Factors Influencing the Implementation of Midwifery Continuity of Care Models in Regional Areas

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This thesis follows the American Psychological Association seventh edition (APA 7) publication manual for scholarly writing style and formatting (APA, 2020). The two exceptions to these guidelines are;

- The purple used for chapter headings, a recognised colour that is synonymous with the midwifery profession.
- The formatting applied to participants' direct quotations throughout the findings chapter's five-seven, follow APA 7th style, they are also italicised for visual clarity.

CERTIFICATE OF ORIGINAL AUTHORSHIP

I hereby certify that the work embodied in the thesis is my own work, conducted under normal supervision. The thesis contains no material which has been accepted, or is being examined, for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968 and any approved embargo.

Elysse Prussing

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ABSTRACT

Background: Evidence demonstrates significantly improved outcomes for women and their babies when supported by Midwifery Continuity of Care (MCC) models. Despite this research and current Australian health directives, widespread implementation of MCC has not been achieved. This is especially true in regional areas.

Aim: The aim of this research was to develop a theoretical understanding of the factors that may facilitate or inhibit the implementation of MCC models within regional New South Wales public hospital settings.

Methods: A Constructivist Grounded theory approach was used to collect and analyse data from interviews with key public hospital informants. Three phases of interviews were conducted, which included Phase one (midwifery advisory roles), Phase Two (midwives) and Phase Three (women).

Findings: Three concepts of theory emerged from within the data analysis that demonstrate a substantial influence over the implementation of MCC models. These included'*engaging the gatekeepers*', '*midwives lacking confidence*' and '*women rallying together'*. Asubstantive theory was generated which strongly recommends that: *A partnership between midwives and women is required to build confidence and enable the promotion of current evidence; this is essential for engaging key hospital stakeholders to invest in the implementation of MCC models.*

Discussion: This substantive theory recommends that a partnership needs to be enabled between women and midwives as this was a key facilitator for engaging necessary organisational support for MCC implementation. These elements need to be considered in light of the categories and sub-categories from which they were raised. Firstly, '*engaging the gatekeepers*' identified the need to acknowledge midwives as the biggest barrier to the implementation of MCC models; concerns were raised about a need for workplace culture change and, a funding for a project officer role. A project officer was essential to facilitating change and staff engagement that is required for successful MCC implementation. The concept '*midwives lacking confidence*' demonstrated that although midwives are wanting to be woman centred carers, they are hindered by a system which they identify as subordinating. Participants also observed the need to support student and new graduate midwives as they are an invaluable resource of knowledge and MCC experience. Lastly, '*rallying together with women*' represents a gap which reveals women do not realise their power to make changes to their health care services and, a lack of MCC awareness is a barrier preventing women from requesting access to MCC. Additionally, women participants felt undervalued by a health system not meeting their needs, further preventing their engagement in service changes such as MCC. Despite this, in some regional areas the closure of maternity services was a crisis that triggered women to advocate for access to MCC models, by seeking out midwifery champions and rallying together. These recounts demonstrated the powerful influence a partnership between midwives and women could have over facilitating the implementation of MCC in regional areas.

Conclusion: It has now been 16 years since the Australian Maternity Action Plan recommended that state and federal government supported increased access to midwifery continuity of care. Although an increase in the number of MCC models is evident, the

number of women with access to them remains limited and widespread implementation and up-scaling of models has not yet been achieved. This thesis contributes to the existing body of knowledge that supports these implementation goals. The findings from this study draw attention to issues that the midwifery workforce face when transitioning into MCC models. Education opportunities are needed to better prepare midwives, to understand MCC ways of working and to address skill issues. Student and new graduates were valued for bridging the evidence-practice gap by role modelling continuity values and current MCC evidence in the clinical environment. Implementation was identified as a coordinated ground up approach that requires widespread dissemination of MCC evidence, directed at hospital executive level management. A partnership between women and midwives facilitated engagement with these key hospital stakeholders, who in turn, showed support by funding a project officer, essential to successful implementation of MCC. Participants identified the project officer was a critical factor that ensured cultural and practical concerns of all stakeholders were resolved. Efforts moving forward need to focus on valuing a midwifery partnership with women and increasing stakeholders (midwives, women and hospital management) awareness of the evidence for MCC.

Implications for Practice and Policy: The findings of this study will supplement current evidence and inform future policy directives relating to: the implementation and upscaling of MCC models across regional settings, enabling a ground up approach to the design and planning of maternity services, promoting autonomy for midwifery practice, staff education and support mechanisms to enable transition into MCC ways of working. These factors will assist with increasing maternity care options that improve vital outcomes for women and their babies.

Relevance of this work to audience: For midwives and birthing services, this research provides insight into the barriers to the implementation of a service model that values midwives and improves outcomes for women, babies and their families. The findings offer a number of strategies to address issues that are currently preventing implementation of MCC models in regional NSW. Some studies also indicate significant cost savings to healthservices with the implementation of this model as well as improved wellbeing and work satisfaction for the midwifery workforce.

Glossary of terms

This glossary provides an explanation for some of the common terms used throughout this thesis.

Terms	Explanation
Caseload	Maternity model of care where a woman has a primary midwife throughout pregnancy, labour, birth and postnatal period. Midwife has an agreed number of women throughout the year (usually 30-40) known as a caseload. Midwives typically work on-call as opposed to rostered shift work.
Continuity of care:	Care provided by a known midwife throughout the childbearing continuum.
Consumer:	A person accessing or receiving health care from a public hospital service.
Doula:	A person privately employed to provide support and guidance to a woman throughout pregnancy, birth and postnatal period.
Gerunds:	A noun formed from a verb, referring to the action, process or state. In English language ending in ‘ing’.

Sensitising concepts:	Grounded theorist often come to their research with already well-established concepts or notions of the study phenomenon. These ideas are acknowledged and provide a loose starting point, however, should not direct the inquiry.
Theoretical Sampling:	A grounded theory approach to sampling. Once a tentative category has emerged the researchers aim to develop its properties further, by seeking additional information through; people, events, revisiting data and other sources that may show relevance during the analysis. This is not to be confused with the quantitative approaches to sample randomly selected populations or representative distributions of populations.
Fragmented maternity care:	Maternity care provided through the Australian public hospital system, whereby a woman receives care throughout her pregnancy, birth and postnatal periods by a number of midwives, and/or other health professionals such as obstetricians.
In-vivo words:	Codes adopted directly from the data, such as telling statements used in participant's everyday language.

Midwifery Group Practice	Midwifery care provided primarily by one lead midwife and/or supported by a small group of midwives (two-four) through pregnancy, labour, birth and postnatal period.
Woman/Women:	A woman accessing, or who has experienced, maternity care in an Australian public hospital.

Acronyms

ACM	Australian College of Midwives
CGT	Constructivist Grounded Theory
CMC	Clinical Midwifery Consultant
MCC	Midwifery Continuity of Care
MGP	Midwifery Group Practice
MoH	Ministry of Health, Australia
MUM	Midwifery Unit Manager
NHS	National Health Service, United Kingdom
NMBA	Nursing and Midwifery Board of Australia
NSW	New South Wales, Australia
RCM	Royal College of Midwives, United Kingdom

Preface

Prior to the birth of my eldest daughter Leila, I had never really considered what it was that midwives do. However, this all changed when I gave birth to our beautiful baby, and I was primarily cared for by midwives at the local public hospital. This experience, along with a little nudge from my mum, opened the door to midwifery and within a few weeks I had enrolled into the Bachelor of Midwifery program at the University of Newcastle.

As a student midwife I had the privilege of supporting a number of women, and their families, throughout their pregnancy, birth and postnatal experiences. This midwifery clinical education requirement is known as a Continuity of Care Experience (CCE). These CCEs were invaluable because the months leading up to the birth provided time to develop familiarity with each woman. I learned about each woman's relevant medical history, meet her chosen support network, and could find out what elements of her care I needed to advocate for during this significant life event. Most importantly, however, I could build trusting relationships with these women.

Three years later, in 2015, I was a registered midwife commencing my new graduate year, while continuing to study a Bachelor Midwifery Honours degree. During this time, I joined a working group developing a business plan to implement a MCC model at my local hospital. Although, a report was finalised, and all appropriate stakeholders seemed to be engaged, momentum towards implementing a model stalled and as a result the working group fell apart. It was at this point that I began to wonder what I could do to contribute. By this time, I had successfully completed my honours degree which opened the opportunity for a scholarship to support my PhD study. I applied for the scholarship hoping it would facilitate the implementation of a MCC model in my local hospital and although this did not occur like I had hoped. My supervisors were quick to rein in my enthusiasm so that, my topic developed

into a much more feasible research project for a PhD which was to explore the factors that influence implementation of MCC models in regional areas.

I am a woman who has twice accessed the local public hospital maternity care, the only option in my home town, for the births of my two children. I am also a registered midwife providing care to the childbearing women in my local community. Knowing the vital health outcomes this MCC model improves, and its underpinning robust evidence (shown in Figure 1), I struggle to understand why MCC is still not an easily accessible option of care, for the majority of Australian women.

In the early stages of my PhD I read an article that has continued to resonate with how I feel about this research topic:

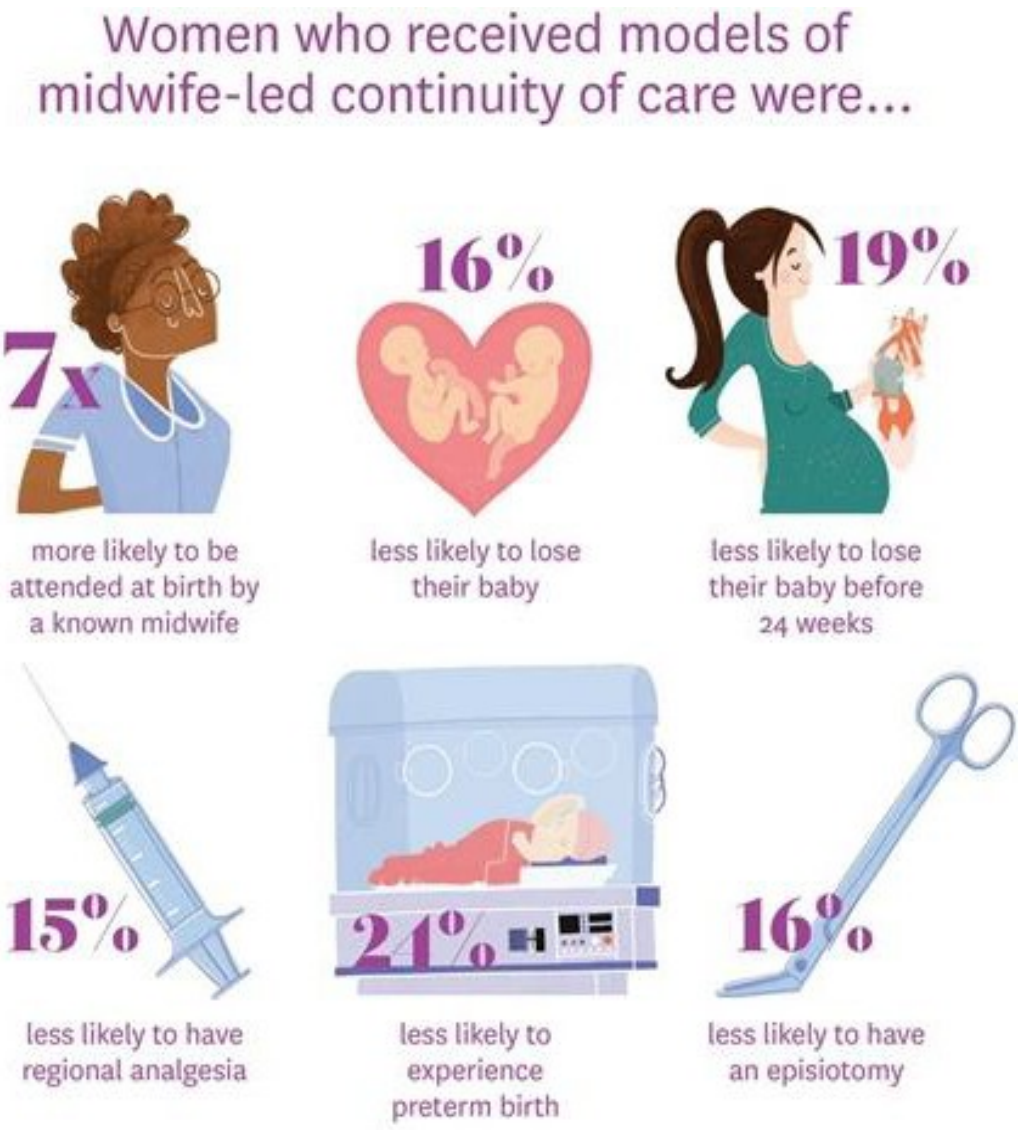
> *'We all know that continuity of midwifery care is a good thing and that research shows its outcomes to be so good that if it was a drug it would be unethical not to give it'.(Kirkman, 2016, p.23)*

This thesis uses a qualitative constructivist grounded theory approach to investigate why midwifery continuity of care is not a mainstream maternity care option for Australian women. Constructivist grounded theory recognises that the researcher is part of the research process and its methods identify that the results are mutually constructed understandings shared between the participants and the researcher. The aim of this approach is to stay true to the participants words; grounded theory is recognised for its inherent quality in advocating for often unheard, or overlooked, perspectives. It was for these attributes that a constructivist grounded theory approach captivated my attention. As an early career researcher, a woman and midwife I understood the benefits of approaching my research topic using these therapeutic relational based concepts. Constructivist grounded theory has allowed me to stay

true to the participants and to remain true to the woman centred, midwife advocate I continually strive to be.

Figure 1

Improved outcomes associated with MCC models



Note: From *A year of opportunity* by J. Dunkley-Bent, 2018*, Midwives, 21*(1), p. 69. Copyright 2018 by Redactive Publishing Ltd.

Thesis Outline

This thesis it presented in ten chapters. A concise summary of each chapter is described below:

Chapter One: outlines a background to this thesis by describing the current Australian maternity services context. This chapter offers a summary of the existing literature on the topic and a justification for the study.

Chapter Two: is an integrative literature review providing an in-depth exploration of the literature available at the commencement of this thesis. This initial review provided an evaluation of quality papers that concerning the implementation of midwifery continuity of care models. In addition to this initial literature review, and in order to stay true to the constructivist grounded theory approach, an updated review of the literature is provided in Chapter 8 and is included throughout the discussions in Chapter 9.

Chapter Three: provides a description of the methodological theory underpinning the constructivist grounded theory approach used to conduct this research project. This chapter considers the theoretical reasoning behind the constructivist research approach to recruitment of participants, data collection and analysis techniques, the incorporation of current literature and the emergent nature of constructivist theorizing.

Chapter Four: provides a an explanation of the constructivist grounded theory methods used throughout each step of the study. A detailed account is provided of the studies; setting, participants, recruitment, ethical considerations and approval, data collection, analysis, the approaches used for presentation of the data and its findings, and a description of the steps taken during the development of the resultant theory.

Chapter Five: A preamble to the findings chapter precedes chapter five and offers an introduction to the participants recruited into this study providing contextual and

demographic information to the data collection and analyses. Next, Chapter five presents the findings from Phase One participants which includes the perspectives from maternity unit managers, clinical midwifery consultants and state advisors. This chapter highlights the need for '*engaging the gatekeepers*' and identifies key stakeholders that can act as a barrier to implementing MCC models. This chapter also recognises that need for '*funding a project officer*', along with a number of strategies that can facilitate '*changing workplace culture'* that is required when implementing a MCC model.

Chapter Six: Offers experiences and understandings from the perspective of Phase Two participants. In this phase midwives were recruited using theoretical sampling after Phase One participants identified midwives are a major barrier to implementation. Phase two participants identified that '*midwives lacking confidence*' prevents many midwives from supporting the transition into MCC ways of working. Although many midwives indicated they are '*wanting to be woman centred carers*' a '*system subordinating midwives*' was described and shown to hinder their capacity to work to their full scope of practice. The importance of '*supporting student and new graduate midwives*' to work in MCC models was also highlighted as a facilitating influence towards MCC implementation.

Chapter Seven: Outlines the substantive categories and concepts from the perspectives of women in regional areas. Recruitment of women in regional communities was indicated as the results from phase two participants showed a gap in the understanding of women's perspectives particularly in relation to MCC implementation. This chapter shows that '*Rallying together with women*' has a substantial influence over successful implementation of MCC models. Women acknowledge the support and knowledge gained through '*rallying together*', particularly with midwives. However, phase three participants acknowledged that '*women not knowing about MCC*' and experiences of hospital maternity care that are not

meeting their needs prevents women engaging with health systems to request changes such as access to MCC models.

Chapter Eight: Provides an explanation of how the concepts of theory emerged from the substantive categories and were developed into the resultant theory. This chapter includes a clear 'decision trail' describing the steps and methods undertaken to identify factors that have a substantial influence over the implementation of MCC models in regional areas.

Chapter Nine: Offers a discussion of the each of the concepts of theory in relation tothe categories and subcategories, outlined in chapters five-eight. Chapter nine proceeds to discuss the findings in relation to the emergent substantial theory: *A partnership between midwives and women is required to build confidence and enable the promotion of current evidence; this is essential for engaging key hospital stakeholders to invest in the implementation of MCC models*. This theory is considered in light of the current midwifery literature and highlights a number of solutions to the barriers and identifies factors that facilitate the implementation of MCC models in regional areas.

Chapter Ten: Presents the conclusions drawn from the findings and discussions of this research. It offers recommendations for practice that will facilitate implementation of MCC models and provides suggestions for further research that will add to the existing body of knowledge surrounding this research topic.