adjusting the accreditation process and providing a mentor to support more midwives to provide the service.*	To provide home birth services, an MGP midwife must complete the Advanced Life Support in Obstetrics (ALSO) - Advancing in Maternity Safety (AIMS) course, which provides training for midwives to effectively recognise and care for women experiencing emergencies and unexpected situations during pregnancy, labour, birth, and the postnatal period. Wollongong Hospital MGP midwives who do not provide home birth services have been allocated to attend an ALSO course in the next 12 months, based on availability of training. Following completion of the training, these midwives will be supported by mentors to attend home births as the second midwife. Once confident, these midwives can attend home births as the primary midwife and, in turn, can mentor other midwives joining MGP. As the Wollongong Hospital MGP service increases, the capacity to provide home birth services will also increase. Once the Shoalhaven Hospital Group MGP is established, home birthing services will also be developed and will utilise the skills of Wollongong Hospital MGP midwives for mentoring.
6. Provide flexible ways of working, allowing midwives to control the way they work, working in pairs with a midwife who desires a similar way of working.	The Wollongong Hospital MGP is made up of 2 teams of 4 midwives. Within each team of 4, midwives work in pairs based on shared philosophies around ways of working. Once established, the Shoalhaven Hospital Group MGP model will initially involve a 3 person team. As the Shoalhaven MGP grows,

	the model will be adapted to facilitate midwives to work in pairs.
7. *Increase access and acceptability for women by providing antenatal care in the woman's home and/or community setting and expanding services for all women.*	Under the current MGP model, midwives provide an antenatal appointment at home at 36 weeks for those women having a homebirth. The District is reviewing options for Wollongong Hospital MGP midwives to provide outreach services at Community Health Centres in the Illawarra. The Shoalhaven Hospital Group Midwife Antenatal Postnatal Services (MAPS) model of care provides an outreach clinic at the St George's Basin Community Health Centre. Once established, the Shoalhaven MGP model of care will consider options for providing outreach services in the community. The District notes that providing routine antenatal care in the home is not always the best use of resources in a large geographic area such as the Illawarra Shoalhaven, which would require considerable travel.
8. *Promote collaboration through providing a named obstetrician to work in partnership with the midwives.*	A dedicated obstetrician is assigned at Wollongong Hospital to undertake the weekly case review with the MGP midwives.

WOLLONGONG MIDWIFERY GROUP PRACTICE: RECOMMENDATIONS FOR EXPANSION

Final Report, April 2019

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EXECUTIVE SUMMARY

Wollongong Hospital has experienced significant consumer demand for increased access to midwifery-led continuity of care model, known as Midwifery Group Practice (MGP). The numbers of women in the local health district who have access to this gold standard model of maternity care is limited due to several local barriers. In response to the consumer voice, the Wollongong Hospital Executive and the Local Health District requested an evaluation of the model, with recommendations for expansion. The Centre for Midwifery Child and Family Health, a research centre within the University of Technology Sydney undertook a comprehensive qualitative evaluation of the existing service using an evidence based quality care framework. The findings indicate there are several positive aspects of the current model that can be replicated in the expansion and there are also challenges that are addressed in the recommendations for the expansion.

Critical to the expansion of this service is the need for visionary leadership through the recruitment of a dedicated manager whose role includes communicating the vision for the model, protecting the philosophy of woman-centred care and the autonomous role of the midwife.

The midwives' current ways of working are too prescriptive and are a barrier to attracting new staff to the model. Midwives should be allowed to work in a way that enhances their work/life balance and the most effective way to achieve this is to choose a "buddy" to work alongside. There are numerous ways midwives can manage their workload within the State Award agreement. The current model of two teams should be dissolved allowing the midwives to work alongside another midwife (in pairs) who desires to work in the same way. In addition, a casual midwife should be employed to cover unexpected leave for all the all midwives working in the model.

Working in pairs the woman is more likely to have care provided by her named midwife. This higher level of continuity of care requires a renaming of the model to midwifery caseload practice. Caseload refers to a model of care where a woman has a primary (named midwife) providing the majority of pregnancy, birth and postnatal care.

Sustainability of the caseload practice is dependent on attracting staff. Placing students with the caseload midwives for clinical practice experience will provide the students with real life experience of what it is like to work in midwifery caseload practice and will prepare them to work in the models at the time of graduation. There is increasing evidence of new graduates successfully transitioning directly into caseload practice across the country and Wollongong should offer new graduates the opportunity to work in their model with support. All midwives transitioning to the model should be offered an initial reduced caseload and support in the form of mentoring.

Women's access and acceptability of the service will be enhanced by offering antenatal care in the woman's home. This can be organised by postcode to minimise travel time for the midwives. Increasing access to publicly-funded homebirth is dependent on supporting more midwives to develop the skills to attend homebirth. Undertaking midwifery practice review and providing a homebirth mentor to support the midwives accreditation for homebirth will make this place of birth option more accessible.

Collaborative practice with a named obstetrician helps to define roles and responsibilities of the midwife and the obstetrician. Collaboration is effective through the obstetrician attending weekly team meetings with the midwives.

All of these recommendations need to be accompanied by the development of evidence based guidelines. The guidelines need to be developed by the midwives and obstetricians together as the changes are introduced to foster ownership and collaborative practice.

SUMMARY OF RECOMMENDATIONS

Summary of recommendations
1. Recruit a dedicated midwifery manager who has an understanding and commitment to midwifery-led continuity of care model .
2. Change the name from Midwifery Group Practice (MGP) to Midwifery Caseload Practice (MCP) to reflect a high level of continuity of care.
3. Increase all women's access to the model through advertising on the Hospital's website and in the community, allow self-referral and liaise with Primary Health Care network to ensure 1st trimester referral from general practitioners.
4. Attract and support the midwifery caseload workforce by; • placing students with the model to prepare them to transition directly to caseload practice • employing new graduates directly into the model • transitioning midwives from other areas of practice into the model with an initial reduced caseload combined with mentoring and support.
5. Increase access to publicly-funded homebirth by adjusting the accreditation process and providing a mentor to support more midwives to provide the service.
6. Provide flexible ways of working, allowing midwives to control the way they work, working in pairs with a midwife who desires a similar way of working.
7. Increase access and acceptability for women by providing antenatal care in the woman's home and/or community setting and expanding services for all women
8. Promote collaboration through providing a named obstetrician to work in partnership with the midwives

1. INTRODUCTION AND RATIONALE FOR THE STUDY

The Maternity Service at Wollongong Hospital is a Level 5 service and is the tertiary referral site within the Illawarra Shoalhaven Local Health District. There are approximately 3500 births per annum across the District with 2500 of these being at Wollongong hospital. Model of care offered include, GP Shared Care, High Risk Clinic, Midwives Clinic, Midwifery Group Practice (MGP), Community Health Adolescents In Need (CHAIN), Substance Use in Pregnancy and Parenting Service (SUPPS) and an Aboriginal Maternal Infant Health Service (AMIHS).

Midwifery continuity of care, known as MGP at Wollongong, can be defined as care provided to women through pregnancy, birth and the early parenting period by a small group of midwives, usually in the hospital or community health centre setting and sometimes in the woman's home. MGP was established at Wollongong in 2004 with a team of three midwives, some of whom still work in the model today. Later in 2004 this expanded to two teams of three midwives. After a period of time the teams expanded to consist of four full time equivalent midwives each. Publicly-funded home birth was introduced in 2008 and, to date, there have been just under 90 births completed at home, averaging less than 10 homebirths per year.

Each MGP midwife has a caseload of 40 women per year and in total the MGP attend a minimum of 320 births per year. The program has a waiting list each month of approximately 50 women who meet low risk criteria; these women are required to be allocated to another model of care. Therefore, the service is not meeting the community expectations for access to continuity of midwifery care. There has been a significant community push for more access to the MGP program at Wollongong, including ongoing media attention (NSW Nurses and Midwives Association 2018).

The Maternity Service underwent an external review in January 2016 from which a number of recommendations were made to provide improved delivery of care to ensure that care provided is woman-focused and within a quality and safety framework. To facilitate the implementation of the recommendations a change project titled 'Project 2020' was developed. As part of Project 2020, The Centre for Midwifery Child and Family Health at the University of Technology Sydney were approached by the Director of Nursing & Midwifery at Wollongong Hospital and asked to provide a review of the existing MGP service in order to make recommendations for its expansion. Dr Allison Cummins is heading the project as she has a significant body of research pertaining to midwifery-led continuity of care models.

The purpose of the study was to:

- Review the current MGP model of care with regard to experiences and outcomes for women, families and staff including the quality of the care provided.

- Identify the principles required to ensure quality of continuity of care across the MGP teams.
- Identify opportunities for the expansion of MGP at Wollongong Hospital in order to address population needs and community expectations in line with the best available evidence.

The following section outlines the literature relevant to midwifery-led continuity of care models.

2. REVIEW OF THE LITERATURE

Midwifery-led continuity of care is recognised as the gold standard of maternity care based on the results of several large studies. A systematic review of 15 Australian and international randomised controlled trials that compared midwifery continuity of care with standard care (family physicians, general practitioners and obstetricians) found that continuity of midwifery care provides significant benefits to women and babies including a reduction in interventions that lead to maternal injury including epidural anaesthetic, instrumental births and episiotomies. Preterm birth was also reduced by 24%, and there was a reduction in the overall mortality rate for babies around the time of birth (Sandall et al. 2016). Pre-term birth is the leading cause of infant death at <4 weeks of age and long-term disability (March of Dimes 2012). Pre-term birth accounts for 8.6% of all births in Australia and internationally the rates of pre-term birth are rising (March of Dimes 2012).

Included in the review by Sandall et al (2016) was an important Australian randomised controlled trial that found women who had midwifery-led continuity of care were less likely to have caesarean sections than women in the standard care group (McLachlan et al. 2008). This is significant because caesarean sections have immediate and long-term effects on the health of women and babies. Another Australian trial that was included found women were more likely to be discharged home earlier and the costs were calculated as $A566.74 less for a woman allocated to midwifery continuity of care models than those allocated to standard care (Tracy et al. 2013). A systematic review found that alternative places of birth, namely home and birth centres led to savings for the health system although there were differences in the health systems included (Perriman, Davis & Ferguson 2018). A smaller scale Australian study found midwifery-led continuity of care in a Queensland maternity service increased cost-effectiveness (Toohill et al. 2012). Consequently, midwifery-led continuity of care is an important intervention for all women.

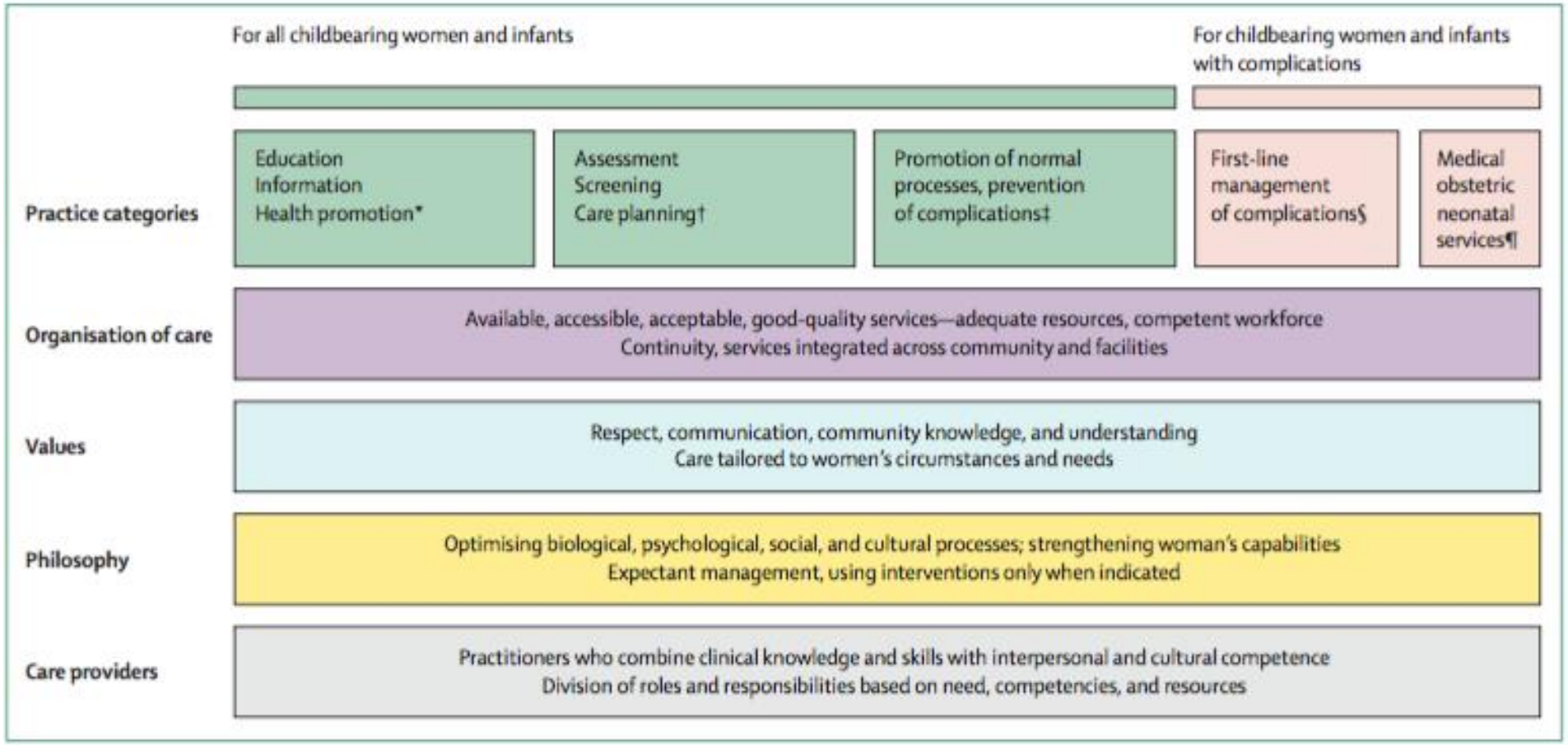
In addition to the improved outcomes discussed above, several studies have demonstrated that women experience greater levels of satisfaction when receiving midwifery-led continuity of care (Forster et al. 2016; Lewis et al. 2016). Furthermore, midwives also report better job satisfaction when providing continuity of care, compared to providing standard care that is usually fragmented with the woman seeing a number of different care providers (midwives and obstetricians) throughout her pregnancy, birth and early parenting period (Collins et al. 2010; Newton et al. 2014).

As such, midwifery-led continuity of care has been recommended in all states, territories and nationally (Australian Health Minister's Advisory Council 2016; NSW Kids and Families 2010). However currently in Australia it has been estimated that only around 10% of women have access (Dawson et al. 2016). This is consistent with the numbers of women reported to have

access to the service at Wollongong Hospital. In addition, there are women on a waitlist for MGP at Wollongong.

In 2014, The Lancet Series on Midwifery published the Quality Maternal and Newborn Care Framework (QMNC) (Renfrew et al. 2014). The QMNC Framework (Figure 1) was developed by 35 experts in the field using the highest-level evidence derived from two sources: the Cochrane Pregnancy and Childbirth Group and the Partnership for Maternal, Newborn and Child Health Review (Renfrew et al. 2014). Analysis of evidence from these internationally recognised rigorous sources informed the QMNC Framework which has five components; practice categories, organisation of care, values, philosophy and care providers (Figure 1). The authors propose the QMNC Framework can be used to assess quality of care; plan workforce development, resource allocation, an education curriculum; or identify evidence gaps for future research (Renfrew et al. 2014). A further call was given for research that would identify the facilitators and barriers to implementing midwifery-led continuity of care as reflected in the QMNC Framework. (Kennedy et al. 2018). The framework has been pilot tested to understand the constituent elements of quality maternity in both Scotland and Australia demonstrating the feasibility of using the QMNC framework as a data collection tool, and as a lens for analysing data (Cummins et al. 2019; Symon et al. 2018).

Figure 1 Quality Maternal Newborn Care Framework (Renfrew et al 2014). Reproduced with permission



3. STUDY DESIGN AND METHODS

3.1 OVERVIEW

A qualitative descriptive approach (Sandelowski 2000; Sandelowski 2010) was taken to identify the opportunities for the expansion of MGP at Wollongong Hospital. Expansion of the service will address population needs and community expectations in line with best practice models and midwifery workforce development. To meet this aim, the research team used an evidence-based framework, The Quality Maternal Newborn Care (QMNC) Framework, in order to review the existing MGP service. The QMNC Framework, developed by Renfrew et al. (2014), differentiates between what care is provided, how and by whom it is provided, and describes the care and services that childbearing women and newborn infants need (Renfrew et al. 2014). The QMNC framework outlines five components of high-quality, cost-effective maternal and newborn care that can be used for analysis and planning of future services (Renfrew et al. 2014).

In our study the QMNC framework was used to evaluate how service users (pregnant women and new mothers) and providers (midwives and doctors) in the MGP model understand or experience the components and characteristics of care that the QMNC framework describes.

3.2 ETHICAL CONSIDERATIONS

Ethical approval was sought and gained from the Illawarra Shoalhaven Local Health District Research Ethics Committee (Approval no. 2018-ETH00288 ISLHD) and UTS Human Research Ethics Committee (Approval no. ETH18-2996).

Participants were made aware that the interview or focus group they participated in would be audio recorded. All focus group and interview data in the form of audio files and interview transcripts are stored in password protected computers and locked filing cabinets within the University of Technology Sydney.

Anonymity of participants was ensured by the assignment of pseudonyms for both service users and service providers. Any identifying information was removed from the data. All participants had the right to withdraw from the study at any stage and were made aware that their participation in the study would not affect their experience of being cared for or working at Wollongong Hospital.

Eight major themes and several sub-themes emerged from the data that described service users' and service providers' experiences and opinions regarding Wollongong Hospital's MGP service. The major themes were: *'Getting ticked off for the model', 'Increasing women's access', 'Struggling with an unsupportive hospital culture', 'Needing midwifery leadership', 'Developing a professional friendship', 'Preparing women for birth and motherhood',*

'Organisation of care', and '*Managing different ways of working'*. Each of the themes and their sub-themes are presented below with supporting excerpts of data from interviews and focus groups conducted with women, midwives and doctors. Recommendations based on our findings are then presented in the following section.

3.3 PARTICIPANTS

Women - A focus group was conducted with seven pregnant women who were receiving care from the midwifery group practice. Six of the women were multiparous (pregnant with their second or subsequent child) and one was primiparous (pregnant with her first child). Several of the multiparous women had experienced MGP care in previous pregnancies, either at Wollongong Hospital or at a hospital in another health district. One-to-one interviews were also conducted with six postnatal women, one of whom was an active member of the local consumer advocacy group who are lobbying for expansion of MGP at Wollongong Hospital.

Midwives - A total of eight midwives participated in the two focus groups conducted with the two MGP teams known as 'Juno' and 'Hera'. Two of the participants had worked with MGP since its inception (>14 years' experience with Wollongong MGP) whilst others had joined the model more recently (within the last 12 months). Two further one-to-one interviews were conducted with a senior MGP midwife and the Clinical Midwifery Consultant who also has experience of working in Wollongong MGP.

Doctors - A one-to-one interview was conducted with the Director of Obstetrics and a focus group was conducted with 13 doctors present. It is important to note that during the focus group with doctors the Director of Obstetrics was present, which may influence the data as more junior staff might have felt intimidated and unable to speak up. It is also important to note that whilst 13 doctors were present at the focus group, only seven actively participated and contributed to the conversation. The group of doctors included participants with a range of experience and level of training from residents to registrars. Some doctors had only recently commenced employment at Wollongong Hospital and were, therefore, unable to contribute as they had very little experience of working with MGP. A summary of participants is provided in Table 1.

Table 1. Summary of participants

Service Users	**Service Providers**
Antenatal women (AN) n = 7	Midwives n = 9
Postnatal women (PN) n = 6	Doctors n = 13
Total n = 13	**Total n = 22**

3.4 DATA COLLECTION AND ANALYSIS

We conducted focus groups and one-to-one interviews to understand service users (mothers) and service providers (midwives and doctors) experiences and opinions regarding Wollongong Hospital's MGP service. Audio recordings of interviews and focus groups were transcribed and de-identified. Braun and Clarke's (2006) model of thematic analysis was then employed to analyse the data (Braun & Clarke 2006). Initially, each team member was assigned a number of transcripts to code. Codes were derived directly from the data and the research team then met to compare, contrast, discuss and develop the data into agreed codes and early themes. Themes were again refined as the findings were written up. The final draft of themes was aligned with the components in the QMNC framework, which was then used to generate recommendations for expansion of the model.

4. FINDINGS

Eight major themes and several sub-themes emerged from the data that described service users' and service providers' experiences and opinions regarding Wollongong Hospital's MGP service. The major themes were: *'Getting ticked off for the model', 'Increasing women's access', 'Struggling with an unsupportive hospital culture', 'Needing midwifery leadership', 'Developing a professional friendship', 'Preparing women for birth and motherhood', 'Organisation of care',* and '*Managing different ways of working'*. Each of the themes and their sub-themes are presented below with supporting excerpts of data from interviews and focus groups conducted with women, midwives and doctors.

Recommendations based on our findings are presented in the following section.

4.1 GETTING TICKED OFF FOR THE MODEL

The notion of women '*Getting ticked off for the model',* was expressed by both service users and service providers. Women wanting to receive continuity of midwifery care were acutely aware that they needed to meet certain eligibility criteria in order to access the program. They described nervously awaiting approval to be cared for by MGP:

> *'I had to get approved for the program because I've got mild asthma and I sort of thought… "Please, please let me go on the program," like you're waiting for this obstetrician to tick you off. Like clearly tick a box to say you can do it' (Rachel, AN woman).*

The notion of 'ticking boxes', was reiterated by other women:

> *'I was pretty much ticking all the boxes for an MGP approval' (Lily, PN woman).*

> *'This will be my third home birth. Yeah, so I guess they've all been pretty much the same. I just come and try to tick all those boxes to make sure that the homebirth is a viable option' (Marina, AN woman).*

Similarly, doctors also referred to 'ticking women off':

> *'So, the first visit is usually when you tick them off to say they are okay for MGP' (Doctor 2).*

Visits with the doctor to assess a woman's eligibility for MGP were not described by women or doctors as therapeutic interactions, but merely a box ticking exercise. This de-humanises the woman and serves as a missed opportunity to build trust and positive relationships between care providers and pregnant women.

4.1.1 NEEDING A NAMED OBSTETRICIAN

'Getting ticked off for the model' didn't just occur in the early stages of women's pregnancies when they were seeking a place in MGP. Even after being accepted into the model, if complications arose in a woman's pregnancy then MGP midwives needed to find an obstetrician to consult with regarding the woman's care and ongoing eligibility. However, no formal system was in place for this and, as such, midwives spent a lot of time seeking out doctors to consult with, as this midwife described:

> *'I've had to go to amazing efforts, just to see a doctor. I have a [woman planning a] VBAC [who] has now been to the doctor's clinic three times and has still not been approved for MGP. We need a set consultant [obstetrician] to go to' (Midwife 4).*

Doctors also described their frustration at being 'chased' by midwives for corridor consultations and felt strongly that this practice compromised the quality of care they were able to provide for women:

> *'Look, I don't think any doctors like to do that. To be fair, you like to see a patient. You like to completely go through the notes. You want to do a good job, because that's your name, and you're responsible [for the woman's care]' (Doctor 2).*

Doctors disliked corridor consultations for several reasons. Firstly, it often interrupted what they were doing and delayed the care they were providing to other patients. Furthermore, they felt uncomfortable about signing off on test results or some other aspect of a woman's care without having time to meet the woman and/or review her notes. They wanted to know the full clinical picture before making a decision:

> *'If you're busy in the clinic and someone's knocking on your door, and there's some random person you've never seen before and they want you to look at results of a thyroid function test, then it is frustrating because you don't know the woman. You've just been shown a TSH and you're like, "Well, I need to look into this." So it does get frustrating when you're busy' (Doctor 1).*

Doctors had a sense that midwives were 'doctor shopping', i.e. seeking out particular doctors in order to find those whom they felt would be more sympathetic to their cause. They recognised that women in MGP tended to be committed to giving birth without intervention and, therefore, their midwives tried to find a doctor who would not advise unnecessary interventions:

> *'I think by the very nature of the patients who go with the [MGP] midwives. These are the women who are low-risk and would rather like to stay low-risk. There is a natural aversion on the patients to be handed bad news, or news about potential, or possible, complications. So, with the MGP midwives, sometimes... they would rather shop around and find out who signs off the normal, versus if someone says, "No, this needs more monitoring" [because then] the patient may not be happy' (Doctor 8).*

Both midwives and doctors agreed that it would be ideal for MGP to have a named obstetrician with whom midwives can consult when needed:

> *'I think the thing that they do in other hospitals, which I think is good, is once a week or once a fortnight, they have a meeting with a designated MGP consultant who will know the patients and will review the notes. I mean, you won't know every single patient but… I think that would be a vast-improvement' (Doctor 1).*

A named obstetrician allows women to receive continuity of medical as well as midwifery care. However, it's important to get the right fit in order to allow for a trusting relationship to develop between doctors and midwives, as this midwife suggested:

> *'You need somebody who's interested, who understands the model and that you can consult with. And who knows the midwives who work in that group' (Midwife 6).*

When the right fit is achieved, communication and collaboration between midwives and doctors is likely to improve along with the quality of care being offered to women

4.1.2 MAPPING TO THE QMNC FRAMEWORK WITH SUPPORTING LITERATURE

Providing a named obstetrician for MGP midwives would improve collaboration and meet the quality framework component of ***Care Providers*** with the appropriate *division of roles and responsibilities.* Other successful and sustainable MGP practices have named obstetricians for individual MGP groups who works closely with the midwives (Hartz, White & Lainchbury 2012). The model described by Hartz et al. 2012, includes obstetricians attending MGP meetings, being available for telephone communication or individual clinical consultation for women with increasing complexity and collaborating on clear plans of care. Collaboration between midwifery and obstetric staff is highly attainable within the MGP model and reinforces the effectiveness of interdisciplinary collaboration (Beasley et al. 2012).

4.2 INCREASING WOMEN'S ACCESS

Both pregnant and postnatal women thought very highly of Wollongong MGP and were desperate to get a place on MGP. Continuity of midwifery care was so important to women that some even considered paying out-of-pocket for private midwifery care if they weren't able to access MGP, as this woman explained:

> *'[Getting into MGP] was like a weight off my shoulders… I would've gone to a private midwife if I hadn't gotten into the program for sure… I was already looking at other options' (Rachel, AN woman).*

Similarly, another woman who was planning a publicly-funded homebirth was prepared to engage a privately practising midwife if she became ineligible for a homebirth under MGP:

> *'If something happens… If my [GBS] swab is positive or something and they said "No, you can't have a homebirth", I still would have gone and got an independent midwife… homebirth is really important to us' (Marina, AN woman).*

Women felt very strongly that access to the model should be increased so that more women in the community were able to experience MGP:

> *'I think a high-risk [model is needed for] adolescents and Aboriginal women, like there's so many more that need it, more than just those having a low-risk birth. If anyone, we should be the last people [to have access], but we [manage to] get on the program' (Isabelle, AN woman).*

They felt there were significant benefits of continuity of midwifery care for women in many different circumstances and wanted all women to have access, even when their pregnancy experience deviated from normal:

> *'My friend had an experience where she was with MGP and had a baby that was quite premature at 30 weeks which then meant she was ineligible for MGP. But she felt like that was when she would have benefited the most from having that one person she could call and talk to. It's a bit backwards' (Nikki, AN woman).*

Other women stated they would have liked to have earlier access to the model:

> *'I found out [I was accepted into MGP] pretty much right on 12 weeks and the relief was like...' (Nikki, AN woman).*

> *'I was a late entrant [to the MGP] last time… it is a long time just to be by yourself' (Isabelle, AN woman).*

Increasing access to homebirth was also identified as a key issue at Wollongong Hospital.

4.2.1 INCREASING ACCESS TO PUBLICLY-FUNDED HOMEBIRTH

Despite the existence of a publicly-funded homebirth program at Wollongong Hospital, women's access to the model appears to be highly restricted. Publicly-funded homebirth was introduced at Wollongong in 2008 and to date there have been just under 90 births completed at home, averaging less than 10 homebirths per year. This compares with other services who provide many more homebirths per year, for example the Royal Hospital for Women in Sydney have had 16 births in 8 months since commencing a publicly-funded homebirth program (Sidery 2018a)

One of the issues that is restricting women's access to publicly-funded homebirth is a lack of accredited MGP midwives. At Wollongong, midwives are required to witness 5 homebirths before they can act as the second midwife for another 5 homebirths and then progress to being the primary midwife. Due to the low number of homebirths occurring each year, this has made the process of new midwives being accredited incredibly slow, as acknowledged by this midwife:

> *'It would take someone a good 12 months or more to get to a point where they can handle a homebirth' (Midwife 6).*

Midwives felt that the publicly-funded homebirth program was not well known by local women, partly because midwives weren't promoting it:

> *'I think there are probably a number of women out there who don't even know that it's an option. So, if you're a midwife who's not really that keen on being involved in that, then you just don't talk about homebirth' (Midwife 5).*

One of the key reasons the model wasn't being promoted was that the MGP didn't have capacity to take on many women due to a lack of homebirth accredited midwives:

> *'I would have to say probably up until now, we haven't advertised [homebirth] rightly because there's only two of us … We were at capacity anyway and when we don't have the staff readily available, there was no point in advertising' (Midwife 6).*

Another aspect restricting women's access to homebirth is a lack of awareness and support for the program from doctors. When asked about the program, some of the doctors were completely unaware that the hospital offered publicly-funded homebirth:

> *'Do we have that? I don't think I've ever seen one while I've been here?' (Doctor 5).*

Women were angry that their access to homebirth appeared to be restricted due to the personal ideologies of doctors when assessing women's eligibility for homebirth:

> *'I had a low risk pregnancy. I had a normal birth with my first. I think on paper I was an ideal candidate for a homebirth, but when my case was taken to the doctor, he didn't approve it based upon my age and that he believed it was too risky, even though I fell within the ACM guidelines… I don't think that's okay' (Elaine, PN woman).*

Increasing access to publicly-funded homebirth should be a priority for the service. Women want access and midwives need to be skilled to support women's choices. Homebirth should be offered in accordance with the evidence and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists' endorsed, Australian College of Midwives guidelines for consultation and referral (Australian College of Midwives 2013).

4.2.2 MAPPING TO THE QMNC FRAMEWORK WITH SUPPORTING LITERATURE

In order to provide *accessible, acceptable, good quality* services the ***organisation of care*** needs to include information for women who are thinking of becoming pregnant including an update of the services available on the hospital's website and early referral from General Practitioners. Resources for the promotion of midwifery-led care available through the Australian College of Midwives (Australian College of Midwives 2018) could be reproduced for the local Wollongong Maternity Services website. There is also a need to expand the MGP service to those women who would clearly benefit from continuity, such as Aboriginal women and young mothers. Expanding services to these women has previously been shown to include significant benefits such reducing preterm birth for young women (Allen et al. 2015) and improving cultural safety, experiences and outcomes in relation to pregnancy and birth for Indigenous women (Corcoran, Catling & Homer 2017). Expanding Wollongong MGP would allow the hospital to offer high quality care addressing the ***values*** of care tailored to women's circumstances and needs and a ***philosophy*** of *optimising psychological, social and cultural processes.*

Accreditation for publicly-funded homebirth midwives needs to be more easily available in order to increase the numbers of women who can access this place of birth. As presented in Table 2, The Royal Hospital for Women (RHW) in metropolitan Sydney has the following requirements for a midwife to become accredited to attend homebirths (Sidery 2018).

Table 2. Publicly-funded homebirth accreditation requirements for midwives at RHW

Registration as a midwife with AHPRA and employment with SESLHD
Demonstrated understanding of the philosophy and facilitation of care for a woman choosing homebirth
Completion of Obstetric Neonatal Training (ONT) or Advanced Life Support in Obstetrics (ALSO) course in the last three years
Participation in mentoring and reflective practice with experienced midwives
Demonstrated commitment to excellent documentation standards
Adherence to RHW best practice Local Operating Procedures
Participation in a structured practice review process
Knowledge and demonstrated use of the Australian College of Midwives' (ACM) National Midwifery Guidelines for Consultation and Referral
*Attendance at a minimum of **two births** at home as a primary midwife (or undertakes to do so with a mentor midwife)*
Demonstrated proficiency in the following skills: *Venepuncture, Cannulation, Perineal Repair, Neonatal Resuscitation (6 monthly skill update), Maternal Resuscitation (6 monthly skill update), Emergency skills management - PPH/Shoulder dystocia (6 monthly skill update), Well Newborn Assessment Accreditation (or working towards completion within 3 months of offering homebirths).*

All of these skills can be obtained in multi-professional training sessions offered in the hospital (Sidery 2018). Similarly, in South Australia the number of homebirths the midwife has to attend to become accredited is not stipulated, but rather the requirements relate to supervision and meeting the educational requirements of recent relevant management of obstetric and neonatal emergencies. There is no standardised approach in Australia to selecting midwives to work in publicly-funded homebirth, although all discuss the importance of providing support for midwives transitioning into the program (Catling-Paull, Foureur & Homer 2012; Coddington, Catling & Homer 2017).

4.3 STRUGGLING WITH AN UNSUPPORTIVE HOSPITAL CULTURE

MGP Midwives described '*Struggling with an unsupportive hospital culture*'. An example of poor hospital culture was the reported response by some core midwifery staff to the addition of birthing props – mats, balls and birthing stools – that are designed to support active birth. As described here:

> *'…Recently when there was a big [consumer] push for using birth props and things like that, there was a lot of resistance from the birth unit [midwives] to use any of those things. Like we got all the balls and the mats and things in and they were all like, "We don't want to clean them". That was an issue with them, they didn't want to have to clean any equipment. It's like, "Everyone wants an epidural anyway, why should we bother with all this stuff?" (Midwife 7).*

On the other hand, MGP midwives were very focused on protecting and promoting normal physiological processes. This midwife directly compared her experience of working as a core midwife on birth unit before coming to MGP:

> *'In the birthing unit, it's very obstetric-led. There's a lot of intervention, inductions and epidurals and things like that. When you go to MGP, it's different because you work to support women through labour and birth we've got [a focus on] advocating for women' (Midwife 7).*

The MGP midwives had significant concerns about obstetric domination over midwifery, as noted here:

> *'Wollongong Hospital is very medically oriented. I think that's partly cultural and… for the last 15 years… there's been a very, very quiet midwifery voice, almost a whisper. We need to bring some of the role back because the profession of midwifery at Wollongong Hospital is subjugated to the medical model. And so, the women are subjugated to the medical model' (Midwife 8).*

> *'We are very obstetrician-led for everything that happens* [redacted] *(Midwife 6).*

Women also described how their care became obstetrically dominated and the culture of both doctors and birth unit midwives took an organisational centred approach rather than a woman centred approach:

"I just wanted my water broken and then to see whether labour would commence naturally. I was told, if I wanted to have the baby today, then I needed the drip" (Lily, PN woman)

This woman continued to tell the story of her first birth experience, without MGP care, explaining the disrespectful treatment she received from the obstetrician and midwives in the birth unit:

'There was no respect, and it was just rude and abusive basically, it was horrible'

When the midwife spoke to her like this:

'Well if you keep making that noise you won't be able to talk tomorrow'

She is of the opinion that her situation may have been different if she had an MGP midwife:

'If I'd had someone encourage me, maybe things would have been different, but that's all, 'possibles' and 'maybes' (Lily, PN woman).

MGP midwives aim to provide woman-centred care against this background of an unsupportive hospital culture. One postnatal woman noticed the lack of support for MGP:

'I don't think there's been the support for the existing midwives in MGP to do really well and thrive and sustain passion and motivation in that team' (Elaine, PN woman).

Several midwives described undergoing an enculturation process at Wollongong Hospital that involved being required to spend a certain amount of time on the birth unit before being allowed to commence their role in MGP. This was enforced regardless of the amount of experience midwives had in other services:

'I have a history of working for a referral hospital for three years as a midwife and then I worked at a rural hospital which was very independent, for three years also, and one year at a tertiary hospital in between those, and then I got the job here in MGP and was told very promptly that I would have to do three weeks in the birthing unit… which kind of basically felt like I was being watched' (Midwife 3).

This 'enculturation process' was couched as being a useful way for midwives to orient themselves to Wollongong Hospital, however midwives felt it would be more useful to have a mentored position within MGP.

4.3.1 MAPPING TO THE QMNC FRAMEWORK WITH SUPPORTING LITERATURE

In order to meet the QMNC framework components of a ***philosophy*** of *optimising biological and psychological processes* and applying *expectant management using interventions only when indicated* requires a shift in the culture of the hospital. Having a named obstetrician would help with collaboration and build trust between ***care providers***, *practitioners who combine clinical knowledge and skills with interpersonal and cultural competence.* Introducing a culture of learning and continuous improvement through multi-professional training has been proposed in the United Kingdom (UK) (National Quality Board 2018) .

Midwives, including new graduates, can orientate directly to MGP with an initial reduced caseload (Cummins, Catling & Homer 2017; Cummins, Denney-Wilson & Homer 2016a; Hartz, White & Lainchbury 2012) rather than becoming part of the labour ward culture where the experience is of high levels of intervention. In this way the maternity service will be more likely to increase the MGP workforce capability.

4.4 NEEDING MIDWIFERY LEADERSHIP

In order to overcome a non-supportive hospital culture, midwives felt that strong midwifery leadership was required. They believed it would be extremely valuable for MGP to have a dedicated manager who can provide visionary leadership and promote and advocate for MGP:

> *'I think we need our own manager. And I don't think it needs to be a MUM necessarily, but a team leader or someone that goes to the table with the other people and gets a say' (Midwife 6).*

Currently, the manager of the birth unit also acts as the MGP manager. [redacted]

It was important for midwives that they had a leader they could trust to look out for their best interests:

> *'[We need] a dedicated manager, who can have other jobs within the hospital service, [someone] to manage MGP and be a go-to person, who can be a confidante and we can say things confidentially…' (Midwife 1).*

It is evident that MGP need a dedicated manager to assist with matters related specifically with the model (such as rosters and annual leave) along with advocating for the model and helping to manage any difficult clinical cases and interpersonal conflicts that may arise. Doctors agreed that if the model were to expand, a dedicated MGP manager would be required:

> *'I think if we're going to expand the MGP service you definitely need someone to oversee it' (Doctor 1).*

A dedicated manager can assist with capacity building for midwives.

4.4.1 CAPACITY BUILDING FOR MIDWIVES

Some doctors expressed concern that MGP midwives didn't have 'enough' experience to work in the continuity of midwifery care model:

> *'I think if you're going to be in the MGP as a midwife, you should probably have a few years of experience behind you. Because you are pretty much ... Even though you are supported by us and other midwives, there are certain things that I think you need experience in managing' (Doctor 1).*

Doctors commented that MGP midwives needed greater skill sets. They agreed midwives should be able to cannulate and suture, in order to provide full continuity of care to women and reduce the workload of doctors:

> *'The majority of midwives can do cannulas but... they should be able to suture... Because, it is absolute continuity. I mean, unless it's a bad tear. Their whole thing is continuity. And we're so busy as well. It's hard if we have to suture every single [woman] that delivers' (Doctor 1).*

They felt that, in comparison to other MGP services they had worked with, the midwives at Wollongong were less independent:

> *'…Most MGPs that I've worked with, the midwives are actually a bit more independent, so they do all the cannula's and all the suturing. And here they don't tend to be skilled as much in some of those areas… that might come into the junior nature of some of the staff. It would be helpful if they had those skills because the women like it' (Doctor 5).*

One midwife described how her experience working as a core midwife in the birth unit did not help her consolidate skills due to the over medicalisation of births:

'I was just feeling like it was just a big production line of inductions and interventions and I was there not enjoying it as much anymore. So, when I started on MGP, it definitely changed my practice a lot more because I'd gotten stuck in that intervention and lost those midwifery skills' (Midwife 7).

She described how joining MGP helped her to regain skills in facilitating normal physiological birth:

'I had to regain some of the skills I'd forgotten about helping them through labour and educating them and that sort of thing' (Midwife 7).

Midwives felt that having a dedicated MGP manager would create more opportunities for them to upskill as the manager would be able to organise and facilitate education sessions.

Women had confidence in their midwife regardless of the length of time they had worked in continuity or other models. Principally this was based on the professional relationship and level of continuity women experienced in MGP. Some women expressed feeling a greater sense of confidence when being cared for by a more experienced midwife:

'I have more faith in the knowledge from the others who have had more experience' (Miranda, PN woman).

However, other women noticed that less experienced midwives tended to have good awareness of current evidence-based practice:

'[The midwife would] say things to me like, "Oh, I recently did some extra training in this or that," and so I started to think, "Wow. She's got a lot of skill,' (Erin, PN woman).

Ultimately, women didn't indicate a preference for the amount of experience their midwife had and none described a lack of skill from their midwife.

4.4.2 MAPPING TO THE QMNC FRAMEWORK WITH SUPPORTING LITERATURE

Capacity building in other MGP services including Westmead Hospital Sydney, Broken Hill Hospital, Far West NSW, as well as Sunshine and Mackay Hospitals in Queensland have incorporated employing new graduate midwives directly into their MGP model to ensure capacity building of a sustainable workforce (Mackay Base Hospital 2018; Women's & Newborn Health 2016). Often students are placed with MGP midwives to complete their clinical practice placement and this has been shown to provide succession planning with the new graduate midwife transitioning straight into practice with support from other MGP midwives and mentoring (Cummins, Catling & Homer 2018; Cummins, Denney-Wilson & Homer 2015, 2016b). The mentoring experiences of new graduate midwives were either

through formal or informal approaches. New graduates were either offered a mentor or found their own, sometimes outside of the MGP group, however all had support from MGP in common (Cummins, Denney-Wilson & Homer 2016b).

In addition, high quality maternity leadership that supports innovative ways of working and, the design and maintenance of a workforce capable of providing continuity of carer is an essential element of caseload midwifery (National Quality Board 2018). This also meets the QMNC framework component of ***care providers*** *division of roles and responsibilities based on need, competencies and resources.*

4.5 DEVELOPING A PROFESSIONAL FRIENDSHIP

MGP midwives were incredibly passionate about their work and firmly believed that continuity of midwifery care was the best possible maternity care a childbearing woman could receive. As such, they got a lot of satisfaction out of providing this care to women:

> *'It's definitely the most satisfying job to work, as a midwife' (Midwife 1).*

In return, women highly valued the relationship they were able to develop with their MGP midwife and felt positively about receiving personalised care that involved their whole family:

> *'She was professional all the time but she became sort of somebody that I relied on, I guess, and almost [like] a friend' (Miranda, PN woman).*

The development of a trusting relationship, sometimes referred to as a 'professional friendship', is a key component of continuity of care that was present in Wollongong Hospital's MGP. Women valued knowing their midwife and feeling that their midwife knew them:

> *'I knew who my primary midwife would be… I trust her completely' (Elaine, PN woman).*

Midwives also valued this aspect of working in MGP and noticed a difference in the attitudes of women who receive continuity of midwifery care:

> *'The women, if they're getting that continuity of care, I personally find they're less stressed, they don't ring as often as, say, a woman in the clinic might ring if this is happening or that is happening. They know they're going to see you the following week or fortnight or whatever and usually, unless it's an urgent thing, they'll save their questions until then. There's that trust that's built up, which they don't get the opportunity to do in the regular clinic, because there's different midwives doing different days all the time' (Midwife 1).*

Women preferred to have their primary midwife present at their birth:

> *'Just the birth, I suppose. lt's nice to have someone you trust and who advocates for you' (Marina, AN woman)*

However, they understood that sometimes this is not possible and also felt confident in the other MGP midwives' capacity to care for them:

'Even if it ends up not being my midwife …the positive experience will happen. And my midwife is on call all over Christmas and New Year's, which is nice' (Ariana, AN woman).

4.5.1 MAPPING TO THE QMNC FRAMEWORK WITH SUPPORTING LITERATURE

We mapped these findings to the QNMC Framework ***organisation of care*** where providing *continuity* is seen as the best quality maternity services. The continuity needs to be of a high level defined as one-to-one, to ensure the professional friendship has an opportunity to develop. We found the care was *available, accessible, acceptable and good quality.* Through developing the professional friendship the ***care providers*** *combined clinical knowledge and skill* with *interpersonal and cultural* competence. When compared to their non-continuity counterparts, Australian midwives providing continuity of midwifery care reported better emotional and professional wellbeing (Collins et al. 2010; Newton et al. 2014). The Wollongong midwives discussed consolidating skills and satisfaction in a similar manner to research that compared midwives working in continuity of care models with those not working in continuity as having lower levels of burnout, depression and anxiety and reported higher levels of professional identity and autonomy and considered themselves more able to draw on the knowledge, skills and resources required to work across the full scope of midwifery (Royal College of Midwives 2018).

4.6 PREPARING WOMEN FOR BIRTH AND MOTHERHOOD

Midwives from both MGP teams described providing women with information and education in order to comprehensively prepare them for labour, birth and early parenting. Women reflected positively on how well prepared they felt for birth:

> *'It felt like her experience was more than just about what she read in a book but having experienced so many births and women' (Ariana AN woman)*

Even when the woman's pregnancy was complicated the women felt prepared as described here:

> *'They come to your medical appointments too so if there is things that you've got questions afterwards, they can answer and can prepare you for them and talk to you' (Connie, AN woman).*

Midwives worked hard to promote normal physiological processes and reassure women that they are capable of achieving a normal birth:

> *'I say to them, "Your body is designed, women's bodies are designed to have babies" …They hear about all the abnormal and the disasters from the rest of the world and everyone who's ever had a baby, they're always talking disaster stories, so they hear about all that anyway, and they all know about that. But we're promoting what is most likely to happen, and I think it's just reinforcing that all the way through, encouraging them and making them stronger' (Midwife 2).*

Such information and education is integrated into the antenatal care provided during antenatal clinic visits and is formally presented at the 'meet the midwives' evening:

> *'So we do education along the way as part of our visits in terms of promoting physiological labour and birth and then we have 'Meet the midwives' as well as a way of the women being introduced to the other midwives if they're potentially going to have to be cared for by another midwife but also again talking about physiological labour and birth' (Midwife 5).*

Women enjoyed the 'meet the midwives' event and appreciated the opportunity to meet all the midwives and other pregnant women. Following these events they tended to feel reassured:

> *'At the meet the midwives last week they ran through everything right from what to pack in your bags to pre-labour, when to come in, when to call your midwife, it was a really informative night' (Rachel, AN woman).*

However, some women expressed wanting to meet the midwives earlier in their pregnancy:

> *So maybe two separate sessions will work and then you've got two opportunities to meet them all (Marina, AN woman).*

The concept of sharing knowledge came under the theme of preparing women for birth.

4.6.1 SHARING KNOWLEDGE

Women valued a midwife with experience, however they also felt that 'younger', or less experienced midwives worked in a way that was highly evidence-based.

> *'She was walking along the same path as me, you know. We were on this together' (Erin PN woman).*

> *'[I] think she's just gone through her training and she's still quite evidence-based' (Connie AN woman).*

At least one doctor agreed that the midwives working in MGP should have experience:

> *'It's not like they've done extra degrees or anything. It's their years of experience makes a difference' (Doctor 8).*

The focus of the discussion was really on how the midwives shared their knowledge with women and helped them feel empowered in their decision-making. This was evident with one woman who developed complications in labour and had to have several visits with the doctors:

> *'I walked into every obstetrician appointment armed with knowledge and understanding of what my choices were and what I was prepared to do and what I wasn't prepared to do….. XXXX guided me around what the conversation could look like' (Lily PN woman)*

Midwives enabled the women to feel knowledgeable and understand their options, know their rights and the women liked the way the midwives involved the family:

> *'Like they get to know your home environment and meet the other members of the family' (Isabella, AN woman).*

> *'Then evidence based, what's my best options to do for myself, my baby, and my family' (Connie, AN woman).*

'My kids come sometimes to the appointments and they explain things to them' (Marina, AN woman).

4.6.2 MAPPING TO THE QMNC FRAMEWORK WITH SUPPORTING LITERATURE

Preparing women for MGP involved promoting normal physiological birth and continuing to offer the "meet the midwives" opportunities as women viewed these sessions less about meeting the group (although this was important) as having clear instruction of when to come, how to get there and what happens when you get there. Preparing women aligns with the QMNC framework component of ***philosophy*** through optimising *biological, psychological, social and cultural processes*. An exploration of first time mothers experiences who had given birth at home or in hospital in Australia found women who gave birth at home were more prepared for birth as they knew their midwives and the midwife had spent time discussing the issues that are important to women when becoming mothers (Dahlen, Barclay & Homer 2008). In other words the MGP sharing the knowledge with women prepared them for birth as it demonstrates the ***values*** of *care tailored to women's needs*. Providing care in the woman's home and involving the family aligns with ***organisation of care*** *as being available, accessible and acceptable.*

4.7 ORGANISATION OF CARE

The MGP midwives expressed their desire to be in control of their own rostering and ways of working. Some preferred a perpetual roster as this allowed for predictability of workdays in advance:

> *'[Perpetual roster] is what we did for ten years … we could plan ahead if we needed some time off, we could... but the way it is now, we've got a month ahead, and when I had the week off last week, that was a bit of a nightmare because I had leave set and then we had to change it... I don't like it' (Midwife 2).*

> *'I like my days off as days off, to just have my time… you know, being on call 24 hours and sometimes seven days a week, by day four you're exhausted, especially if you've had some busy days' (Midwife 3).*

However, both teams did not agree about this and staff instability made it impossible to maintain:

> *'We did have [a perpetual roster] system going up until probably, roughly six months ago when there was a lot of change in staff, and the two teams combined and worked on one roster because the other team had always done [a] 'request roster' and… they didn't want to do the perpetual roster so that kind of went by the way' (Midwife 1).*

Both teams agreed a fifth midwife per MGP team would be advantageous in order to cover unexpected leave due to staff illness or holiday leave:

> *'When somebody goes on sick leave, we get no replacement for that person, no matter how long they are off…and it does lead to an excess workload' (Midwife 1).*

> *'Definitely having a fifth member of the team, at least' (Midwife 4)*

The fifth midwife was describe by one midwife as capacity building for MGP:

> *'We need a fifth person on each team as a rotational model to have that built in. Give people a taste of what MGP is like. They have their idea of what on-call is like' (Midwife 6).*

Another idea discussed was making the workload more flexible:

> *'Six on the team and a mixture of full time and part time' (Midwife 5).*

Antenatal care is located within the hospital where there is a lack of space in the antenatal clinic, restricting antenatal care to 20-minute visits with women. Other services provide the

majority of care in the woman's home, allowing longer antenatal visits. Some midwives found the idea of routinely providing antenatal care in women's homes appealing:

> *'I would prefer that…. I can plan my time and go to their house and spend more time with them, more quality time as opposed to half an hour in a clinic, where you go, "Get out the door, I've got to see the next one' (Midwife 5).*

Midwives felt that providing care to women in the community setting, either in women's homes or community-based clinics would provide the dual benefits of removing the need for women to travel to the hospital and would also free up space for doctors clinics:

> *'A further thing we're… having a discussion around is doing bookings at home, like at the woman's home, to allow for antenatal room for doctors' clinics, because doctor's clinics are so overbooked and women wait there for hours on end, so doing an hour and a half booking history at home would make sense...' (Midwife 3).*

It was acknowledged that geographical distances could prove challenging as women in the catchment would potentially require midwives to travel as far South as Gerringong and North to Helensburgh. This could be managed if midwives arranged their care based on women's location, eg., Northern home visits on Mondays.

4.7.1 MAPPING TO THE QMNC FRAMEWORK WITH SUPPORTING LITERATURE

This theme is in direct contrast to the QMNC framework that states the ***organisation of care*** should be *available, accessible, and acceptable and of good quality*. The issue of limited space to perform antenatal appointments needs could be addressed by *integrating care across the community and facilities* providing at least some of the care in the woman's home. This would make the care *available, accessible, acceptable, good quality services with adequate resources* and a *competent workforce*. Through providing extra midwifery workforce and community antenatal care the MGP would increase the ***value*** of quality care through *tailoring care to women's circumstances and needs*.

4.8 MANAGING DIFFERENT WAYS OF WORKING

MGP midwives had varying levels of experience, with some having worked in Wollongong MGP since its inception more than 14 years ago and others having joined MGP within the last 12 months. For the most part, team members worked well together and provided collegial support to one another. However, it was evident that there was some tension around '*Managing different ways of working'*.

Each team described being happy with the way they worked, however, they saw problems with the way the other team worked. Primarily this was centred around the organisation of rostered days off and whether midwives want to be called in for women on their days off:

> *'My opinion… is that the two teams work very differently and have different philosophies of care, so the other team liked to be called on their days off to come in and things… it's not the whole team, but some of the midwives in that team… And I guess on this team we like to have our days off as days off, but I may say to a midwife that's on over my days off, "call me or message me, whatever, if this person labours" and make that decision from there' (Midwife 3).*

Team Juno appears to be offering a model of care similar to 'team' while Hera are offering 'caseload'. Team midwifery usually comprises six to eight midwives providing care in a midwifery-led unit such as a birth centre or an alongside midwifery-led unit (Homer, Brodie & Leap 2008; Rayment et al. 2015). Midwifery group practice (MGP) usually refers to groups of four midwives who have a caseload of women with the flexibility to have rostered time off including sick and annual leave with backup from one or more midwives in the group (Homer, Brodie & Leap 2008). Ultimately, all MGP midwives were trying to balance the needs of women with their own needs for time off, however the disagreement lay in how this was best achieved.

Women didn't report noticing any difference between the two teams:

> *'I was in team Juno for both pregnancies and some of my close friends were in team Hera, and we have compared our experiences and from our perspective, we couldn't really tell the difference in how they managed the teams' (Elaine, PN woman).*

Doctors had noticed tensions between some MGP midwives and were concerned that this might impact the care being offered to women:

> *'Any tension between a team of people who works for a group of people will definitely affect the patients' (Doctor 2).*

4.8.1 FINDING A BALANCED WORKLOAD

Workload was a matter of significant concern for the MGP midwives and there were divergent views amongst midwives as to how best to manage rosters and hours. Managing their workload in order to avoid burnout was a major concern for some midwives:

> *'I guess that's also a big element, in my opinion, of burnout. I like my days off as days off, to just have my time because obviously, you know, being on call 24 hours and sometimes seven days a week, by day four you're exhausted, especially if you've had some busy days' (Midwife 3).*

However, other midwives were driven by a desire to care for as many women as possible:

> *'I think 40 [births per year] is ridiculous and it's not enough. And I've always said that… There is so much time that you could add that you can actually fit other people in…. Dear God, if you get another xxxx meeting for me to go to I'll scream and that's how my time is utilised. I do busy work and I hate busy work. I want to look after women!' (Midwife 6).*

Managing unexpected leave and sick leave was also a significant concern, as there didn't appear to be a firm system in place:

> *'When somebody goes on sick leave, we get no replacement for that person, no matter how long they are off. And even though your numbers of clientele are reduced, you become a smaller team, so therefore you share more hours, I guess, with the women, and it does lead to an excess workload' (Midwife 1).*

Some midwives were concerned about burnout due to excessive hours being worked:

> *'Sometimes [we do] extraordinary hours, which then leads to exhaustion, fatigue, ill health, and sadly burnout, and in the time I've been with MGP, I've seen burnout happen with a couple of colleagues. Even though that hasn't been stated to be the reason for their departure from the teams [it is]' (Midwife 1).*

At times, issues of understaffing of core midwives on birth unit meant that MGP midwives were unable to hand over care of their women, despite having worked the maximum amount of hours allowed:

> *'I do believe that we sometimes have unreal expectations on our time. We are all rostered, and we all do certain amount of time before we get relief, but quite often when things get hectic within the MGP practice, everybody's done their hours, we need to hand over the care of our women very, very occasionally to hospital staff, so for*

example, in the birthing unit. And sometimes this is just not possible, because they are so overstretched and overworked and understaffed themselves that they cannot take over care of the women we're looking after' (Midwife 1).

Doctors were also concerned about the workload of MGP midwives:

'I think if someone has to do more hours than are required then it will affect them because they are tired. And I know that with certain periods of time there will be a rush of women delivering on the MGP service and there will be a lot of changeover, and a lot of the MGP midwives will work a lot of hours. And I think if there's disharmony between [the midwives] and people are not agreeing to come in when they should, then the MGP midwives will get overtired' (Doctor 1).

Doctors were concerned about midwives having adequate rest so they could work safely:

'Staff exhaustion is really important. If they are really getting exhausted, they are not safe' (Doctor 2).

Following discussion about safe working hours, doctors agreed that midwives shouldn't be asked to come to work for women in labour on their days off. They felt that women would accept the possibility that their primary midwife wouldn't be able to attend their birth if she was on a rostered day off:

'I think that if you communicate to the women that this is the way it works then it should be acceptable' (Doctor 1).

4.8.2 NEEDING A CONSISTENT APPROACH

In addition to different ways of managing the on-call component of care, some midwives were concerned that women were receiving a very different type of care, depending which MGP team they were assigned to:

'One of my overall issues when I came to MGP was that, a group of women were essentially getting two very different [types of care]… What were we offering? Women were getting some stuff from some midwives and nothing from other midwives - yeah. And if a woman is coming to a service… or a model of care then shouldn't they be getting everything that is offered to them? Not purely just because of which team they've been allocated to' (Midwife 5).

There were calls for a more consistent approach so that all women had access to the best quality care.

4.8.3 MAPPING TO THE QMNC FRAMEWORK WITH SUPPORTING LITERATURE

The midwives require extra workforce for backup to ensure they provide quality care. There were different ideas amongst midwives about how best to manage their workload. Some midwives wanted more flexible ways of working and others wanted a regimented roster system, but all wanted extra backup from a fifth midwife. We recommend midwives work in ways that suit their work/life balance. Working in pairs rather than larger teams would allow midwives to decide how they work in agreement with their chosen partner/buddy. This will reduce the conflict around ways of working, however the midwives need to be cognisant of the safe levels of practice adhere to the award and annualised salary requirements. It has also been shown that employing a midwife to cover both unexpected and expected leave between the MGP midwives reduces the need for midwives to work over their hours (Hartz, White & Lainchbury 2012).

In the United Kingdom it has been proposed certain conditions are required to develop these new ways of working and to support staff (Royal College of Midwives 2018). In accordance with these guidelines we recommend staff establish their own ways of working that meet the needs of the women and babies in their case load with staffing levels adequately planned across the MGP (Royal College of Midwives 2018). This will enhance ***care providers*** who are *based on need, competence and resources*.

5. RECOMMENDATIONS

5.1 Visionary leadership through an allocated midwifery manager

In order to expand the midwifery-led continuity of care model is it essential that a dedicated manager be appointed. Major differences in philosophy between midwives and their managers create stress for all staff and for women receiving care (Australian College of Midwives 2017). We found evidence of this accurately depicted in the following quote;

> *'There's been a very, very quiet midwifery voice, almost a whisper. We need to bring some of the role back because the profession of midwifery at Wollongong Hospital is subjugated to the medical model. And so, the women are subjugated to the medical model' (Midwife 8).*

A leader of midwifery caseload practice is required to communicate the vision for the model, protect the philosophy of woman-centred care and support and understand the autonomous role of the midwife (Australian College of Midwives 2017). [redacted]

"Holding the ground for midwifery, for women" (Hewitt, Priddis & Dahlen 2019, p. 170) was proposed as a key attribute to effectively manage midwifery-led continuity of care models. This concept refers to protecting the service for midwives and the birth space for women (Hewitt, Priddis & Dahlen 2019). [redacted] The new expanded model needs a manager with an ability to 'midwife the midwives', manage the service, have a well-developed understanding of the philosophy as well as highly developed skills to juggle competing clinical and workforce demands (Hewitt, Priddis & Dahlen 2019). An example of a position description for a Midwifery Unit Manager (MUM) for a caseload midwifery service details the incumbent needs to have: demonstrated ability to work within a multidisciplinary team environment using advanced leadership skills and highly effective interpersonal and communication skills, a sound knowledge of contemporary midwifery issues in maternity care and commitment to woman centred/evidence based practice with

evidence of commitment to consumer care, involvement in care and the quality improvement processes (NSW Health Service -Western Sydney Local Health District 2019).

We propose a new manager is recruited who has an understanding and commitment to midwifery-led continuity of care model , who understands the needs of women who access the model and the needs of the midwives who work in the model. The manager needs to know how to provide support to the transitioning midwives as the model expands and build relationships of trust to ensure effective collaborative relationships with the doctors.

5.2 Change the model to Caseload Midwifery with the expansion

Caseload midwifery means each woman has a primary midwife providing the majority of her care through pregnancy, being on call for her birth and during the postnatal period. The midwife will organise her time flexibly around the woman's needs and her own on-call capacity (Australian College of Midwives 2017). This model of continuity of carer enables the development of a trusting relationship that we termed a *professional friendship*. In order for the midwives to provide a high level of continuity to ensure the development of a *professional friendship* it is necessary for the midwives to work in a caseload model where they are the primary midwife for a number of women per year as per the annualised salary (Australian College of Midwives 2017). Working in this way will provide high quality care as described in the QMNC framework and provide flexible ways of working for the midwives already working in continuity. Providing high quality care in flexible ways is satisfying to midwives and will attract new midwives to work in caseload.

5.3 Increase women's access to the model to enhance expansion

Good quality maternity care is accessible and acceptable to women. We found that a number of women were unaware of the midwifery group practice and only heard through friends or relatives. To increase access we recommend advertising the service to women in the area.

Women also stated they did not book or meet their midwife until after the first trimester. The Australian care in pregnancy guidelines specify women should commence their antenatal care with a longer visit within the first 10 weeks of pregnancy (Department of Health 2018). We found midwives are the ideal health care providers to offer this comprehensive appointment. In this booking appointment the midwives will; seek women's views about care, involve her partner/family, provide emotional support, undertake history, screening and provide advice on place of birth and consult and refer as required (Australian College of Midwives 2013; Department of Health 2018).

Women should either self-refer to midwifery services at Wollongong hospital or receive referral prior to 10 weeks from their GP. The comprehensive booking visit can be conducted in the woman's home using the ACM consultation and referral process (Australian College of Midwives 2013).

Midwifery-led continuity of care models should not be restricted to women without any complexities in their pregnancy. Increasing access to women who need it the most, such as Indigenous women and young women will improve their outcomes.

Midwifery-led continuity of care has been proposed as an important intervention to 'close the gap' for Aboriginal mothers and babies (Kruske, Kildea & Barclay 2006). These models have been found to be positively evaluated by Aboriginal women (Corcoran, Catling & Homer 2017). Providing midwifery caseload practice to Aboriginal and Torres Strait Islander women has been shown to provide ease of access to the service through trusting relationships with caregivers, in the Malabar service in New South Wales. This service also found a reduction in cigarette smoking during pregnancy through providing continuity of care (Homer et al. 2012).

Another group that would benefit from access to midwifery-led continuity of care models would be the young women's group who access Wollongong hospital for care. Young women allocated to caseload care at booking compared to standard care are less likely to have preterm birth or a neonate admitted to intensive care (Allen et al. 2015). The midwives who currently provide antenatal care for these women through CHAIN may wish to move into caseload practice. These midwives will require the same level of support that all midwives who wish to transition from working in a traditional rostered model of care to working across the full spectrum of midwifery care require.

5.4 Increase and sustain the midwifery caseload workforce

In order to increase the workforce and make it sustainable there needs to be a plan for moving midwives into caseload. Placing students with caseload midwives ensures they are prepared to work in the model at the time of graduation (Cummins, Catling & Homer 2017). Placing students with midwives in caseload practice enhances their confidence and competence and provides a real-world view of what working in caseload could be like on graduation (Sidebotham & Fenwick 2019). This could also be the case for Indigenous midwifery students wishing to work with midwives providing caseload care to Indigenous women (West et al. 2016) ensuring care providers are equipped with cultural skills as per the QMNC framework.

Midwives wishing to transfer from working on the wards into caseload need support similar to new graduate midwives transitioning. Support is usually an initial reduced caseload and an opportunity to practice all necessary skills. Support can also be in the form of mentoring by a more experienced midwife who has worked in caseload or a manager or educator who acts as a mentor (Australian College of Midwives 2017). Mentoring can be formal (allocated and within a specific time frame) or informal, where the midwife finds their own mentor and engages in professional development (Australian College of Midwives 2017). Midwives who have worked in a traditional model of maternity services such as the birth unit for several years are not necessarily equipped to move directly into midwifery caseload practice. It would be recommended there is a staged approach and the midwife needs to obtain all necessary skills to work in autonomous practice (Australian College of Midwives 2017).

The doctors in this study identified a need for the midwives to upskill to provide continuity and to minimise the need for a doctor to attend women to undertake suturing when the woman had received all her care from a known midwife. Skills required will include but are not limited to; venepuncture, cannulation and perineal repair, also other skills such as woman centred language that enhances communication between women, midwives and doctors (Australian College of Midwives 2017). All midwives at the point of registration will have had the theoretical background and experience in venepuncture, cannulation and perineal repair as part of their degree (Australian Nursing and Midwifery Accreditation Council 2014). Midwives require practice of these skills in the real world setting and should be supported to reflect on their skills and develop learning goals towards becoming confident with these skills.

Undertaking midwifery practice review (MPR) enables all midwives to gain the skills necessary to move into caseload practice (Australian College of Midwives 2017). MPR enables midwives to develop their professional portfolio including documenting professional development achieved and plans for further development (such as working towards homebirth), clinical practice and outcomes and reflections on their practice, it is assessed by accredited professional and consumer reviewers (Australian College of Midwives 2017). This is a formal and fair review process and removes any subjectivity. We recommend midwives working in

midwifery caseload practice or planning to work in caseload and provide homebirth must undertake the MPR.

5.5 Increase access to publicly-funded homebirth

Consistent with the expansion of midwifery-led care is the expansion of access to homebirth for women. Pregnant women in New South Wales (NSW) have very limited access to homebirth (Australian Institute of Health and Welfare 2017). The largest analysis of planned homebirths in Australia provides valuable evidence to assist in the development of services and to support the need for ongoing data collection (Homer et al. 2014). Wollongong publicly-funded homebirth service has an opportunity to be a leader in New South Wales and Australia with the expansion of the midwifery caseload practice providing homebirth access for women based on consumer demand.

The Royal Hospital for Women in Metropolitan Sydney has recently implemented a publicly-funded homebirth service. Key to this implementation was the employment of a clinical midwifery educator who has experience in homebirth to assist with mentoring midwives to provide homebirths (Sidery 2018b). Wollongong has suitably qualified and experienced homebirth midwives who could move into a mentoring role to support the accreditation of midwives who can provide homebirth, increasing access for women. The accreditation process needs to be less rigid and more individualised. For example, some midwives may only need to attend two homebirths before they feel confident to be the primary midwife whereas others may require five or ten. It is important to note providing homebirth is within the normal scope of practice for a midwife, however midwives without prior exposure to homebirth will need mentoring and support from colleagues and managers (Coddington, Catling & Homer 2017). We recommend a homebirth mentor is employed to provide support for midwives to become more confident to offer and provide homebirth services in order to meet community demand. One of the experienced homebirth midwives could be moved into this position and another midwife employed to provide a caseload.

5.6 Attract midwives through flexible ways of working

Allowing the midwives to work in whatever way suits their work/life balance will attract midwives to work in the model and help to sustain the continuity of care model. In one large metropolitan hospital where 32 fulltime equivalent (FTE) midwives moved into MGP models of care, there were 8 groups working in a mix of; on-call and roster systems, decided by the midwives (Hartz, White & Lainchbury 2012). Some work on call with a rostered system with one weekend off a week, others are on call for their women during the week and share on call over the weekends; other midwives are on call 7am-7pm then hand the phone over to one midwife overnight (Hartz, White & Lainchbury 2012). This is an example of how a variety of ways of working will suit the individual needs of midwives to achieve a work/life balance.

Providing flexible ways of working attracts midwives to work in the model. We previously studied another large metropolitan site that has 16 FTE midwives working in pairs to provide a caseload service (Cummins et al. 2019). Working in this way provides flexibility for midwives to manage their own time while providing care to a caseload of 35 women per year (Cummins et al. 2019).This flexibility benefitted midwives, many of whom were mothers themselves, as it allowed them to fulfil their own responsibilities as carers whilst maintaining a full caseload of women (Cummins et al. 2019). In this practice there is an example of two midwives who work part time and share a caseload with great success for both their home and professional life.

The Westmead caseload practice includes antenatal care provided primarily in the woman's home, or in the hospital setting when required. Midwives are on call for their caseload of women during labour and birth with a reported 80% of women having a known midwife present at the birth. Women are discharged home as early as possible after the birth (minimum hospital stay is four hours) with the midwife providing postnatal care in the woman's home on a daily basis until seven days postpartum (Cummins et al. 2019). This hospital has midwifery-led continuity of care listed as an ongoing model of care in the Maternity Care Classification System (MaCCS): Model of Care Report (Australian Institute of Health and Welfare 2016).

We recommend midwives work in pairs with a midwife partner; together they decide on the way they would like to work. This pair of midwives would have another pair of midwives as their backup. We also recommend the employment of a midwife to cover unexpected leave to "float" between all the midwives. This midwife could already be employed casually to work in other areas of the hospital and may be interested in working in the caseload model. The benefits of the redesign in the hospital employing 32 fulltime equivalent midwives in caseload practice, found a reduction in the need for agency casual staff to replace roster shortfalls with a sustained, reduced requirement of less than two FTE casual staff per month (Hartz, White

& Lainchbury 2012). We propose just one midwife be employed as a floater as the number of midwives at Wollongong will not be as high as this setting.

5.7 Conduct antenatal visits in the woman's home

Midwives providing continuity of care usually conduct antenatal care at the hospital or in the woman's home. Providing care in the home provides insight for the midwife into the woman's home environment, her social support network and other support networks (Australian College of Midwives 2017). Increasingly midwives are providing care in other community settings such as community health centres, shopping centres and other practitioners' clinical spaces, including that of medical practitioners. This increases access options for the woman and her family and for care to be located closer to her home (Australian College of Midwives 2017). Expansion of MGP will require more antenatal clinic space, therefore we propose some of the antenatal care should be provided in the woman's home or alternative setting.

Other midwifery caseload services provide antenatal care in the home (Cummins et al. 2019) and the Australian Pregnancy Care guidelines state that care should be provided as close to a woman's home as possible citing research that has found a reduction in rates of domestic violence and an increase in breastfeeding rates (Department of Health 2018). We found women at Wollongong were well prepared for the birth and there was an emphasis on including the partner and other children. Certainly for women considering a homebirth, antenatal care should be provided in the home. Evidence suggests women who give birth at home appear more prepared for birth than women in the hospital setting as they are supported by midwives who they know and who spend time discussing the issues that are important to women becoming mothers (Dahlen, Barclay & Homer 2010). Antenatal home visiting should be included as part of the expansion of MGP, arranged via postcode allocation to minimise travel time for the midwives. This will meet the requirement of accessible and acceptable organisation of care.

5.8 Promote collaboration through providing a named obstetrician

Critical to high quality maternity care is the provision of a named obstetrician for caseload midwives to collaborate with when consultation and referral is necessary. This maps directly to the appropriate division of roles and responsibilities of care providers within the QMNC framework. Collaboration with a known obstetrician demonstrates effective and professionally satisfying maternity care (Beasley et al. 2012). Key to collaboration is the weekly meeting of midwives and an obstetrician where the woman's history and plans for ongoing care can be discussed as per the Australian College of Midwives guidelines for consultation and referral (Australian College of Midwives 2013). In one setting a study over a 12month period found 50.1% of women being cared for by the MGP midwives were discussed at the weekly meeting (Beasley et al. 2012). At these meetings the woman's management plan was recorded 97% of the time and the notes were 100% legible (Beasley et al. 2012). Staff were highly satisfied with having this form of consultation and the obstetrician described the meetings as collaborative, enjoyable, educational and productive with a desire to involve more junior doctors in the meetings (Beasley et al. 2012).

We highly recommend this approach to collaboration as we found the midwives were finding it difficult to access medical support and the doctors did not want to and should not have to conduct corridor consultations without knowing or seeing the woman. Successful implementation in maternity care requires medical engagement and support (Australian College of Midwives 2017). We recommend providing a named obstetrician for the caseload model. This will enhance midwifery and medical staff's satisfaction with working together.

Evidence based contemporaneous guidelines need to be developed in a collaborative manner to guide practice. The guidelines should be developed by the people who are using them for practice, this is the midwives and doctors together. The sign off and publication of these evidence based guidelines needs to have both midwifery and medical staff approval/sign off to ensure midwives and doctors are cognisant of and work within the evidence.

6. CONCLUSION

In the Wollongong and Illawarra Shoalhaven Local Health District there is community demand for increasing access to midwifery-led continuity of care including publicly-funded homebirth. Midwifery-led continuity of care has been evaluated as the best model of care to improve outcomes for mothers and babies, reduce costs and increase satisfaction rates for women and midwives. MGP at Wollongong hospital is an example of midwifery-led continuity of care.

Our research found a clear demonstration of the positive aspects of MGP at Wollongong and these include; the opportunity for women and midwives to develop a professional friendship, evidence that the women are well prepared for birth and motherhood through the sharing of knowledge. Every component of the QMNC framework is positively addressed and this reinforces the gold standard of midwifery-led care referred to as caseload. .

The challenge for Wollongong Hospital is to address the negative findings to ensure a harmonious expansion of the model that will meet both consumer and organisational needs. Both service users and service providers were frustrated by the process of getting ticked off for the model and the delay in referral to the MGP. In order to meet the requirements of the QMNC framework women need to self–refer to the midwives and/or GP's need to provide referral in the first trimester.

Women could not readily access publicly-funded homebirth mostly because there were not enough midwives accredited to provide the care. Wollongong Hospital needs to develop a system of accreditation for midwives to provide homebirth in accordance with other NSW hospitals to increase access. There are experienced midwives who can mentor midwives to become accredited for homebirth. Midwives can develop reflection on their practice and goals towards accreditation for homebirth through undertaking midwifery practice review.

The midwives were quite vocal about struggling with an unsupportive hospital culture and a need for midwifery leadership. A strong recommendation is the recruitment of a dedicated manager to lead the expansion of the midwifery-led continuity of care model. The manager needs to share the philosophy of promoting normal physiological birth and be able to support the transition of midwives into the model. Support includes but is not limited to mentoring, providing an initial reduced caseload and allowing the midwives to work in pairs.

The midwives need to find their own way of working within the annualised salary agreement. The current groups prescribe a certain way of working and these groups should be disbanded to enable midwives to work in pairs with a backup of another pair. In pairs the two midwives will decide how they want to work, this increases the level of continuity the woman experiences and provides more control for the midwives over their work/life balance. Employing a casual midwife as a 'floater' is required to cover unexpected leave.

Placing students with the caseload midwives to experience first-hand what it is like to work in midwifery-led continuity of care as a new graduate will help with expansion. Midwives do not need have a compulsory amount of time in the birth unit or years of experience to become a caseload midwife. Any midwife who is registered should be able to apply for a position, so long as they have all the necessary skills and knowledge. Undertaking Midwifery Practice Review enables midwives to recognise these skills and plan professional development. It is critical all new midwives moving into caseload practice are supported by their manager with an initial reduced caseload and mentoring. These changes will assist to not only expand the model but also sustain the model.

Finally the midwifery caseload model requires a named obstetrician who attends their regular weekly meetings to discuss any woman that the midwife has identified needs consultation. Having a named obstetrician will enhance collaborative working arrangements.

In order to meet these recommendations for expansion the caseload midwives and the obstetricians need to develop evidence based guidelines/local business rules concurrently with the expansion of the model to ensure collaborative practice.

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