Co-creation of guiding principles and a practical framework for a midwifery continuity of carer model: a cooperative inquiry with midwives.

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Co-creation of guiding principles and a practical framework for a Midwifery Continuity of Carer model:

A Cooperative Inquiry with midwives

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Abstract

Background: Current NHS policy recommends transformation of maternity services to provide midwifery continuity of carer (MCoCer). This model is evidence based best practice and has been shown to improve outcomes and maternity experiences. Whilst the evidence suggests that this model of midwifery is also associated with positive practice for midwives, it poses professional and personal challenges. A systematic review of midwife experiences of providing continuity of carer was undertaken to foreground what is currently known about this domain. The findings of the review indicate that midwives working in continuity of carer models value the ability to manage their own working practices and develop contextually and personally relevant strategies to help them negotiate potential challenges of MCoCer and sustain them in practice.

Aim: To engage midwives to co-create a vision for a MCoCer model which is relevant to them.

Methods: A cooperative inquiry (CI), based on midwives' contextual practical knowledge, sought to bring about understanding of how MCoCer could be implemented and sustained for a group of midwives. Cooperative Inquiry is a branch of action research methodology which was chosen for its strengths in personal transformation and social emancipation. Eight midwives participated from a range of settings in NHS Grampian to explore their views on MCoCer and generate contextual knowledge and understanding from their perspectives through phases of reflection and action.

Outcomes: The informational outcomes of the CI were a Shared Philosophy of Care which informed the Team Charter and a Framework for MCoCer. The transformational outcomes included change in Perspectives, Focus and Autonomy of the CI midwives.

Conclusions: The systematic review highlighted the importance of a person-centred model of practice which answers the needs of women and midwives as key to the success and sustainability of MCoCer. Strategies which promote person centred practice and sustain midwives in MCoCer was a key finding of the review. The CI equally identified that supportive structure was necessary for work-life balance, and that alignment of the organisation with a person-centred model was required to facilitate this. The Team Charter and Framework were co-created to provide this contextually and personally relevant structure, to help support design and implementation of a sustainable model of MCoCer in NHS Grampian. The Team Charter and Framework are applicable and transferable to other midwives and regions to support sustainable implementation of MCoCer models.

Keywords: Midwifery continuity of carer, systematic qualitative review, cooperative inquiry, co-create, person-centred model, shared philosophy of care, strategies to sustain, solutions for practice, whole of organisation support

Researcher Perspectives

I approach this study as a woman, a midwife, an advocate for women, gender and social equality, human rights and as an environmentalist. My own understandings have contributed to the rationale and methodology selected for the study. As the researcher in a qualitative study I must be immersed in the perspectives of the cooperative midwives whilst being aware of my own biases and preconceptions and how these may influence the inquiry (Dwyer and Buckle 2009). As such I must inhabit 'the space between' (Dwyer and Buckle 2009) simultaneously being internal and out with the inquiry, reflecting on my role and potential influence over the study continuously throughout the study.

As a caseloading midwife I have experienced positives and challenges of providing continuity of carer for women. Appendix A. is a reflexive account which embodies this. My own personal and professional experiences mirror comparable challenges experienced by other midwives providing continuity of carer as highlighted in the literature. These included notions of work-life balance, sustainability and burn out. Despite the challenges I encountered I found this way of working immensely positive and empowering for women and midwives. Working in a continuity of carer model which supported both women's and my own autonomy, captured the essence of what midwifery is and was inspiring. Yet there were times I was concerned about the long-term sustainability of practising this way and realised that there was a clear and pressing need to develop contextually relevant and supportive continuity models of care for sustainable midwifery practice.

Glossary and Definition of Terms

Autonomous Practitioner	Independent and self-sufficient, self-directed practice with midwives and women in partnership making informed decisions.
BBA- Born before arrival	Unplanned birth at home or before reaching planned place of birth (typically a hospital or midwife unit).
Caseload Midwifery	Caseload midwifery a model of continuity of carer characterised by a midwife undertaking responsibility for the continuum of care throughout pregnancy, birth and the postnatal period for a small identified number of women (Biro et al. 2003).
Continuity of care	All the professionals involved "share common ways of working and a common philosophy" (Green et al. 2001).
Continuity of carer	The provision of care by a known healthcare professional throughout an episode of care or for an ongoing condition incorporating the concepts of informational, management and relational continuity (Haggerty et al 2003).
Cooperative Inquiry (CI) Midwives	This term refers to the midwives who participated in this study and acknowledges their collaborative role as co-inquirers into the subject of midwifery continuity of carer.
Fragmented Model of Care	Current model of care in the UK for maternity services which involves the delivery of services according to the need of the client without the continuity of a known healthcare professional, leading to a lack of informational and management continuity.
Holistic	The parts of something are intimately connected and explicable only by reference to the whole.
Lead Maternity Carer (LMC)	The New Zealand model of care is an established continuity of carer model predominantly involving midwives as the lead maternity carer. Women contact and book with an LMC when they are pregnant who is then the responsible coordinator and point of contact for that women throughout the perinatal period. This model promotes a high percentage of continuity of carer involving a flexible work ethic and commitment to on call. LMC's are independent and autonomous practitioners who are paid for the care they provide in agreement with the government.
Midwifery Continuity of Carer (MCoCer)	The provision of care by a known midwife throughout the pregnancy, labour, birth and postnatal period incorporating the concepts of informational, management and relational continuity (Pace, Crowther and Lau 2018).
Midwifery Group Practice (MGP)	Midwifery Group Practice (MGP) involves the majority of care provided by a primary midwife supported by a small group of midwives throughout their pregnancy, during childbirth and in the early postnatal period.
Model of care	There are different ways to look after the health and wellbeing of women and babies during pregnancy birth and afterwards- these ways are called 'models of care'. (Sandall et al. 2016).

NIPE	Newborn infant physical examination. Check performed within 72 hours of birth by trained healthcare professional to identify and refer any anomaly of the heart, hips, eyes or testes.
Person-centred Care	Person centred models provide healthcare in partnership with individuals to ensure that their needs are met in an holistic way. McCormack (2010b) proposes that this model should also address the needs of the healthcare professional to ensure sustainable partnership models.
Rotational Midwifery Post	A rotational system of practice where qualified midwives move between antenatal, intrapartum and postnatal posts on a scheduled rotation. The aim of this is to ensure the maintained skills of midwives, and adequate staffing of institutions. However fragmented care and lack of collegial relationships created through this way of working is a concern.
Royal College of Midwives (RCM)	The UK's only trade union and professional organisation led by midwives for midwives. The RCM supports midwives to achieve excellence in practice and encourage leadership and innovation in maternity care.
Team midwifery	Model of maternity care where a group of midwives provide care and taking shared responsibility for a group of women from the antenatal period, through labour and postnatal care (Begley et al. 2011).
Woman centred Care	Woman centred care is a concept in midwifery care which: • Focuses on woman's individual needs and aspirations in a holistic way • Recognises the need for each woman to have choice, control and continuity of caregiver and her expertise in decision making • Encompasses the needs of the baby, family and anyone else important to the woman as defined by her (Leap 2000). Woman centred care is the conceptual basis for MCoCer models.
Women-centred Care	Leap (2009) argues that women-centred care is a contested concept which focuses the locus of control from women as individuals to the control of the institution and healthcare professionals. Leap instead suggests the use of 'woman-centred care' to ensure the locus of control remains with the woman herself.

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CHAPTER ONE

INTRODUCTION

1.0 Introduction

Maternity services in Scotland and England are charged to implement continuity of carer models of practice (Scottish Government 2017). Although the evidence for midwifery continuity of carer improving outcomes for women and infants is now substantial (Sandall et al. 2016) any NHS practice change requires careful consideration to ensure that new arrangements are acceptable and sustainable. This study is an exploration of NHS midwife views in a Scottish region as they plan for a practice change to a continuity of carer model. This study reveals ways to support midwives in this change of practice through use of a co-operative inquiry that seeks to work collaboratively 'with' and not 'on' midwives.

This chapter introduces the research and provides the operational, political and personal context of its conception. The chapter continues with the aim and objectives of the research and provides information on the definitions of continuity and midwifery models of relational care. The personal researcher perspectives and theoretical framework which structures and provides meaning to the research are identified and the chapter concludes with the overall structure of the thesis. The use of pronouns has been decided to acknowledge the cooperative nature of the inquiry and my own part in it as one of the CI midwives as well as the researcher. As such the outcomes will not be reported in the 3rd person. I begin with outlining the socio-political context of the study, including the current situation of maternity services in the UK and the proposed practice change to provide MCoCer.

1.1 Socio-Political Context

Evaluation of midwife continuity of care models consistently demonstrates improved outcomes for mothers and babies and overall satisfaction of maternity experiences (Homer et al. 2017; Sandall et al. 2016; Taylor 2015; Williams et al. 2010; Waldenström and Turnbull 1998). These findings are sufficiently supported in evidence through randomised control trials (McLachlan et al 2008)

comparative studies (Tracy et al. 2013) and qualitative studies (Forster et al. 2016; Leap et al. 2010b). Based on these findings the World Health Organisation (WHO) antenatal care and intrapartum guidelines (WHO 2018; 2016) have recently been revised to recommend midwife continuity of care models. It is clear from the current caesarean section rate (Boerma et al. 2018) and perinatal morbidity and mortality rates (Draper et al. 2018) that MCoCer must be implemented to improve the care and outcomes for women in maternity services.

The transformation of maternity services to provide continuity of carer for women in the UK was originally outlined in *Changing Childbirth* (Department of Health (DoH) 1993) following the findings of *The Winterton Report* (House of Commons 1992). Implementation of MCoCer has been approached in various ways at a local level based on the publication of *Changing Childbirth* (DoH 1993), yet there has been no effective national uptake in the UK (McIntosh and Hunter 2014; McCourt and Stevens 2006). Kirkham (2013) indicated reasons for this included pressure on services due to staffing shortages, increasing birth rate and complexity of pregnancies, medicalisation of childbirth and a nationwide strategy approach for MCoCer implementation. These findings are reflected in the recent State of Maternity Services reports (RCM 2018a; 2018b), which relate to the ongoing concern in UK maternity services of staff retention, indicating that current midwifery models continue to be unsustainable (RCM 2017b). The RCM 'Caring for you' campaign (2016) was launched in an attempt to address the continuing issues of burn out and staff retention in the UK maternity services that had been identified in recent reports (NHS 2015; Hunter and Warren 2014). Evidence indicates dissatisfaction with the current model of care and a lack of control over work practices as key reasons for attrition of midwives (Hunter et al. 2018; Hunter 2014). This includes the lack of professional autonomy and ability to form meaningful relationships with women and colleagues due to the fragmented nature of managed and rostered practice with rotational roles (see Glossary).

MCoCer is known to support meaningful relationships with women and increase job satisfaction for midwives due to the autonomous nature of the MCoCer role (Newton et al. 2014). However, it is also associated with burnout due to challenges of achieving work-life balance for midwives (Jepsen et al. 2016; Newton et al. 2014; Collins et al. 2010). Although midwives working in fragmented models find difficulty addressing personal needs when on duty (NHS 2015; Hunter and Warren 2014), the nature of a managed rostered shift work guarantees a distinction between personal and professional life to some extent. Themes of self-care and work-life balance feature more heavily in studies of continuity of carer models (Homer 2016; Edmondson and Walker 2014; Newton et al. 2014; Mollart et al. 2013; Collins et al. 2010). The impact of on call in particular is recognised as a factor which make self-care problematic for continuity midwives and is associated with burnout

(Young, Smythe and McAra-Couper 2015; McAra-Couper et al. 2014). The cooperative inquiry by Donald (2014) revealed that the New Zealand caseloading midwives felt constantly conflicted between their own needs and needs of women, experiencing significant feelings of guilt when they had to address their own.

The dissatisfaction expressed by midwives working in both fragmented models and MCoCer indicates a certain amount of exploitation of the altruistic nature of those working in the midwifery profession (Shallow 2016; Donald 2012). While midwifery care must ensure the wellbeing of women, midwives must not be expected to sacrifice their own needs to do so (Buetow 2016). This sentiment is reflected in an Australian study 'How can we go on caring when nobody here cares about us?' (Reiger and Lane 2012). As stated by Crowther (2017, p.197);

> *Maternity care providers [midwives] face a host of challenges – it is imperative that their individual needs are recognised, identified and appropriate strategies employed....[midwives] need to be treated fairly, be heard, be valued, enjoy open non-hierarchical communications, feel safe and experience wellbeing.*

Inattention to the voices of midwives means that the challenges they face in practice will continue to exist. The research rationale in relation to the socio-political context of maternity services and proposed practice change is outlined below.

1.2 Research Rationale

While *Changing Childbirth* (DoH 1993) has had a considerable effect on discourse in midwifery, it has not been reflected in practice (Winterton 2013). Midwife continuity of carer continues to be a strong focus in NHS policy recommendations and maternity services are charged with the task of implementing these models nationally by 2022 (Scottish Government 2017; NHS England 2016). Providing this model of care will pose new challenges for midwives, including negotiation of work-life balance as shown by the literature. Recruitment and retention also continue to be key concerns for maternity services (RCM 2018a; 2018b). In light of this it is imperative that midwife views are considered and actioned in the design and implementation of new models of care to ensure they are applicable and sustainable (Kirkham 2013).

The review group for Best Start (Scottish Government 2017) consisted of representatives from key stakeholders of maternity services including women and midwives to ensure that the recommendations were firmly based on their views. The design and implementation of MCoCer to answer these views must continue to consider the needs of women and midwives to ensure that the models are both relevant and sustainable in practice for those providing care (Sustainable Development Unit 2014).

While there is a large and growing body of evidence regarding maternal experiences and outcomes associated with MCoCer, there is relatively little on the experiences of midwives providing this type of care, or of the features which sustain them in it. A synthesis of the current literature on midwife experiences of MCoCer was undertaken to identify strategies which sustain midwives in these models. The findings from this review clearly illustrated the necessity to work with midwives directly and ensure their voices are heard in any practice changes that directly influence their daily working lives. It became evident in the review that a participatory action style of research was required.

1.3 Justification of Methodology

Change is challenging, and job satisfaction, recruitment and staff retention are key concerns for maternity services. The importance of engaging with midwives during the transformation of services to develop a contextually relevant and sustainable continuity of carer model is vital.

Forster et al. 2011 identify that theoretical understandings can assist implementation of sustainable models of care, while Jacobs (2013) promotes the use of a theoretical framework for assisting organisational change. However, findings show that theoretical understandings alone are not sufficient to assure contextually relevant or personally supportive solutions for individuals in maternity service development (Hunter 2013). It is evident that practice change needs to be both supported through theory and grounded in contextual significance to implement continuity of carer successfully. As such a grass roots approach to practice and practice change would ensure solutions are relevant and assist sustainable practice (Alexander 1999). The systematic review provides the theoretical underpinnings, while a qualitative collaborative methodology supports the generation of contextually relevant knowledge. Cooperative Inquiry (CI) was chosen as a branch of participatory action research (PAR) to support the development of contextually and personally relevant solutions for sustainable practice.

Collaboration with service users and healthcare providers for the design of relevant and applicable models of care is a process which is beginning to be recognised for its benefits in the context of health care (The King's Fund 2013). Change guided by midwives to develop knowledge and action simultaneously has been shown to create context specific and personally relevant solutions (Donald 2012; Deery 2005). The nature of CI allows the generation of knowledge and actions from the perspectives of key stakeholders, ensuring that the solutions co-created are applicable and sustainable for them. For this research study midwives working in the area were engaged to participate as the key stakeholders in maternity practice change, to address their perspectives and develop practical solutions. The following section outlines the aim and objectives of the CI.

1.4 Aim

To engage midwives to co-create a vision for a MCoCer model which is relevant to them.

1.5 Objectives

1.   To explore the midwives' views about continuity of care and carer and its implementation within their own practice.

2.   To co-create solutions based on these views which support the midwives.

3.   To evaluate the inquiry and its ability to support midwives in the current practice change.

1.6 Theoretical Framework

Woman centred care is a key principle in midwifery, as described by Leap (2009:12) it focuses on,

> *…the woman's individual needs, aspirations and expectations, rather than the needs of the institution or professionals.*

This is with the aim of promoting respectful and individualised care which upholds the principles of human rights to have choice and control over decisions affecting your own body, health and wellbeing.

Continuity of carer facilitates woman centred care through the nature of the close professional relationships it supports (McCourt and Stevens 2006). For midwives, providing continuity of carer can come at the cost of their own wellbeing (Young Smythe and McAra-Couper 2015; Caza 2007). The systematic qualitative review in Chapter Two identifies a person centred rather than solely woman centred approach to care, to incorporate the needs of midwives alongside women and sustain MCoCer practice. Based on these findings the theoretical framework for this research is Person Centred Theory (McCormack 2017). McCormack et al. (2010a, p.13) describe person centred care as;

> *an approach to practice established through the formation and fostering of therapeutic relationships between all care providers…patients and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development*

Person-centred theory underpins the important concepts of relationships, which lie at the heart of continuity of carer models of care. Person centred theory is about appreciating the significance of people, relationships and their contextual realities. The use of a person-centred theory therefore

supports the inquiry aims to engage with the CI midwives and identify their views on MCoCer and solutions for practice directed by them. Person-centred theory is therefore congruent with the emancipatory capability of cooperative inquiry as a research methodology, and with the research objectives which aim to develop contextually and personally relevant solutions for practice from the perspectives of those approaching practice change.

1.7 Definitions of continuity

There is no consensus on the definition of 'continuity of care', its concept or reality within midwifery or across multidisciplinary boundaries in health (Haggerty et al. 2003). An evaluation by Haggerty et al. (2003) identifies three dimensions within the concept of continuity as; relational, informational and management continuity. Informational continuity relates directly to provision of evidence based, person centred information (McCormack and McCance 2011; Haggerty et al. 2003) relating directly to the concept of continuity of care. Relational continuity is achieved through close professional interaction between the client and health care provider over the period of the episode of care by a sole provider (Haggerty et al. 2003), which relates to the concept of continuity of carer. Management continuity refers to the coordination of timely and complementary services, requiring both informational and relational continuity (Haggerty et al. 2003) and therefore continuity of care and carer. Figure 1 is taken from the Kitzinger report (Sandall et al. 2015) describing the continuity of care hierarchy.

Relational continuity
Supportive relationship over time between an individual and their care provider ensures care co-ordinator and partnership

Management continuity
Consistent and responsive management across multi-disciplinary team ensures care meets changing needs

Information continuity
Fast and current information is shared across organisations and professionals to help ensure current care is appropriate to an individual

Figure 1. Hierarchy of continuity (Sandall et al. 2015 p. 14)

The findings from maternal experience surveys 1995-2014 support the current policy recommendations for midwife continuity of carer models (Henderson and Redshaw 2017). However, a structured literature review (Green, Renfrew and Curtis 2000) and a qualitative study by Fawsitt et al. (2017) identified consistent information giving and supported choice as key concerns for women, whether from an individual midwife or small team with a shared philosophy of care, highlighting continuity of care over carer. McCourt and Stevens (2006) argue that continuity itself is not the ultimate goal, but an important facilitator of woman centred care and positive maternity outcomes and experiences. However, Freeman and Hughes (2007) identified that only relational models of continuity have shown benefit to clinical outcomes for women, meaning that management or information continuity alone are not sufficient.

A clear definition of midwife continuity of carer assists more effective understanding and evaluation (Forster et al. 2016; McCourt and Stevens 2006). Therefore, for the purposes of this study MCoCer is defined as:

> *The provision of person-centred care for each woman from a midwife or small team of midwives who coordinate care throughout the perinatal period that incorporates relational, informational and management continuity.*

1.8 Midwife continuity of carer models

Many different MCoCer models exist and there is much debate about which is the most effective (Donnolley et al. 2016). There has been relatively little evaluation of 'continuity' models implemented following *Changing Childbirth* (DoH 1993) and a lack of definition on continuity creates difficulty in evaluating the impact that different models will have on practice (Donnolley et al. 2016). Current policy recommendations outline continuity of carer to be provided through caseloading models of midwifery (Scottish Government 2017). Caseloading practice is the gold standard of care, providing continuity through a single midwife carer supporting the midwife-woman relationship and promoting autonomy and empowerment for women and midwives (Homer et al. 2017; Wiegers 2009). However, challenges for caseloading midwives include lack of control over work time and hours leading to work/life imbalance and subsequent burn out (Newton et al. 2014; Morrow et al. 2013; Yoshida and Sandall 2013). Clear characterisation of continuity of carer models is needed to provide more effective evaluation and implementation of policy recommendations (Homer et al. 2017; Donnolley et al. 2016).

1.9 Structure of the Thesis

This thesis reports on the systematic qualitative literature review and the co-operative inquiry. The structure of the thesis is as follows;

Chapter One: Introduction

This chapter introduces the research and provides the operational, political and theoretical context of its conception, the justification for undertaking the study and its aim and objectives.

Chapter Two: Literature Review

A qualitative systematic review of midwife experiences of providing MCoCer. The review identifies both the positive and challenging aspects of working as a MCoCer midwife and the strategies they develop to sustain them in their practice.

Chapter Three: Methodology and Methods

This chapter outlines the Co-operative Inquiry (CI) methodology and procedures to ensure validity. The structure of the inquiry and recruitment procedures are outlined and the process and methods of data generation and collection. The process of meaning making without traditional data analysis is outlined and justified.

Chapter Four: Inquiry Process

This chapter reports the phases of reflection and action to signpost the development of understandings and the inquiry outcomes through the iterative process of the CI.

Chapter Five: Inquiry Outcomes

The informational and transformational outcomes of the CI are presented in this chapter.

Chapter Six: Concluding

The concluding chapter addresses the outcomes in relation to the aim and objectives of the study. A critical appraisal is presented that includes analysis of the themes identified through my personal reflections on the process and outcomes of the CI as well as those identified through the qualitative systematic literature review. This chapter also addresses the validity of the cooperative inquiry, identifying its strengths and limitations and its ability to support the midwives through the process of practice change. Implications of the research and recommendations for future work and dissemination plans are outlined and key findings of the thesis are presented.

CHAPTER TWO

SYSTEMATIC QUALITATIVE LITERATURE REVIEW

2.0 Introduction

The importance of qualitative evidence in systematic reviews is beginning to be recognised in healthcare (Noyes 2013; DoH 2006). The evidence from qualitative research in combination with the quantitative data can assist in the understandings of the complex nature of practice change and may assist successful implementation of new models of care (Noyes et al. 2015). The views of midwives as practice change to MCoCer is approached is imperative for successful implementation. This chapter therefore reports a qualitative systematic review of midwife experiences of working in continuity of carer models to foreground the research study.

2.1 Background

The systematic Cochrane review by Sandall et al. (2016) compared midwife-led continuity models of care with other models of care for women focusing on the outcomes and maternal experiences. The review looked at fifteen studies involving 17,674 women and concluded that continuity of carer improves outcomes and experiences and reduces interventions for women of low or increased risk.

The M@NGO trial (Tracy et al. 2013) compared standard care with caseload care for 1748 women of any risk and deduced that the caseloading model of care was safer for all women, regardless of complexity. Maternal perspectives of continuity of carer consistently show that it improves experiences and is a desired model of maternity care by service users (Forster et al. 2016; Jepsen et al. 2016). Women randomly assigned to caseload groups reported increased satisfaction with antenatal, intrapartum and postnatal care (Forster et al. 2016) and more control during labour, less anxiety and more likely to have a positive experience of birth (Leap et al. 2010b).

Preliminary searches in Cochrane Database for Systematic reviews and electronic healthcare databases indicate a qualitative review of midwife experiences of continuity of care has not been undertaken, and a search of the Prospero database indicates there is no planned review of this focus. A systematic review focusing on midwife experiences of continuity of carer models is particularly relevant given the current policy recommendations in the UK for maternity service transformation

to this model of care (Scottish Government 2016; NHS England 2016). Therefore, this qualitative systematic review identifies and synthesises findings from studies that explore midwife experiences of practising within continuity of carer models.

The beneficiaries of this review will be midwives, policy makers, funders and managers if the findings are observed alongside the existing evidence of Sandall et al.'s (2016) review to design and implement continuity of carer models in the UK. This review underpins the co-operative inquiry that follows by foregrounding the salient issues and concerns that have been previously been explored and published on midwife experiences of continuity of carer.

2.2 Aim

The aim of this qualitative systematic review is to offer insight and understanding of existing research into midwives' experiences of providing continuity of carer through identification and synthesis.

2.2.1 Review Questions

From this aim two questions were developed through application of Stern, Jordan and McArthur (2014) acronym 'PICO' (Participants/Interest/Context/Outcome), see Table 1.

 -What are midwife experiences of providing continuity of carer (CoCer)?

-What do these experiences highlight in terms of sustainability of continuity of carer models?

Table 1: PICO Framework for Review Questions

Criteria	Description
Participants	Midwife/midwives, student midwives
Interest	Midwife experiences
Context	Working in continuity of carer models
Outcomes	Positives and challenges of providing continuity of carer experienced by midwives and ways of working which facilitate sustainability

2.3 Methods

This systematic qualitative review was conducted in accordance with PRISMA guidelines (Moher et al. 2009) as a rigorous methodology to reduce bias and produce replicable findings (Paez 2017). Qualitative studies on midwife and student midwife experiences of continuity of carer models in more economically developed countries with an established midwifery culture were used. This was to provide data from maternity systems of comparable contexts with the UK to ensure contextual

significance with the research study and those implementing policy recommendations (Scottish Government 2017; NHS England 2016).

The Quality Appraisal, Data Extraction and Thematic Synthesis were independently reviewed by another member of the review team and discussed at each stage to ensure robust and trustworthy process and synthesis findings (Table 3). Quality of each study was assessed using the validated JBI appraisal tool (Appendix B). Data was extracted using the validated JBI qualitative data extraction tool (Appendix C) and analysed using meta-synthesis methods informed by Noblitt and Hare's (1988) 7 step meta-ethnography process.

The GRADE CERQual system for assessing the confidence of the evidence from reviews of qualitative research was applied to ensure robust and trustworthy findings informed by the four stage process described by Lewin et al. (2018). This involved independent review by another member of the review team (Pace, Crowther and Lau).

2.3.1 Search strategy

Three different methods of searching were applied to reduce selection bias and improve the scope and diversity of sources covered for the review as recommended by Whittemore and Knafl (2005):

- Electronic databases searched with a pre-agreed systematic framework as published on Prospero register (Pace 2017)

- Hand Selection

- Expert Opinion

Initially databases were searched with the pre-agreed systematic framework (Pace 2017). Hand selection was applied to the included studies to include references from the bibliographies of each document. Expert opinion was also sought from colleagues, supervisors and review team with an interest in continuity. Six electronic databases;-The Cochrane Library, CINAHL with Full Text, Intermid, MIDIRS, Pubmed and British Library EThOS were searched using the phrases identified below. The search strategy for unpublished research work included database search of the British Library EThOS, and hand selection from included studies.

Initial searches and primary reading in the subject area of continuity of care and carer in midwifery led to the development and trialling of search terms for the review. Terms used in the Haggerty et al. (2003) paper in relation to the definition of continuity were trialled in each database initially on the premise that they were synonymous and interchangeable with the concept of 'continuity of care'; informational, management and relational. However, the terms 'informational' and 'management' continuity did not yield results relevant to the review aim. 'Relational continuity' was

included as one of the final search terms. Studies published between 1980-1992 and 1992-2017 were included to identify papers before and after the publication of *The Winterton Report* and *Changing Childbirth* (1993). Contra to expectations the results from these search terms were predominantly from after 1992. Even following the hand selection and expert opinion stages from the included text reference list there were no studies included from before 1997. This indicated 'continuity of care' in midwifery was not a predominant focus in research before 1992, and that systematic research was not conducted with the same focus at this time.

2.3.2 Search terms

The final search terms used were; "continuity of care*" AND midwi*, "caseload*" AND midwi*, "relational care*" OR "relational continuity" and midwi* and "group practice" AND midwi*. The combinations of the words and Boolean operands were used as identified. Searches were repeated with the search terms by another member of the review team to ensure replicability of the primary collection of studies.

2.3.3 Inclusion/Exclusion criteria

Table 2 outlines the inclusion/exclusion criteria applied by the review team. Only studies reported in English were included. Unpublished research work was included in publication type due to its considerable potential to contribute to the findings of the review (Paez 2017).

Table 2: Inclusion/Exclusion Criteria

Inclusion/Exclusion Criteria	Description
Research topic and scope	Definition of CoCer as defined by Sandall et al 2014, as "continuity models of care which provide a named midwife who follows women throughout pregnancy, birth and the postnatal period to all women, both low and high risk and in all settings including obstetric units".
Research design	Qualitative studies only.
Setting	Studies undertaken in Middle to High Economic Developed Countries which have a defined midwifery led culture with all pregnant care provided or coordinated by midwives, comparable to the UK in terms of education, regulation and care.
Perspective	Midwife centred, studies with student midwives to be included.
Time Frame	1980-1992 and 1992-present.
Evaluation	Identifying experiences of midwives working in a midwifery continuity model as defined by Sandall et al. 2014.
Publication Type	Research papers only (published and unpublished) found through open sources.
Focus	Specifically CoCer focus, not the impact of CoCer on specific groups of women.

2.3.4 Quality Assessment

The assessment of data quality was performed to ensure the inclusion of high calibre research and reduce the risk of bias of the studies included for the final review in line with systematic review methodology as described by Noyes and Lewin (2011) and guidance for qualitative research in systematic reviews for the Cochrane Collaboration Qualitative Methods Group (2018). CASP, EPPI and JBI tools were assessed and trialled for their use as data quality and extraction tools. JBI tools were decided for their rigour and ability to compare and contrast the data extracted from the studies (Appendices B and C). Two members of the review team are accredited with JBI training improving the rigour of the use of these tools (Crowther, Lau).

2.3.5 Analysis strategy

Qualitative data analysis tools are controlled by the researcher using them and are therefore data management rather than true analysis tools (Zamawe 2015). As such manual data extraction methods were chosen over data analysis software as supported by Harden et al. (2004).

The analysis of the included studies was based on the inclusive meta-ethnographic method first described by Noblitt and Hare (1988) which follows an iterative process of constant comparison. Table 3 details the seven-step process of analysis and synthesis as informed by Noblitt and Hare 1988 in Downe et al. (2018).

Table 3: Seven step meta-ethnographic analysis process informed by Noblitt and Hare (1988)

Stage of analysis	Process used in this review
Step One: Initial readings	Papers examined and emersion in the data to identify commonalities.
Step Two: Data extraction	Themes and findings identified by the study authors entered into JBI data extraction tools.
Step Three: Thematic framework	Themes of each study entered into a table to compare and contrast findings and begin thematic framework of reference.
Step Four and Five: Reciprocal Analysis Confirming and Disconfirming	Simultaneous analysis of what is similar and what contradicts the pattern of findings across the studies.
Step Six: Refutational Analysis	Alternate explanations and groupings tried and added to the insights created to amend and confirm theme meanings and names as a review team.
Step Seven: Line of argument synthesis	Confirmed themes synthesized into a robust line of argument both explaining the phenomena of the studies reviewed, and creating transferable conclusions applicable to a wider range of settings and circumstances.

All final review themes were created using the extracted author themes and findings of each study, ensuring that the synthesis was transparent and represented the original meanings of the included studies while creating new concepts. The final themes derived at stage six of the meta-ethnography process by the review team were assessed using the GRADE-CERQual (Lewin et al. 2018) tool to assess confidence in the quality, coherence, relevance and adequacy of the data contributing to them. The final GRADE- CERQual assessment results were classified as High to Moderately High Confidence in findings (Table 8).

Dissonance within the thematic synthesis process is discussed further in the findings. The finalised themes were synthesised into a robust line of argument which incorporates and confirms the thematic direction (p.58).

2.4 Findings

2.4.1 Included studies

Database searches were conducted between 12th January and 4th of February 2018. Reference lists of included studies were checked and included (hand selection) along with papers suggested through expert opinion as appropriate. Full text screening was performed independently by two members of the review team using the inclusion/exclusion criteria (Table 2) and discussed for final decision. The PRISMA diagram (Figure 2) shows the results of the applied search strategy as detailed in the *Methods* section. An updated search was performed in August 2018 to confirm original findings and identify new literature. No additional studies matching the original search strategy were identified for inclusion.

Figure 2. PRISMA Flow Diagram

PRISMA 2009 Flow Diagram

Stage	
Identification	Records identified through database searching (n =1945)
	Records after duplicates removed (n =1673)
Screening	Titles and Abstract screened (n =1673) → Records excluded (n =1561)
Eligibility	Additional records identified through other sources (n =9)
	Full-text articles assessed for eligibility (n =121) → Full-text articles excluded (n = 104): Publication Type (n=40), Research Design (n=23), Evaluation/Aim (n=26), Unable to source (n=13), Repeat Study (n=2)
Included	Studies included in qualitative synthesis (n = 17)

2.4.2 Quality Appraisal

For clarity the studies are reported according to the number they were assigned in the identification stage of the review according to alphabetical order of the first author. The included studies were assessed for quality using the 10 point JBI tool (Appendix B). Threshold for inclusion was confirmation of questions 3,4, 8,9 and 10 with a minimum of seven quality criteria achieved. All seventeen studies satisfied the necessary quality criteria as outlined and were therefore included in the final review. Five of the studies reported on all ten of the quality appraisal criteria (Gray et al. 2013; Donald et al.

2012; Fereday and Oster 2010; Moore 2009; Engel 2003) with (Cox and Smythe 2011; Sandall 1997) receiving the lowest score on quality assessment with seven criteria addressed in these studies. See Table 4 for quality appraisal results.

Table 4: Quality Appraisal Results from Included Studies

STUDY NO.	STUDY	QUALITY CRITERIA MET
1	BROWNE ET AL. 2014	2,3,4,5,7,8,9,10
2	COX AND SMYTHE 2011	2,3,4,5,8,9,10
3	CUMMINS ET AL. 2015	1,2,3,4,5,8,9,10
4	DONALD ET AL. 2012	1,2,3,4,5,6,7,8,9,10
5	EDMONDSON AND WALKER 2014	1,2,3,4,5,8,9,10
6	ENGEL 2003	1,2,3,4,5,6,7,8,9,10
7	FEREDAY AND OSTER 2010	1,2,3,4,5,8,9,10
8	GILKISON ET AL. 2015	1,2,3,4,5,7,8,9,10
9	GRAY ET AL. 2013	1,2,3,4,5,6,7,8,9,10
10	HUNTER ET AL. 2016	1,2,3,4,5,8,9,10
11	JEPSEN ET AL. 2016	1,2,3,4,5,6,7,8,9,10
12	MCARA-COUPER ET AL. 2014	1,2,3,4,5,8,9,10
13	MCCOURT AND STEVENS 2006	1,2,3,4,5,6,8,9,10
14	MOORE 2009	1,2,3,4,5,6,7,8,9,10
15	NEWTON ET AL. 2016	1,2,3,4,5,8,9,10
16	RAWNSON 2011	1,2,3,4,5,7,8,9,10
17	SANDALL 1997	2,3,4,5,8,9,10

2.4.3 Characteristics and of the included studies

The data from the studies was extracted verbatim into the JBI format (Appendix C) Table 5 presents the descriptive characteristics and Table 6 the methodological approaches of the seventeen studies selected for the review.

Four countries are represented across the studies UK (n=3), Australia (n=7), Denmark (n=1) and New Zealand (n=6). Gilkison et al. 2015; McAra-Couper et al. 2014 and Hunter et al. 2010 report on different aspects of the same study and were all included for their individual contribution to the review aim. It was surprising that no studies emerged from the Netherlands as continuity of carer is the predominant model of maternity care. The definition of continuity, provision type and women cared for (Table 5), was a significant characteristic which related directly to the findings of each study. The relevance of these definitions in relation to the findings are identified in the *Discussion* section (p.58).

Also notable are the breadth of methodological characteristics across the seventeen studies. Seven of the studies applied qualitative descriptive methods (see Table 6) with all the data collected using individual or group interview or focus group methods. Collectively the studies represented the voices of 240 midwives and student midwives providing continuity of carer.

Table 5: Summary of descriptive characteristics of the included studies

STUDY NO.	STUDY	DATE	AIM	SETTING	CONTINUITY PROVISION	PARTICIPANTS
1	BROWNE ET AL.	2014	Continuity experiences of student midwives	Australia	All risk student Caseloading (30 women over 3 years)	15 final year students, 14 RM mentors of graduating students,6 maternity managers
2	COX AND SMYTHE	2011	Experiences of three LMC midwives leaving practice	New Zealand	All risk Caseloading	3 LMC midwives with 5-11 years experience who left practice 6months-3 years before interviews
3	CUMMINS ET AL.	2015	Experience of newly qualified midwives in continuity models	Australia	Various models (MGP, caseloading, integrated) mixed settings, risk not clear	13 NQ midwives (2ACT, 8NWS, 3 South Australia) working in CoCer models
4	DONALD ET AL.	2012	Investigating work-life balance of caseloading midwives to develop solutions to improve	New Zealand	All risk Caseloading	16 LMC midwives (including lead researcher)
5	EDMONDSON AND WALKER	2014	Experience of midwives providing caseload care and how they maintain work-life balance	Australia	Low risk Caseloading (40 women)	7 midwives ages 40-60 with 3 years or less in CoCer models
6	ENGEL	2003	Experiences of LMC midwives caseloading	New Zealand	All risk Caseloading	5 midwives from MGPs
7	FEREDAY AND OSTER	2010	Exploring how midwives achieved work-life balance in a continuity of carer model	Australia	Low risk Caseloading (40 women)	17 midwives 3months-2 years experience in CoCer MGP
8	GILKISON ET AL.	2015	What sustains on-call, caseloading Lead Maternity Carer (LMC) midwives in New Zealand	New Zealand	All risk Caseloading	11 LMC midwives 12-20 years experience in practice
9	GRAY ET AL.	2013	Explore the follow-through experience from a student midwife perspective, to identify learning and identify personal impact	Australia	Student Caseloading, 10-30 women, mixed settings, risk unclear	28 students (11 1st year, 9 2nd year, 4 3rd year and 4 graduates
10	HUNTER ET AL.	2016	What sustains LMC midwives in midwifery practice over time	New Zealand	All risk Caseloading	11 LMC midwives 12-20 years' experience in practice
11	JEPSEN ET AL.	2016	Advance knowledge about the working and living conditions of midwives in caseload midwifery and how this model of care is embedded in a standard maternity unit	Denmark	All risk Caseloading (typically pairs, 1 week on call, 1 week off 60 women per year	12 caseloading midwives in observational study +1 for semi-structured interviews
12	MCARA-COUPER ET AL.	2014	To understand what sustains on call case-loading LMC midwives who have practised as LMCs for at least eight years	New Zealand	All risk Caseloading	11 LMC midwives 12-20 years' experience in practice

13	MCCOURT AND STEVENS	2006	An ethnographic study of the experiences of midwives in a caseload midwifery practice (setting up and sustaining)	UK	All risk Caseloading 40 women/year in MGP buddy pairs in a team of 6	36 caseload midwives
14	MOORE	2009	Experiences of midwives commencing a new MGP	Australia	Low risk caseloading within MGP of 7 midwives	7 midwives in MGP
15	NEWTON ET AL.	2016	to explore caseload and standard care midwives' experiences of midwifery work in two new caseload models in Victoria	Australia	Caseloading- risk status unclear but likely to be low risk from included quotes	14 midwives aged 30-50 years with 1-15 years' experience initially, 1 midwife on Mat leave at 2 years
16	RAWNSON	2011	Experiences of caseloading for students and how this has impacted their learning to becoming a midwife	UK	Student caseloading 1-18 women during final 18 months of course. Risk status unknown as caseload selected by students	8 final year students aged 23-50 from 5 NHS Trusts
17	SANDALL	1997	To examine the impact of changing childbirth on midwives' work and personal lives across 3 sites providing continuity on a continuum	UK	All risk caseloading, MGP of 6 caseloading and traditional midwifery care.	48 midwives 7/7 MGP, 22/28 team continuity, 19/23 traditional community practice

Table 6: Summary of methodological characteristics of included studies

STUDY	METHODOLOGY	SAMPLING METHODS	DATA COLLECTION	DATA ANALYSIS
BROWNE ET AL.	Qualitative descriptive	Recruitment strategy not explicit	Focus Groups (1 student, 3 MWs/managers) and Interviews. Not clear if structured/unstructured	Descriptive thematic analysis by independent researcher and confirmation of final themes with reference group
COX AND SMYTHE	Qualitative interpretative informed by phenomenology	Purposive sampling (conscious sampling by researcher)	Unstructured in-depth interviews	Constant comparison method- Manual identification and grouping of themes
CUMMINS ET AL.	Qualitative descriptive	Purposive sampling strategy of NQ midwives followed by snowball sampling	Semi-structured interviews face-to-face, telephone or skype	Thematic analysis using NVIVO software to code into groups and identify themes
DONALD ET AL.	Cooperative Inquiry (Action Research)	Open invitation through NZ College of Midwives Journal	Focus groups audio recorded with consent	Recordings transcribed verbatim and manually grouped by researcher
EDMONDSON AND WALKER	Grounded Theory	Purposive sampling through invitation to midwives working at a birth centre	Individual semi-structured face to face interviews lasting 30 minutes	Individual recordings transcribed verbatim and checked with midwife. Constant comparative methods used to identify and group themes
ENGEL	Qualitative narrative	Recruitment strategy not clear	Recorded narrative of the participants experiences	The framework approach to analysis used. 5 step analytical process to preserve original accounts and observations of the people studied.
FEREDAY AND OSTER	Qualitative interpretive	Purposeful sampling of midwives working in the MGP invited	In depth semi-structured interviews lasting 45-60 minutes	Data driven thematic analysis of verbatim transcripts in 3 stages. NVivo software used to define and group themes which were member checked with participants in stage 3.
GILKISON ET AL.	Qualitative descriptive	Purposive sampling through networks available to the midwives followed by snowball sampling	Face to face interviews, unclear if structured or semi-structured	Thematic and content analysis used to group data from the verbatim transcripts
GRAY ET AL.	Qualitative descriptive	Random sampling from a purposive group of 65 students	Structures survey (not included in review) and semi-structured telephone interviews	Inductive thematic analysis of verbatim transcriptions by independent service
HUNTER ET AL.	Qualitative descriptive	Purposive sampling through networks available to the midwives followed by snowball sampling	Face to face interviews, unclear if structured or semi-structured	Thematic and content analysis used to group data from the verbatim transcripts
JEPSEN ET AL.	Qualitative ethnography	Purposive sampling of caseload midwives working at a location in Denmark	Observation of practice and individual semi-structured interviews	5 step thematic analysis following the thinking of Van Manen (2014)

MCARA-COUPER ET AL.	Qualitative phenomenology- inspired by ethnography	Purposive sampling through networks available to the midwives followed by snowball sampling	Face to face interviews, unclear if structured or semi-structured	Thematic and content analysis used to group data from the verbatim transcripts
MCCOURT AND STEVENS	Qualitative ethnographic	Midwives who joined the caseload pilot scheme were all involved	In depth unstructured and focus groups	Verbatim transcriptions were analysed using grounded theory techniques to identify themes. Constant comparison techniques employed
MOORE	Hermeneutic Phenomenology	Purposeful sampling of midwives in specific MGP	Semi-structured interviews	Verbatim transcriptions analysed using Gadamers theoretical model
NEWTON ET AL.	Qualitative descriptive	Purposive sampling of midwives in a caseload model	In depth semi-structured interviews at 6 months and 2 years or at time of resignation	Thematic analysis of verbatim transcripts using Normalisation Process Theory
RAWNSON	Grounded theory	Purposive sampling of final year midwifery students from 5 NHS Trusts	In depth semi-structured interviews	Verbatim transcripts checked by student midwife. Line-by-line analysis and open coding to group codes and produce themes
SANDALL	Qualitative descriptive	Recruitment strategy not clear	Semi-structured individual interviews	Verbatim transcriptions analysed using computerised qualitative data analysis package

2.5 The Thematic Framework

This section reports the themes and subthemes which emerged through the synthesis of the included studies. Direct quotes from the midwives and author themes of the included studies were extracted into the JBI data extraction tool (Appendix C). These first and second order constructs from the original data were used to develop a thematic framework by the review team to ensure reliability and trustworthiness of the synthesis. Appendix D shows the original author themes extracted from each paper and Figure 3 provides an example of the process of synthesising the review themes from these original author themes.

Figure 3. Synthesis process of the review themes
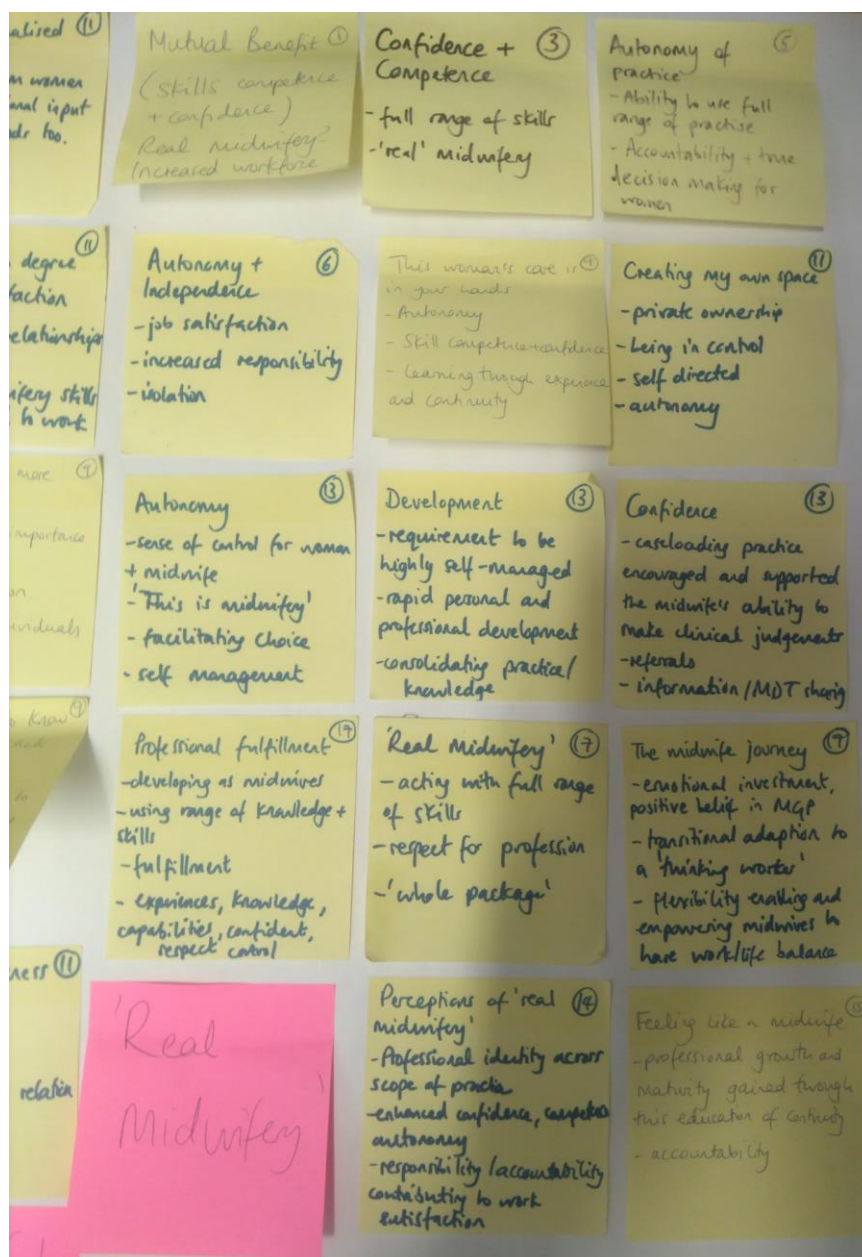
Five overarching themes were identified through iterative synthesis: 1) Joy of Practice, 2) Real Midwifery, 3) Counting the Personal Costs, 4) Working in a System, and 5) Strategies to Sustain. Theme 1) Joy of Practice included the sub-themes *Knowing and being known* and *More than a job*. Theme 5) Strategies to Sustain consisted of three sub-themes, *Defining professional boundaries*, *Community of practice* and *Flexibility and Structure*.

Table 7 displays the representation of each of the themes and sub-themes across the studies.

Table 7: Overview of synthesised themes represented in each study

THEME/STUDY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
JOY OF PRACTICE																	
Knowing and being known	x	x	x		x	x			x		x	x	x	x	x	x	x
More than a job		x	x			x			x		x	x	x	x	x	x	
REAL MIDWIFERY	x	x	x		x	x			x		x		x	x	x	x	
COUNTING THE PERSONAL COSTS	x	x		x	x	x	x		x		x		x		x	x	x
WORKING IN A SYSTEM	x				x	x			x				x	x	x	x	x
STRATEGIES TO SUSTAIN																	
Defining professional boundaries	x			x	x	x	x	x		x		x	x		x		
Community of Practice	x		x	x	x	x	x	x		x				x	x	x	x
Flexibility and Structure			x	x	x	x	x	x			x			x	x		x

2.5.1 Quality assessment of the Review Themes

The GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative research) approach was applied to assess the Coherence, Adequacy and Relevance and the confidence of the thematic findings (Lewin et al. 2018). This process defines to what extent the review findings are supported by the original data in the primary studies and therefore the trustworthiness of the synthesis. Table 8 summarises the ratings of the evidence. The assessment suggests with high to moderately high confidence that the thematic synthesis represents the experiences of midwives and student midwives across the included studies.

Table 8: CERQual assessment of thematic framework

THEME NO.	KEY THEMES	SUBTHEMES	STUDIES CONTRIBUTING TO REVIEW FINDING	ADEQUACY OF DATA	COHERENCE OF DATA	RELEVANCE OF DATA	CERQUAL ASSESSMENT
1	**Joy of practice:** featured in thirteen of the included studies and comprised of two sub-themes 1) Knowing and being known and 2) more than a job.	**Knowing and being known:** The relationship midwives build with women as part of the continuity experience. Part of this meaningful relationship was experiencing reciprocity from women.	13 studies- 1,2,3,5,6,9,11,12, 13,14,15,16,17	Rich data from a range of settings and contexts.	Minor concerns- data reflects that relationships were not always reciprocal and one study described difficulty developing meaningful relationships due to the lack of engagement from women (15).	Finding in accord with context of review question	Moderate Confidence
		More than a job: The midwives felt that being a CoCer midwife went beyond a job and considered it a vocational role.	10 studies- 2,3,6,9,11,12,13, 14,15,16	Rich data from a range of settings and contexts.	Findings across studies are consistent and coherent.	Finding in accord with context of review question	High Confidence
2	**Real midwifery:** The midwives felt that knowing women and working in this way meant that they could practice across the scope of care, offering choice in an autonomous way.		10 studies- 1,2,3,5,6,9,11,13, 14,15,16	Rich data from a range of settings and contexts.	Findings across studies are consistent and coherent.	Finding in accord with context of review question	High Confidence
3	**Counting the personal costs:** These are the elements of CoCer practice which were challenging		12 studies- 1,2,4,5,6,7,9,11, 13,15,16, 17	Rich data from a range of settings	Findings across studies are consistent and coherent.	Finding in accord with context of review question	High Confidence

	and affected the midwives personally.			and contexts.			
4	**Working in a system:** The reality of working in a system to provide woman centred care created discord in the majority of studies due to different aims of the institution and midwives and challenge to their professional and personal autonomy.		9 studies- 1,5,6,9,13,14,15, 16,17	Minor concerns about adequacy of data as theme not as prevalent across the studies	Minor concerns- one study indicated that the system they worked in supported CoCer (17)	Finding in accordance with context of review question	Moderate confidence
5	**Strategies to Sustain:** Midwives identified strategies which were key to their enjoyment of and continued practice in MCoCer. Three sub-themes were identified as 1) Defining Professional Boundaries, 2) Community of Practice and 3) Flexibility and Structure.	**Defining Professional Boundaries:** The importance of setting expectations with women from the beginning of contact to establish boundaries for the midwives was a key strategy for work/life balance	10 studies- 1,4,5,6,7,8,10,12, 13,15	Rich data from a range of settings and contexts.	Findings across studies are consistent and coherent.	Finding in accord with context of review question	High
7		**Community of Practice:** the importance of a shared philosophy of care, working practices and expectations to develop a welcoming environment of mutual trust with	12 studies- 1,3,4,5,6,7,8, 10,14,15,16, 17	Rich data from a range of settings and contexts.	Findings across studies are consistent and coherent.	Finding in accord with context of review question	High

		colleagues and the wider MDT.					
8		**Flexibility and Structure:** The midwives reported both structure to reduce unpredictability, and flexibility of their individual work practices as necessary for enjoyable and sustainable practice	10 studies- 3,4,5,6,7,8,11,14, 15,17	Rich data from a range of settings and contexts.	Findings across studies are consistent and coherent.	Finding in accord with context of review question	High

2.5.2 Thematic Synthesis

This section describes the themes derived from the original data, their meanings and the evidence from each study supporting it. Each subtheme is reported individually below with a thematic framework table as supporting evidence. Each table includes the study author name and number for easy identification in relation to the findings.

2.5.2.1 Theme: Joy of Practice

The theme 'Joy of practice' featured in thirteen of the included studies and comprised of two sub-themes 1) *Knowing and being known* and 2) *More than a job*. Thirteen of the studies reported these positive attributes of continuity of carer practice (Table 9).

2.5.2.1.1 Subtheme: Knowing and being known

The thirteen studies listed above identified the importance for the midwives to know the women in their care and to be known by them (Table 9). Continuity with women enabled midwives to provide responsive (Gray et al 2013; McCourt and Stevens 2006) and individually tailored woman centred care (Moore 2009). This element constituted the 'knowing' and provided the foundation of woman centred care as described by Jepsen et al. 2016; Cummins et al. 2015; Browne et al. 2014; Edmondson and Walker 2014; Gray et al. 2013; Moore 2009. The ability to provide woman centred care in partnership with women was made possible through the development of mutual relationships. This was described as 'cohesiveness', 'togetherness', (Jepsen et al. 2016) 'holistic' and 'personalised care' (Newton et al. 2016).

The development of meaningful relationships with women was a key component for the midwives' job satisfaction which was made possible through the continuity of carer models they were working in. This incorporated both the 'knowing' described by studies Jepsen et al. 2016; Cummins et al. 2015; Edmondson and Walker 2014; Cox and Smythe 2011; McCourt and Stevens 2006; Engel 2003; Sandall 1997) and the 'being known' by women was highlighted by three of the studies (Jepsen et al. 2016; McAra-Couper et al. 2014; Rawnson 2011). This indicated a reciprocal relationship of mutual respect (McCourt and Stevens 2006), and recognition of the needs of the midwife as well as the woman (Jepsen et al. 2016), as well as a being '…part of the whole family…' (Rawnson 2011; 790)

Table 9: Thematic Framework for Joy of Practice: Knowing and being known

STUDY NO.	STUDY	AUTHOR THEME	THEME DESCRIPTION	SUPPORTING DATA
1	BROWNE ET AL.	Woman centred care	The continuity experience provided student midwives with an appreciation of the benefits of continuity models of care and facilitated a woman-centred focus.	*I think for me, continuity has brought home woman-centred care…because you've got the relationship with this woman... (p.575)*
2	COX AND SMYTHE	Passion and commitment	The midwives' experiences and relationships with women, particularly during labour and birth, had been incredibly special to them.	*I love midwifery, I love working with mother and babies (p.16)*
3	CUMMINS ET AL.	The relationship with the woman	The relationship with the woman was valued in so many aspects of the care provided by the participants.	*I loved the satisfaction that women got…also the satisfaction I got and the midwives would get from seeing them from the beginning to end (p.441). 'I really love the relationship' (p.440)*
5	EDMONDSON AND WALKER	Continuity of care	Participants believed continuity of care enhanced the construction of the birth centre midwife role through the development of meaningful and trusting relationships with the women.	*I get to meet them early in their pregnancy and we develop that relationship so that by the time they come to birth it's just like having a friend around.' (p.35)*
6	ENGEL	Job Satisfaction	The meaningful relationship with the woman seems to be at the heart of job satisfaction for the midwife and yet the most difficult to pull back from.	*…the actual continuity and satisfaction…and having women coming back baby after baby is lovely. (p13)*
9	GRAY ET AL.	'You really get to know what makes her tick'	This notion of 'really knowing the woman' was a strong theme. Each woman was recognised as being unique and students felt that by forming a relationship with her, they were able to learn about more than just her pregnancy.	*You really get to know what makes her tick' (p401) …that connection, that continuity that you get with women… (p.402)*
11	JEPSEN ET AL.	Cohesiveness through knowing	To know each other was the glue of the model and created cohesiveness.	*When I am in my car driving to the hospital-I know who I will meet. I think of a specific woman, who has a face, who I know, and can relate to. (p.66)*
		Being a personalised professional	The midwives used 'an affair' to illustrate the intense but short relationship demanding a professional midwife's willingness to show herself as a person, because an affair is a two-way relationship and demands intimacy. The midwives' comments revealed the interconnections between them and women as being 'known'.	*They are very attentive to my needs, too. A much greater recognition … that I am also a human being (p.65)*

		Having a high degree of job satisfaction	The midwives felt that they were doing a good job and this feeling led to high engagement which again led to a meaningful relationship – a positive circle developed.	*I get a high degree of job satisfaction…I feel that it means something that we know each other. (p.65)*
12	MCARA-COUPER ET AL.	Working in partnership with women	Midwives in this research identified the primary factor that sustains them is the joy experienced in the reciprocal relationship formed when LMC midwives work in partnership with women and their families/whanau, increasing job satisfaction and reducing stress- echoing McCourt and Stevens (2006).	*Women turn up at my practice and I've thought, 'well, this is why I'm here.' They've given me so much back. So that's been so rewarding and that's what you do it for is the clients. (p.30)*
13	MCCOURT AND STEVENS	Relationship and Reciprocity	This theme captures an aspect if the midwife-woman relationship, which emerged as a central characteristic of a caseload practice. The relationship was valued highly be the woman and the midwives. It was more reciprocal than generally found in traditional professional-client relations.	*Knowing women who I provide care for makes the job fulfilling and meaningful. (p.16)*
14	MOORE	Women and midwives together	All the midwives described how the MGP model enabled them to work together with the women across the continuum.	*The women feel empowered because they feel they've had so much involvement in their own birth and they have felt in control. (p.110)*
15	NEWTON ET AL.	Working with women	Forming relationships with women was the focus of the caseload model, and thus provided an opportunity for midwives to engage with women in a way that many had not previously experienced.	*As far as the actual working as a midwife, it's probably the most rewarding thing I've done. I've been a midwife for twenty-five years. . .[it's] because of the relationship you build up with the women. (p.228)*
16	RAWNSON	'Making it good'	The 'Caseloading Bloom' described in the pictorial representation of their experience symbolised the development of the students through meaningful learning relationships with women.	*She invited me into her family, I felt kind of like part of the whole family…(p.790)*
17	SANDALL	Developing meaningful relationships with women	Providing continuity of care was a major source of satisfaction to all of the midwives, the type of caseload in the three sites either enhanced or reduced the opportunities to 'know' women.	*Continuity; knowing everybody; the social side; sometimes I don't feel like I'm going to work, more like I'm going to visit a friend who is having a baby (p.109).*

2.5.2.1.2 Subtheme: More than a job

This sub-theme represented the emotional connection the midwives experienced in their role (Table 10). Words used to describe this connection to their profession which the midwives felt were, 'special' (McCourt and Stevens 2006), and 'vocation' (Cox and Smythe 2011) symbolising their feeling that this was more than a job for them. The midwives' identification with midwifery was described in an emotive way, that they felt passionate and committed to their role and the significance they associated with their own identity and the importance of midwifery practice.

Evocative descriptions from the ten studies highlighted an emotional connection of the participants to midwifery and their role as a continuity midwife. The midwives often referred to their role as a continuity midwife in relation to their previous roles in fragmented and institutionally focused models, favouring their experiences in MCoCer roles (Newton et al. 2016; Rawnson 2011; Moore 2009). Professional autonomy, meaningful relationships and flexible working were highlighted as reasons for the midwives preferring to work in this way (Jepsen et al. 2016; Newton et al. 2016; Gray et al.2013; Cox and Smythe 2011).

The continuity role was described as being all encompassing and absorbing. While this was perceived as a positive aspect of MCoCer in some of the studies (Jepsen et al. 2016; Newton et al. 2016; Cummins et al. 2015; McAra-Couper et al. 2014; Gray et al. 2013; Cox and Smythe 2011; Rawnson 2011; Moore 2009), several of the studies discuss the challenge that this posed to their ability to separate their professional and personal lives (McCourt and Stevens 2006; Moore 2009; Rawnson 2011).

> *There is something romantic about people becoming everything to other people,*
> *becoming an important part of their lives. (Engel et al. 2003:13)*

The seeming paradox highlighted by the findings is that while joy for midwifery is the key reason why midwives wish to work in MCoCer models, the personal/professional boundary must be negotiated to ensure balance for midwives and prevent burn-out. These findings reflect the conclusions of McAra-Couper et al. 2014 about what sustains midwives in MCoCer practice. The theme 'Counting the Personal Costs' further outlines the challenges which midwives experienced working in MCoCer models, while the theme 'Strategies to Sustain' identifies the ways midwives negotiated these challenges to create sustainable practice.

Table 10: Thematic Framework for Joy of Practice: More than a Job

STUDY NO.	STUDY	AUTHOR THEME	THEME DESCRIPTION	SUPPORTING DATA
2	COX AND SMYTHE	Passion and commitment	Although the LMCs had left their practice they still looked back on their experiences of caseloading practice as positive and fulfilling.	*And I looked and thought I love midwifery...the demand I had when I was doing it was my satisfaction. (p.18) 'vocation' (p.19)*
3	CUMMINS ET AL.	Finding satisfaction with continuity	Working in continuity of care was reported as satisfying and rewarding.	*...get tingles every time I see a woman starting her mothering journey (p.441)* *They [the women] were always happy to have me there. (p.441)*
		The relationship with the group: Prepared to work in continuity of midwifery care	The midwives described their feelings about continuity of carer with emotive language, highlighting the importance of this model for them.	*We learnt about the benefits of it [continuity] and it all just makes sense. (p.442)* *...I developed a passion for group practice' (p.442)*
6	ENGEL ET AL.	Job satisfaction	Several of the midwives described a 'love' for midwifery along with a reluctance to relinquish that relationship when they have put so much of themselves into that women's care.	*I think the job can be quite idealised. There is something romantic about people becoming everything to other people, becoming an important part of their lives. (p.13)*
9	GRAY ET AL.	'it is something more meaningful, something different'	The follow through experience provided an opportunity that was very different from any other in the midwifery course.	*You connect- and it is something more meaningful, something different. (p.402)*
11	JEPSEN ET AL.	Working in an obligating but rewarding job	A sense of honour and pride in the feedback women gave them for the effort of providing them with continuity and women centred care.	*When they say they are so happy to see me, you really put your heart and soul into it. (p.66)*
12	MCARA-COUPER ET AL.	Joy of midwifery practice	The sense of specialness in midwifery, the magic of mother and baby meeting at the birth and the initial home visit moments were described as joyful. (30) 'More than just a job' 'with woman'.	*I mean the thing that keeps me in midwifery is the first time a mother looks at her baby....I think of that moment... and also the second point for me is the first time you visit a family at home...Those two things are what keeps me in midwifery. (p.30)* *I really wanted to provide continuity to women, the actual concept of doing LMC work, I love it. (p.30)*

13	MCCOURT AND STEVENS	Being there	Our studies suggested that midwives and women valued 'being there' very highly and that being with women is about more that a physical presence. The midwives felt a sense of getting something back from the women, on a personal and professional level.	*We like to think they want us and are upset if we are not there, but it isn't true. Now it is us that wants to be there, that's why you put yourself on call so much, you don't want to miss the end – it's the icing on the cake (p.17) Described as 'special' (p.18)*
14	MOORE	Emotive expressions	The emotional investment of the midwives throughout the MGP program indicated the passion and joy they experienced through their midwifery role.	*It's been really good, really good, as much as I want to go home I don't because this, it's just magical… (p.93)*
15	NEWTON ET AL.	Perceptions of 'real' midwifery: Satisfaction	The combination of meaningful relationships with women and practising autonomously gave satisfaction and was described emotively by the midwives.	*. . . essentially working like this has been the pinnacle of my midwifery career, there's nothing would ever beat this way of working. (p.228)*
16	RAWNSON	Learning partnerships	The overwhelming desire and concern to meet and facilitate women's expectations was experienced by the students. The emotion which the students reported recognition for their input, from women conveyed the deep-seated nature of being 'needed' and 'valued'.	*With your caseload ladies you sort of want to go out for them 110%, you really do (p.789)*

2.5.2.2 Theme: Real Midwifery

The theme 'Real Midwifery' featured in eleven of the included studies, and reflects the midwives' experiences of working as autonomous individuals across the scope of practice (Table 11). 'Real midwifery' was understood as the ability to work in partnership with women throughout their pregnancy journey, supporting them to make informed choices about their care. Statements made by the midwives included 'this is midwifery' (McCourt and Stevens 2006) 'the 'whole package (Moore 2009) and 'real midwifery' (Cummins et al. 2015; Browne et al. 2014; Moore 2009). There was a clear link between the midwives' ability to practice 'real midwifery' and the satisfaction and fulfilment they experienced from their role in all ten of these studies. The importance of supporting physiological pregnancy and birth processes was an important part of the concept of 'real midwifery'.

Professional autonomy was linked to the midwives providing woman centred care which they felt they were trained and competent to provide (Newton et al. 2016; Engel 2003). Working across the scope of practice and providing individual and woman centred care required 'rapid personal and professional development' (McCourt and Stevens 2006) which was described as a transition to become a 'thinking worker' (Moore 2009).

The recognition the midwives received for their professional input and personal effort made this physical and emotional investment worthwhile. The midwives associated working in continuity of carer models with increased competence in their midwifery skills (Newton et al. 2016; Cummins et al. 2015; Browne et al. 2014; Gray et al. 2013; Moore 2009) and confidence in decision making as an autonomous healthcare professional (Edmondson and Walker 2014; Moore 2009; McCourt et al. 2006). For the student and newly qualified midwives, continuity of carer practice was perceived as the consolidation of practice and knowledge which they developed through their training (Browne et al. 2014; Gray et al.2013; Rawnson 2011). While all eleven studies reported autonomous working as a positive of MCoCer roles, several also identified the challenges, as reported in the theme 'Counting the Personal Costs'.

Table 11: Thematic Framework for Real Midwifery

STUDY NO.	STUDY	AUTHOR THEME	THEME DESCRIPTION	SUPPORTING EVIDENCE
1	BROWNE ET AL.	Mutual Benefit	The continuity experience consolidated skills and made students more confident in their abilities. The students like they were 'really doing midwifery'.	*I think for me…the skills that I've learnt working in continuity…I feel much more confident working with the women. (p.575) …really doing midwifery. (p.575)*
2	COX AND SMYTHE	Passion and commitment	Being alongside women and supporting their normal process in an holistic way was described by the midwives in the way they provided care.	*It was a lovely birth and a home birth. No intervention. Yes, that was awesome. I'll never forget that. (p.18)*
		Passion and commitment	Professional autonomy.	*I love the autonomy. (p.18)*
3	CUMMINS ET AL	The relationship with the woman: Consolidating skills and finding confidence through continuity of care	The relationship and continuity increased the midwives' confidence and helped them consolidate their skills through experience.	*I liked the full range of my skills being used. (p.441) I wanted the whole scope. (p.441)*
		The relationship with the group: Prepared to work in continuity of midwifery care	The participants felt they were prepared to work in continuity through their education, and described an authenticity to the way they practiced.	*…consolidated everything you learn at uni. (p.442) I feel like a real midwife. (p.442)*
5	EDMONDSON AND WALKER	Autonomy of practice	Autonomy was viewed as the ability to use the full scope of their skill set to care for women and the capability to develop as professionals.	*I feel enabled to practise as a midwife and utilise all the skills that I have. (p.33)*
6	ENGEL	Job satisfaction	Some of the midwives expressed the enjoyment they gained from the professional autonomy they had with independent practice as an LMC.	*…a midwife needs to be able to use all the knowledge she has gained during her training and experience…That is where I get my job satisfaction. (p.14)*
9	GRAY ET AL	'This woman's care is in your hands'	The second theme involved the learning that occurred for the students as they engaged with women and had the women's care in their hands.	*Having the follow-through experiences made you feel you were actually studying to be a midwife. (p.403)*
		'it is something more meaningful, something different'	The nature of follow through experience meant that the student midwives began to focus on the woman as an individual not a set of risk factors to be managed.	*I think the really, really, really big positive is that it teaches you so clearly that 'normal' is not 1, 2, 3. It's all sorts of things. (p.404)*

11	JEPSEN	Having a high degree of job-satisfaction	The midwives felt that they were doing a good job and this feeling led to high engagement which again led to a meaningful relationship – a positive circle developed.	*..good, old fashioned midwifery. (p.65)* *I feel that I am able to use all the skills that I have been trained with. (p.65)*
13	MCCOURT AND STEVENS	Autonomy Confidence Development	Midwives described feeling more control over how they work. They reported more opportunities to make decisions supporting a strong sense of professional and personal identity, and developed confidence through practice.	*…working in this way is very, very rewarding. This is midwifery. (p.14)* *…a person again, not just a cog in a wheel. (p.14)*
14	MOORE	Professional fulfilment	Development as midwives through the use of the range of their skills and knowledge. Essential components were reported as; experience, knowledge, capability, knowing, transparency, safe spaces, respect, control, confidence.	*It's a big learning curve…because it's the whole package…so you learn a lot more. I have learnt a lot more. (p.101)* *…there's a respect for the fact that we are responsible professionals and that we are doing what we're meant to do. (p.103)*
15	NEWTON ET AL.	Perception of 'real midwifery: Autonomy and Legitimacy	This model was associated with an increased professional identity, responsibility and accountability. The ability to provide care (skills) autonomously across the scope of practice.	*…you have a greater ability to work as an autonomous midwife, as a caseload midwife. (p.228)*
16	RAWNSON	Feeling like a midwife	The student midwives' experiences of continuity and how this affected their learning journey to become a qualified practitioner.	*I know now that I am competent to practise on my own…um so yes, if you can be autonomous as a student, it's increased my autonomy as a practitioner without a doubt. (p.791)*

2.5.2.3 Theme: Counting the personal costs

The theme 'Counting the Personal Costs' outlines the aspects of the model which the midwives felt were detrimental to them on a personal level which were present in twelve of the studies (Table 12). Eight of the included studies reported challenging attributes of continuity of carer practice, six of these also reported the positive aspects of working in this way (Newton et al. 2016; Browne et al. 2014; Gray et al. 2013; Cox and Smythe 2011; Rawnson 2011; Sandall 1997). Donald et al. (2012) and Fereday and Oster (2010) reported on the challenges they faced in their practice and development of practical strategies to address them.

The challenges the midwives identified were emotional, physical and financial in nature. The theme 'Joy of Practice' described the positive emotional feedback the midwives received from MCoCer. Knowing women and developing meaningful and mutually respectful relationships were considered core reasons for MCoCer practice. However, midwives also reported the development of close relationships sometimes affected their ability to achieve a work-life balance (Jepsen et al. 2016; Donald et al. 2012; Cox and Smythe 2011; McCourt and Stevens 2006 Engel 2003). Several of the studies highlighted a dependence of the midwives to be personally needed by women (Donald et al. 2012; Rawnson 2011; McCourt and Stevens 2006). This 'need to be needed' effectively disrupted the work-life balance of midwives;

> *So it becomes unbalanced when we feel we're indispensable… (Donald et al. 2012;115)*

while others reported the expectations of the women made it difficult for the midwives to get time off (Jepsen et al. 2016; Donald et al. 2012; Cox and Smythe 2011; Engel 2003).

For some of the studies the organisation of the model affected them financially and controlled the extent to which they managed their work life balance. The New Zealand studies (Hunter et al. 2016; McAra-Couper et al. 2014; Donald et al. 2012; Cox and Smythe 2011; Engel 2003) and studies involving student midwives (Browne et al. 2014; Gray et al. 2013; Rawnson 2011) identified that providing continuity of carer often disadvantaged them financially. For the LMC's in New Zealand the financial model subsequently affected their physical wellbeing as they felt unable to take time off due to the impact on their income.

Professional autonomy was identified as a positive aspect of MCoCer practice but was also associated with specific challenges. These were identified as difficulty of working autonomously in a medicalised model of care or in organisations which were not aligned with a woman-centred model (Newton et al. 2016; Browne et al. 2014; Edmondson and Walker 2014; Gray et al. 2013; Rawnson 2011; McCourt

and Stevens 2006; Engel 2003; Sandall et al. 1997). For midwives who reported working in unsupported environments or out with guidelines there were also concerns about the degree of responsibility they felt as a MCoCer midwife (Jepsen et al. 2016; Newton et al. 2016; Edmondson and Walker 2014; Gray et al. 2013; Rawnson 2011; Cox and Smythe 2011; Engel 2003; Sandall 1997). Increased accountability and responsibility were also reported as a sense of professional (Edmondson and Walker 2014; Gray et al. 2013) and emotional burden in the same studies (Newton et al. 2016; Rawnson 2011; Engel 2003) and unpredictable and isolated working (Jepsen et al. 2016; Newton et al. 2016; Cox and Smythe 2011; Sandall 1997). All of these elements contributed to a sense of a personal cost for midwives providing continuity of carer.

Table 12: Thematic Framework for Counting the Personal Costs

STUDY NO.	STUDY	AUTHOR THEME	THEME DESCRIPTION	SUPPORTING DATA
1	BROWNE ET AL.	Counting the cost	The students felt that there was a financial, social and emotional investment cost to their degree which was a barrier to them enjoying their role.	*It's an expensive degree...extremely expensive...but it's not only monetary, it is emotional, and physical and it effects your whole family...(p.576)*
2	COX AND SMYTHE	The emotional impacts of practice: Feeling betrayed	The values of trust, respect and honesty gave value to the negotiated boundaries of their professional relationships. When these values were undermined it was distressing.	*... you reach a point when you think: I have a life. (p.19)* *Would I call a midwife from the hospital? Well I'd probably get agro for that and I'd never hear the end of it and it really wouldn't help me. (p.20)*
		The emotional impacts of practice: Feeling excessively responsible	The midwives described feeling responsible for the care of the woman and managing normal and unexpected situations. The potential threat of unsupported situations and outcomes was carried personally by the midwives.	*... and I guess it makes you feel very aware...for the outcome ...I sort of felt I'm in control but this is my total responsibility and potentially it could have been....(p.20)*
		The emotional impacts of practice: Feeling outraged	The midwives described being confronted to the point of feeling overwhelmed and outraged when they saw their clients and their babies treated with neither care nor respect.	*I know I became emotionally exhausted from my distress of seeing what had been done to her and could have been done differently with a bit more informed consent and decision making." (p.20)*
4	DONALD ET AL.	Tension between work and home commitments-expectations and empowerment	The tension which arose between the allegiance the midwife believed she had to the woman and the need to meet her own personal commitments.	*So it becomes unbalanced when we feel we're indispensable, in the sense that we feel that we have to be there. Or we feel guilt because we're not there. (p.115)*
		Tension between work and home commitments-commitment to self and family	Expectations of the women dictated the working practices of the midwives due to the allegiance they felt through meaningful relationships.	*The continuity of care thing has happened and with that it has created this picture of where women come first, and we have trouble putting ourselves or our families first or recognising that we have needs. It has become a life of putting the women first. (p.106)*
		Tensions between work and home commitments- Financial security	The LMC model meant that midwives were affected financially if they did not attend a birth regardless of location.	*You really can't go away (have time off) because if you miss one, then financially you're at a disadvantage. (p.107)*

		Personal autonomy recreational and social needs	Being constantly available made it difficult to have choice how they lived their lives.	*The downside of course is the fact that the women kind of own you. (p.111)*
5	EDMONDSON ET AL.	Autonomy of practice	Professional autonomy enhanced job satisfaction for the midwives but also increased responsibility and accountability.	*I am totally responsible for their care, which is sometimes quite scary but ultimately rewarding. (p.34)*
		Good work-life balance	Disengaging from work even when the midwives were off call was difficult for some due to the investment they put in with women.	*. . .I still think about em. . .I probably get far too attached to my patients.. .it's really hard not to be there for them cause you develop this one on one with them. (p.34)*
6	ENGEL	Keeping the balance	The absolute intensity of the relationship may need to be diluted a little to help the midwife keep a sense of balance when it comes to 'letting go' for regular time off.	*We could choose to take more time off if we wanted to but we don't actually want to miss the birth. (p12)* *I think for many of us we are trying to pull back a bit from that, but it is hard because it is a trade-off between satisfaction in the job and becoming really aloof from it all and that would change the whole relationship… (p.10)*
			The nature of on call and women's expectations meant that the lines between work and personal life were blurred.	*The relationship with the women does mean you are going to be on call for them and very accessible. (p.11)*
7	FEREDAY AND OSTER	Unable to 'switch off'	Although the midwives identified that a period of adjustment was needed to being on call and carrying a pager, others described the difficulty of being unable to 'switch off' from the responsibilities of being a primary midwife. They constantly thought about their women, worrying about them even on their days off.	*I couldn't stop thinking about the women, and if they were due [to give birth] and I wasn't on, I'd make phone calls on my days off to the other midwives asking about how they were going. (p.315)*
9	GRAY ET AL.	'It was gruelling… It really was'	Difficulty in the process and requirement to provide a set number of follow through experiences. While important for learning, as a student you are not able to organise practice in the way you want and must conform to current/mentor systems.	*This was not a course that you could close the books, shut the door and walk away from it. If the phone rang you would say 'I hope it's not someone in labour'. (p.403)*
11	JEPSEN ET AL.	Working in an obligating but rewarding job	Disadvantages in caseload midwifery were mostly about how to get their job and family life to correlate within the undefined working hours.	*My boy does not know whether to say good night or good bye in the evening. (p.66)*

		Working in an obligating but rewarding job	The midwives wanted to attend all their women and it was a source of frustration if they were not able to do so.	*I hate to miss some of the births…it is so annoying and frustrating to let down people's expectations. (p.66)*
13	MCCOURT AND STEVENS	Being there	The midwives indicated that being present at the birth held as much, if not more, significance for midwives than mothers. This caused emotional turmoil with work-life balance and sadness for the midwife if the birth was missed.	*We like to think want us and are upset if we are not there, but it isn't true. Now it is us that wants to be there, that's why you put yourself on call so much, you don't want to miss the end – it's the icing on the cake. (p.17)*
15	NEWTON ET AL.	A different way of working: Being 'on call'	Unpredictable and uncertain but key to responding to the activity fluctuations. Period of adjustment. Constant readiness and need to respond impacting and life and wellbeing.	*…was so distracted because I was on-call so I just didn't feel like I could wind down. (p.227)*
		Perception of 'real' midwifery: Responsibility and Accountability	The professional autonomy gained through caseloading was also associated with increased responsibility and accountability. This responsibility was acutely felt when significant negative clinical outcomes made midwives question themselves.	*So if you miss something, you are responsible and that is something you have to come to grips with. (p.228).* *You carry it a little bit more and you feel that your effort sometimes it's harder to let go. You put in all of that work and all of that effort and you gave enormous amount, you sacrificed things… (p.228)*
16	RAWNSON	Afterwards	The participants experienced feelings of loss as caseloading concluded and they returned to traditional placements without continuity.	*It's, it is a bit like losing a limb! Cause you've seen them for so long and you think 'ooh, ooh bye then! (p.791)*
17	SANDALL	Developing meaningful relationships with women	For some midwives, there was a commitment to an ideal of continuity of carer which was unachievable in the team system, and after an attempt to do so, these midwives tended to leave disillusioned.	*To my mind they were nearly over dedicated to their job…the job came before anything else…I think as a result they were totally exhausted from it. (p.108)*
		On call	All of the midwives said that being on call was stressful because of an element of uncertainty.	*Since we've given up our weekends off, I think it's been a major source of the stress for some of us. (p.110)*
		Social support	Lack of teamwork led to dissatisfaction for midwives.	*The other main problem I saw was poor communication between the team. You didn't meet up…I found there was no team spirit as such. (Team midwife p.110)*

2.5.2.4 Theme: Working in a system

> *…a person again, not just a cog in a wheel…(McCourt and Stevens 2006;14)*

This theme was identified in nine of the included studies (Table 13), incorporating both the positive and challenging aspects the midwives experienced of the organisation or institution they worked in whilst providing continuity of care. Some of the midwives felt that the institution or organisation was not suitably set up to support a relational model of care (Newton et al. 2016; Sandall 1997).

In several studies midwives expressed that institution focused models of care affected both their autonomy as professionals (Edmondson and Walker 2014; McCourt and Stevens 2006) and ability to provide woman centred care (Browne et al. 2014; Engel 2003). A lack of congruence between the focus of the midwife and the woman and that of the institution led to a sense of competing pressures which was difficult to satisfy (Browne et al. 2014; Edmondson and Walker 2014; Gray et al. 2013; Engel 2003). In one of the studies the midwives felt that they had to earn the right to be respected as autonomous practitioners (Newton et al. 2016). A positive relationship with the wider multidisciplinary team was present in the studies where 'low risk' caseloading was offered which was a feature represented by the Australian studies (Newton et al. 2016; Cummins et al. 2015; Browne et al. 2014; Edmondson and Walker 2014; Gray et al. 2013; Moore 2009) but not supported for midwives looking after women with complexities, indicating that respect for autonomy was limited to care of women who were physiologically normal and not seeking care out with the recommended guidance.

> *…and that's a part of the big issue…as a caseload midwife you really need to be autonomous whereas the system doesn't support the autonomy. (Newton et al. 2014;228).*

Care provision for women with complexities within a relational model of care but institutionally focused organisation was reported as 'inflexible models' by several of the studies (Newton et al. 2016; Gray et al. 2013; Rawnson 2011; Engel 2003). Quotes indicated that as a midwife you had to learn 'how to play the game' to make the system work for,

> *…a woman in a system that's not always woman-friendly. (Browne et al. 2014; 575)*

The theme of 'inflexible models' also related to the way the midwives could structure their working day or the competition between academic and clinical for the student midwives. As described in the theme 'Counting the Personal Costs' the financial payment method was not always aligned with a relational model of care which supported women and midwives. For the LMC midwives in the New Zealand studies (Gilkison et al. 2015; McAra-Couper et al. 2014; Donald et al. 2012; Cox and Smythe

2011; Engel 2003) there was difficulty maintaining their work-life balance due to the number of women they had on their caseloads, and the necessity to attend every birth which was dictated by the payment model. This inflexibility led to overwork and the risk of burnout for the caseloading midwives.

Table 13: Thematic Framework for Working in a System

STUDY NO.	STUDY	AUTHOR THEME	THEME DESCRIPTION	SUPPORTING DATA
1	BROWNE ET AL.	Woman centred care	The system did not support women to make individual choices outside of the recommended guidance. Student midwives learnt in their follow through experiences to work within a prescribed system to advocate for women and negotiate with maternity staff.	*I think that when students do continuity too, they learn how to work the system a bit, like how to play the game, that we all have to, sort of, negotiate…how do you make that work for a woman in a system that's not always woman-friendly'. (p.575)*
5	EDMONDSON AND WALKER	Guidelines for practice	The ACM National Midwifery Guidelines were implemented at the birth unit for referral to consultant care if their condition changed to higher risk. This instigated strict protocol, making some of the midwives feel comfortable but others felt it was restrictive to individualised care.	*….not only for the protection of women but for the protection of myself as a practitioner. (p.34).* *The policies can be quite restrictive and they are totally black and white. (p.34)*
6	ENGEL	Balance depended on the funding model	Funding of any service ultimately has a major impact on how that service is delivered. The modular system may have negative financial implications for midwives working in shared care arrangements. There was also a sense of a medicalised model of care controlling midwifery.	*Funding definitely directs the way one practices, as in any business. (p.14)* *…the power the medical profession have has influenced decisions that are affecting midwifery practice. (p.14)*
9	GRAY ET AL.	'it was gruelling. It really was'	The number of follow through experiences was dictated by the model adopted by the university. For students expected to complete 30 continuity episodes this changed the way they experienced the model and applied themselves. Obstructions from midwives working in the hospital settings also prevented the students from completing the birth part of the continuity experience.	*It was unrealistic and too much. So without support from the education system and from the providers, then us poor old students really get pushed from pillar to post. You end up in despair sometimes and it's all too hard. (p.403)* *There were women who asked that their follow-through student be rung while they were in labour, and the midwife would simply not do it. And so students missed out on being at the birth purely because the midwife refused to ring, and that happened a lot. (p.403)*

13	MCCOURT AND STEVENS	Autonomy	Midwives described feeling more in control about the opportunities they had to make decisions and working with not deferring to other healthcare professionals.	*…a person again, not just a cog in a wheel… (p.14)*
14	MOORE	Mutual Respect: Whole of organisation support	The use of a framework to implement the model created partnership.	*I have the support of my colleagues and we've all been working together…None of us are fighting the establishment. (p.85)* *…this is a partnership model; its not a hierarchy system that I have worked in before. (p.85)*
		The midwives journey: Adaption to a thinking worker	The midwives were functioning autonomously and supported to do so by their colleagues and the model they worked in.	*There's a respect for the fact that we are responsible professionals and that we are doing what we're meant to do. (p.84)*
15	NEWTON ET AL.		There were challenges in achieving a level of autonomy and legitimacy in their caseloading role. Some midwives indicated that they had to 'earn' the right to practice autonomously and needed 'approval' from medical staff.	*…and I wouldn't have been trying so hard to meet her needs when they were in conflict with the hospital system… (p.228)* *…and that's part of the big issue…as a caseload midwife you really need to be autonomous whereas the system doesn't support the autonomy. (p.228)*
16	RAWNSON	Developing and managing caseload	Developing, managing and carrying a personal caseload alongside university, academic and social commitments was challenging. This model was created by the academic bodies and was not flexible for individual circumstances.	*I think if I hadn't had all the other assignments to do I probably would have done more[caseloading] and I would've enjoyed it, enjoyed doing more… (p.789)*
17	SANDALL	Developing meaningful relationships with women	A major source of burnout is the disillusionment that results from an inability to provide continuity of carer in a system that is designed for team care.	*That's one thing I do miss...the birth, the whole continuous thing, and for me that's one of the best things of the job. (p.109)*

2.5.2.5 Theme: Strategies to Sustain

The second question posed for the review was 'What do the midwives experiences highlight in terms of sustainability of continuity of care models?' In fifteen of the studies midwives identified strategies which were key to their enjoyment of and continued practice in their continuity of carer model (Hunter et al. 2016; Newton et al. 2016; Cummins et al. 2015; Gilkison et al. 2015; Browne et al. 2014; Edmondson and Walker 2014; McAra-Couper et al. 2014; Donald et al. 2012; Rawnson 2011; Fereday and Oster 2010; Moore 2009; Engel 2003; Sandal 1997). There are clear similarities across the studies in the strategies the midwives describe. Three sub-themes emerged within the overall theme of 'Strategies to Sustain'; 1) *Defining Professional Boundaries*, 2) *Community of Practice*, 3) *Flexibility and Structure*.

2.5.2.5.1 Sub-theme: Defining Professional Boundaries

This theme focused on the importance of setting expectations with women from the beginning of contact to establish boundaries on work life for the midwives (Table 14). Expectation setting featured in nine of the studies and included the working practices of the midwives and when and how to contact midwives (Hunter et al. 2016; Newton et al. 2016; Gilkison et al. 2015; Browne et al. 2014; Edmondson and Walker 2014; McAra-Couper et al. 2014; Fereday and Oster 2010; Engel 2003). Expectations about contact included the reasons women should call midwives out of hours and the mode that they could contact them on. Setting of expectations around contact for women helped to protect the midwives work life balance. In one study the midwives discussed their decision to use pagers not phone to further control their work-life boundaries (Gilkison et al. 2015). Agreement of expectations with colleagues was also important for the midwives to maintain professional boundaries they set with women (Newton et al. 2016; Gilkison et al. 2015; Browne et al. 2014; Fereday and Oster 2010; Moore 2009; Engel 2003). This meant that women and their named midwife could trust they would be cared for by someone who shared the philosophy and structure of working.

Table 14: Thematic Framework for Strategies to Sustain: Counting the Personal Costs

STUDY NO.	STUDY	AUTHOR THEME	THEME DESCRIPTION	SUPPORTING EVIDENCE
1	BROWNE ET AL.	Into the future	Continuity experience for student midwives was perceived as contributing to the development of midwives who were woman rather than institution-centred; a positive attribute regardless of the future workplace setting of the midwife.	*…my understanding is that, there is a lot of interest in continuity models and that they're actively trying to promote those…they've got that experience, they're got that in their head as, as I guess the ideal form of midwifery, and so when you want to resource those, you will get a whole bunch of girls who then say 'yes that's the model I want to work in'. (p577)*
4	DONALD ET AL.	Changing assumptions about commitments	The second theme showed that for successful change to occur the midwife needed to gain awareness of her own needs and change assumptions surrounding her commitments to the woman and herself.	*We actually need to say, no, I'm looking after myself, or no, I'm being a mum today. And there's nothing wrong with that. (p125)* *You might be very involved with people, but don't forget you're not indispensable and you can't be everything to everybody all the time. (p132)*
5	EDMONDSON AND WALKER	Good work-life balance: Setting Boundaries	Participants set boundaries with the women, themselves and their midwifery partners in order to establish and maintain work–life balance. Through the establishment of these boundaries participants had a break from work and did not feel guilty for not being available for the women.	*. . .let your women know as well that there are times that you might not be available. (p34)*
6	ENGEL	Setting boundaries on practice	Setting boundaries with woman was important to maintain work life balance for the midwives. This differed between midwives according to the way they liked to work and their philosophy but had to be shared between colleagues working together.	*I am sorry but I do that type of care within regular hours. (p14)* *…the women don't mind. I have explained it to them beforehand, I make it clear. (p14)*
7	FEREDAY AND OSTER	Establishing realistic expectations with women	It was important that boundaries were set with women to ensure the midwives maintained a balance between work and life. Flexibility for these midwives was interpreted as needing to be of benefit for their own lives, as well as offering an individualised service for women.	*But we don't promise anything that we're not prepared to give and recognise that we may have a little bit less continuity [with women] but that we really need that balance between our personal life and working life. (p315)*

8	GILKISON ET AL.	Sharing arrangements with women	The sharing of practice arrangements with women helped the sustainability of the model. The sharing of these practice arrangements of colleagues underpinned the concept of partnership.	*…we offer information about the practice philosophy, how we work, the back-up midwife, the time off… (p13)*
10	HUNTER ET AL.	Negotiating boundaries	For the midwives to remain generous of spirit, certain strategies are required to support and sustain this quality. These strategies appear to be around negotiating and maintaining professional boundaries that support generosity of spirit, and invariably come as an evolution of practice.	*After 10 years of feeling guilty for everything that I didn't do and every text that I told off or every phone call that I didn't answer….[then] that guilt actually went away…when I made my boundaries clear to me… (p53).*
12	MACARA-COUPER ET AL.	Negotiating and keeping boundaries	An important part of the reciprocity of the partnership is about negotiating boundaries with the women. This underpins the concept of partnership, sustaining the midwives and the model.	*As long as you tell the women when you book them, 'this is how I work… these are my boundaries. This is when I work'. (p30)*
15	NEWTON ET AL.	A different way of working: Working on call	Over time, caseload midwives also became more protective of their off duty time as a component of self-care.	*…if its urgent ring me, anytime. But if it can wait 'til morning just ring in business hours only. (p227).*
		A different way of working: Avoiding burnout	This study did not find any increase in burnout for the caseloading midwives however there was an increased sense of awareness and understanding that there needed to be personal and group strategies in place to avoid this.	*So I think a lot of midwives who've left blamed the model, that it has not worked, that its not fun, but it might be more about how you handle it. (p227)*

2.5.2.5.2 Subtheme: Community of Practice

Community of Practice was the second subtheme of 'Strategies to Sustain' which focused on an open and trusting practice environment involving colleagues, the wider multidisciplinary maternity team and the institution or system (Table 15). Nine of the studies discussed the importance of a shared philosophy of care, working practices and expectations to develop a welcoming environment of mutual trust and support for the continuity of carer midwives (Hunter et al. 2016; Newton et al. 2016; Cummins et al. 2015; Gilkison et al. 2015; Edmondson and Walker 2014; Moore 2009; Engel 2003; Sandall 1997).

Supportive professional relationships were described by one of the studies as the greatest stress reducer across several different models of continuity (Sandall 1997), while a lack of teamwork and professional isolation led to dissatisfaction (Newton et al. 2016; Sandall 1997). Supportive practice was described as 'generosity of spirit' and 'good will' (Hunter et al. 2016), a mutual arrangement between midwife colleagues which involved open-hearted and responsive practice towards other midwives to aid their work-life balance and sustain their practice. This included a shared philosophy of care to ensure that midwives and women felt secure in receiving the same care even when their named midwife was not available.

> *…you want similar things for your women. You couldn't get other midwives to cover you that didn't kind of work in a similar way... (Gilkison et al. 2016;12)*

This enabled work-life balance for midwives working in MCoCer, as they felt able to take time off without compromising the woman centred approach to care they wanted to provide. This concept of continuity of care from colleagues mitigated the need for continuity of carer at all times and reduced mutual dependence within the midwife-woman relationship. Sharing care also reduced the feeling of complete responsibility described by some of the midwives, whilst maintaining professional autonomy.

> *Absolutely I'm not isolated, I'm not working on my own I have got professional answers to my professional questions…(Moore 2017;92)*

Isolation of the midwives through independent practice was negated through regular meetings to keep in touch, share practice arrangements and the responsibility of caseload decision making to reduce the burden of accountability (Gilkison et al. 2015; Moore 2009). For student midwives, positive experiences of continuity of carer with supportive mentors and a cohesive working environment encouraged them to seek these roles once qualified (Browne et al. 2014; Rawnson 2011). Midwives also greatly appreciated the support of student midwives and the ability to encourage the next generation of MCoCer.

Table 15: Thematic Framework for Strategies to Sustain: Community of Practice

STUDY NO.	STUDY	AUTHOR THEME	THEME DESCRIPTION	SUPPORTING EVIDENCE
1	BROWNE ET AL.	Into the future	Continuity experience for student midwives was perceived as contributing to the development of midwives who were woman rather than institution-centred; a positive attribute regardless of the future workplace setting of the midwife.	*My understanding is that, there is a lot of interest in continuity models and that they're actively trying to promote those.. they've got that experience, they're got that in their head as, as I guess the ideal form of midwifery, and so when you want to resource those, you will get a whole bunch of girls who then say 'yes that's the model I want to work in'. (p.577)*
		Mutual Benefit	The experience of continuity was mutually beneficial to the student and current midwives. Students gained confidence and competence from their mentors and as such were able to work alongside the midwives to lighten their workload. This engendered an environment of mutual trust and respect between the student-midwife partnership.	*Certainly for myself, I think working with students is fantastic...it's just lovely to have another person caring for the woman with you, and obviously they help you...(p.576)*
3	CUMMINS ET AL.	The relationship with the group: Finding support from within the group	These midwives felt more supported in continuity compared with working in the standard transitional support programme. This included approachable knowledgeable colleagues and care for them as an individual.	*I have been extremely supported by the midwives around me. (p.442)*
4	DONALD ET AL.	Changing assumptions about commitments	The second theme showed that for successful change to occur the midwife needed to gain awareness of her own needs and change assumptions surrounding her commitments to the woman and herself.	*Development of an MGP with a 'shared philosophy' to ensure regular time off. (p.5).*
5	EDMONDSON AND WALKER	Effective working relationships	This was important to all the birth centre midwives as a group, the shared philosophy and aim to achieve positive outcomes for all.	*...this is the best place for me to have been working because we're all of the same...well we've all got the same philosophy, philosophy of midwifery care... (p.35) ...doctors we speak with weekly seem to...respect us and are mostly open to discussion rather than just absolute policy. (p.35)*

		Good work-life balance: supportive family	Having a supportive family was important to the participants and an essential feature in enabling them to construct their birth centre caseload midwifery role. This support allowed them to have a sense of the freedom of choice in how they constructed their role.	*. . .and he's fine and it's worked out really well…* *(p.34)*
6	ENGEL	Keeping the balance	The midwives highlighted the need to maintain balance of work and life to sustain midwifery practice as an LMC.	*My colleague and I are both comfortable with each other's philosophy of care* *if you can find someone who is philosophically compatible to work with, to back you and you back them, that is the absolute key to keeping your sanity. (p.13)*
7	FEREDAY AND OSTER	Working as a member of a team	The majority of midwives enjoyed the role of primary midwife and were content for their like- minded colleagues to be proxies when they had time off work because they shared the same philosophy of care. With experience many of the midwives realised that 24/7 sole responsibility for each woman was not sustainable. A group philosophy and agreed working practice were necessary for this.	*Generally in our group, we don't actually ring each other on days off and I think that's brilliant because you need to get away to stop your mind churning. (p.314)*
8	GILKISON ET AL.	How practices work	Regular practice meetings were one area which they saw as important. The purpose of the meetings varied, and ranged from having a social catch up, to discussing birth plans for women who were due, to serious debriefing and problem solving related to practice or clinical dilemmas. Some went as far as indicating that, for them, these meetings were the "glue" that held the practice together.	*We're always kind of revisiting how we work as a practice. We have a meeting every fortnight…keeping things updated. (p.13)* *…you want similar things for your women. You couldn't get other midwives to cover you that didn't kind of work in a similar way… (p.12)*
10	HUNTER ET AL.	Generosity of spirit	The data in this New Zealand study show the power and influence of generous behaviours and their impact and contribution towards sustainability.	*…it's about generosity towards your midwifery partner…thoughtfulness and consideration….I do think that gives you longevity in LMC practice. (p.52)*
14	MOORE	Mutual Respect: Whole of organisation support	Support from midwifery colleagues and not working in isolation and partnership throughout the organisation as a result of and sustaining the model.	*Absolutely I'm not isolated, I'm not working on my own I have got professional answers to my professional questions…(p.92)*

				Definite number one is to get the support from everyone, so without the support from everyone within a health care facility it's not going to work. (p.85)
		Mutual Respect: Welcoming	Integral to the organisational support was the sense that the midwives involved in the group practice were made to feel welcome. This involved a mutual relationship or 'kinship' with each other.	*I feel I'm part of wherever I go and work I feel very welcome. (p.86)*
15	NEWTON ET AL.	A different way of working: Working together and working alone	Words such as, "belonging", "team", "friendships", were commonly used to describe he partnerships formed with caseload colleagues. These were a strong and important feature of the model, with a 'shared philosophy' with other caseload midwives identified as a key factor for sustainability.	*…in the past not have said to anyone 'I'm struggling here' but now I'm more inclined to ring my [midwife] partner and just say… (p.227) …that's the big issue with other groups I've seen too…philosophies not the same…attitudes are different. It affects everything… (p.228).*
16	RAWNSON	Learning Partnerships	Participants described the importance of developing learning partnerships with the mentors and women. Positive feedback from women and mentors was key to the students enjoying the model and thriving.	*I really enjoyed it because I had a good mentor that was very supportive of me. (p.789)*
17	SANDALL	Social Support	Supportive professional and personal relationships were reported as the greatest stress reducers for midwives.	*It's all very pally, all very nice. (Traditional Midwifery Model p.109)*

2.5.2.5.3 Structure and Flexibility

The midwives reported both structure to reduce unpredictability, and flexibility of their individual work practices as necessary for enjoyable and sustainable practice (Table 16). Six of the studies from the synthesis identified solutions which they developed to maintain work-life balance and sustain them in practice (Edmondson and Walker 2014; Engel 2003; Fereday and Oster 2010; Gilkison et al. 2015; Newton et al. 2016; Moore 2009).

The midwives valued flexibility to work around their own personal lives and commitments while providing the care women needed (Newton et al. 2016; Edmondson and Walker 2014; McAra-Couper et al. 2014; Fereday and Oster 2010). This ensured the ability to have the work-life balance the midwives sought.

Everything else you can fit in, absolutely to your own life. (Sandall 1997;108)

Structured strategies to ensure effective work-life balance (Hunter et al. 2016; Newton et al. 2016; Gilkison et al. 2015) included regular and scheduled time off, responsibility sharing, caseload size, on call and financial arrangements. Regular and scheduled time off was protected by the ethos of colleagues and setting expectations with women (Gilkison et al. 2015; Fereday and Oster 2010; Engel 2003).

Group antenatal care was one of the strategies employed by midwives in MGP to facilitate regular time off and share responsibility for women's care planning. This increased the opportunity for women to know the other midwives, to empower them through the contact with other pregnant women and reduce dependence on one midwife (Moore 2009).

Table 16: Thematic Framework for Strategies to Sustain: Structure and Flexibility

STUDY NO.	STUDY	AUTHOR THEME	THEME DESCRIPTION	SUPPORTING EVIDENCE
3	CUMMINS ET AL.	The relationship with the group: Finding support from within the group	The support from the group structure including regular meetings with the other midwives, mentorship and a reduced caseload were all strategies applied to structure the newly qualified midwives transition to caseloading.	*'weekly meetings', 'monthly meetings', 'at least once a week we meet', 'professional practice support', 'mini-audit' of practice and discussion of 'evidence' to inform care and support the midwives.* *…it really helped to have a reduced caseload. (p.442)*
4	DONALD ET AL.	Changing assumptions about commitments: Stepping out	Midwives gained satisfaction from providing caseloading care, however concerns about their work life balance and their sustainability in the model caused some of them to reflect and initiate strategies to ensure regular protected time off.	*So we came up with a structure where we work alternatively, first on-call, second on-call, and we have the third week off completely. (p.125)*
5	EDMONDSON AND WALKER	Good work-life balance: Flexible hours	The flexibility provided by the caseload model of care enabled them to adjust their working hours to suit their personal life while still being available to meet the needs of the women.	*. . .I diarise things quite strictly and I put a line through you know, a couple of hours in the morning if I'm going to a gym class or. . . (p.34)*
6	ENGEL	Setting boundaries on practice	Ensuring practice boundaries with clients to ensure balance between work and life and maintain job satisfaction. The nuts and bolts of sustainable/unsustainable practice.	*- I am strict about having structured time off…(p.12)* *Once you overcome that hurdle of 'letting go' it gets easier. (p.12)* *…the need to formally pull back sometimes. (p.12)*
		Setting boundaries on practice	The major theme of *balance depended on the funding model* highlighted that as self-employed midwives the business side of the LMC role had to have structure to prevent problems.	*..we keep the money side of things very business like, so that it does not cause problems between us [midwifery colleagues]. (p.13)*

7	FEREDAY AND OSTER	Flexibility and structure for the individual	It was evident that some of the midwives really embraced the flexibility of hours within a caseload midwifery model, and planned their workloads to accommodate their personal lives. Some midwives were able to arrange their work to ensure another day off every two weeks- an advantage of managing their own flexible hours.	*It's actually very easy to pick my daughter up from school, drop her off at school, because I make my appointments to suit me. (p.314)*
		Flexibility and structure at an organisational level	Midwives within MGP work within the parameters of an industrial agreement, which allows for an average of two days off duty per week free of planned work, on call and recall. These allocated days off each week were seen by many as 'sacred' and work should not be scheduled. All midwives described the scheduled 'days off' as essential to work–life balance.	*I see days off as sacred. (p.313)*
		Practical support systems enhance flexibility	The importance of women being allocated in a reasonable geographical distance to the midwife was important to maintain continuity and reduce travel time for the midwife.	*…If you've got a handful of women who are within 5 mins of your home, it's not a problem at all. (p.316)*
8	GILKISON ET AL.	Financial arrangements	Midwives in this study spoke of a variety of financial arrangements, sometimes very detailed, and sometimes inexact but whatever the arrangements were, midwives said it was crucial that clear, agreed, financial arrangements were negotiated by the practice at the beginning, and were very clear to all midwives in the practice.	*…just one of us takes all the calls over night and the same happens at the weekend so you're not constantly tied to your pager and nobody gets your cell phone number. (p.14)*
		Sharing arrangements with women	The midwives shared a commonality for increasing time spent with the women antenatally to empower them- this subsequently reduced the amount of out of hours calls they received.	*…and if you've done your homework really well antenatally, then they'll generally phone you less with minor questions and do better in the labour and birth. (p.13)*
		Caseload size	The LMC midwives in this study spoke about having a manageable caseload size as being one of the factors which sustained them. There remains a question as to what is a "manageable" caseload however when all	*…so that we're not covering too much… Two of us work together… so that when one of*

			practice partners have a similar caseload size no-one can become overwhelmed.	*us is off the other isn't swamped. (p.13)*
11	JEPSEN ET AL.	Working in an obligating but rewarding job	While no specific strategies were identified in this study, the flexibility of working was appreciated by the midwives around personal life.	*I have small children, if I…was working full time…then I would never be at home. (p.66)*
14	MOORE	The midwife journey: Adapting to a thinking worker	Flexibility enabled and empowered the midwives to practice around their personal commitments and maintain work/life balance.	*I am enjoying the time management that way I can sort my own time out. (p.90) …the flexibility works in my favour…(p.96)*
15	NEWTON ET AL.	A different way of working: Avoiding burnout	Using the structure of partnerships or small groups to enable back-up was an important strategy to avoid burnout. While finding it difficult to leave 'their' caseload women, the midwives recognised that this was an important and protective feature of the model in avoiding exhaustion and potential burnout.	*I don't feel burnt out by it at all…I think having days off knowing that they are set days off works really well for me…(p.227)*
		A different way of working: Avoiding burnout	Unplanned and extended periods of leave impacted on the availability of back up. It was a source of frustration for midwives to find that there were so few clear strategies for the management of these situations which increased stress and the risk of burnout, especially if these events happened frequently.	*…the sick leave relief… it just increases sort of the pressure and stress on the other members of the group. (p.227)*
17	SANDALL	Occupational autonomy	For the MGP midwives the ability to manage their own workload around their personal lives gave them the ability to reduce uncertainty and the impact this had on them personally.	*Everything else you can fit in, absolutely to your own life. (p.108)*

While these themes have been reported individually, they coexist as interconnected aspects of each midwife's experience of MCoCer. A line of argument to represent the relationship between the themes was generated from the thematic framework:

For continuity of carer midwives the development of mutually reciprocal relationships through knowing women and passion for midwifery create a joy of practice. Midwives enjoy the autonomy and freedom to practice across the scope of the childbearing continuum in partnership with women to facilitate their choices. While these factors created a positive role they were also responsible for the challenges midwives faced working in this model of care and could lead to burn out if work and life were not kept in balance. Creation and implementation of strategies to promote this balance sustained positive practice for midwives. In order to create these strategies which are relevant to individual circumstances and contexts midwives must be free to decide their own practice arrangements according to their needs and supported by the organisation to do so effectively. A shared ideology of person-centredness which supports midwives and women is necessary for this.

2.6 Discussion

To our knowledge this is the first review to synthesise midwife experiences of working in continuity of carer models. This systematic review has identified themes through synthesis of 17 qualitative studies on this topic. The overarching themes identified through this synthesis are 1) Joy of Practice, 2) Real Midwifery, 3) Counting the Personal Costs, 4) Working in a System, and 5) Strategies to Sustain. While there were a relatively small number of studies included in the review (n=17), the inclusion/exclusion criteria and quality appraisal process has ensured that the quality of data and relevance to the review questions were high. The GRADE CERQual ratings of the synthesis findings indicate that they are transferable to midwives working in similar contexts with high to moderate confidence.

The line of argument generated from the findings of the review surmises that while there are positives of working in this way, midwives must construct professional boundaries to protect their own personal needs. The strategies to sustain which the midwives created enable the positive elements of MCoCer practice whilst negating the challenges presented by working in this way. Support from colleagues and the wider multidisciplinary team enable the midwives to create and implement these strategies for enjoyable and sustainable practice.

The majority of the studies identified that continuity enabled meaningful relationships which were both rewarding and obligating. The paradoxical nature of the midwife-woman relationship is identified by Davies (2017) as,

A Nexus- Women need midwives and midwives need women. (p.139)

The findings in the included studies represented a continuum of midwife perception from predominantly positive experience of this relationship, to overly challenging. Previous studies have also reported that midwives become emotionally fatigued when the development of meaningful relationships with women were either not possible (Sandall 1997) or reciprocal (Deery and Hunter 2010; Deery 2009). The two studies which reported the most positively about continuity of carer practice (Hunter et al. 2016; Moore 2009) evidenced addressing the needs of the midwife, including reciprocal relationships with women, colleagues and support from the wider organisation. The studies which focused on the challenging aspects of MCoCer without the positives signified there was a lack of balance and reciprocity within the midwife-woman relationship (Donald et al. 2012; Cox and Smythe 2011; Engel 2003) which led to the midwives feeling exploited and burnt out. The midwives need for reciprocity in the midwife-woman relationship identifies with the concept of person centred, not simply woman centred practice.

Challenges experienced by the midwives centred around an inability to build meaningful relationships and a lack of work/life balance. Expectation setting with self (Hunter et al. 2016; Edmondson and Walker 2014; Donald et al. 2012; Engel 2003), midwife colleagues (Hunter et al. 2016; Newton et al. 2016; Cummins et al. 2015; Gilkison et al. 2015; Edmondson and Walker 2014; Moore 2009) and with women (Newton et al. 2016; Cummins et al. 2015; Gilkison et al. 2015; McAra-Couper et al. 2014; Edmondson and Walker 2014; Donald et al. 2012; Engel 2003) to create clear practice guidelines and establish professional boundaries helped the midwives negotiate and define their relationship with women, enabling the joy of practice and necessary personal freedom. The importance of this balance is summarised in McAra-Couper et al. (2014):

Although midwives are inspired and sustained by partnership and reciprocal relationships, they also need to negotiate boundaries and ensure their professional and personal lives are integrated and balanced. (p.30)

The importance of working in a system which supports the midwives was paramount to the success of the model. This included the ability for the midwives to organise their own working practices to answer their own needs as well as those of women and a welcoming environment with a shared philosophy for woman centred care with colleagues and the wider institution. Student midwives experienced considerable difficulty in negotiating the expectations of the education system with

their own lives. Students highlighted the pressure to complete a certain number of continuity experiences and a lack of choice about how and when they worked as key factors in affecting their enjoyment of their caseloading experiences. Student midwives who were able to organise routine care with women and had supportive mentors enjoyed their experience, which directly reflects the experiences of qualified midwives in continuity of carer models.

The model of continuity which the midwives worked in ranged from mixed risk caseloading practice to team midwifery. Midwives working in low risk caseloading and midwifery group practice in midwife led units did not find working within the system a challenge compared with those who provided all risk caseloading, highlighting the tensions of low and high risk caseloading. The comments made by midwives working in all risk caseloading indicated that they were not supported to practice across the scope of midwifery care, which challenged their ideology and autonomy. Midwives working with low risk women did not experience the same challenges and felt supported and autonomous in their roles. This was described in Moore (2009) as,

None of us are fighting the establishment (p.85)

This finding indicates that while the current system may support midwives to provide care for women without complexities, it appears that the autonomous nature of MCoCer is potentially threatened when complexity and complications are present for women in their care. Both a medically organised model and a financially driven system were discussed in the studies which found the system challenging. A financially driven system is incongruent with the nature and practice of midwifery and therefore causes tension between the aims of the institution and midwives. Midwives who did not feel that they worked in a model which supported woman centred care and supported them as autonomous practitioners experienced frustration and disillusionment, which in turn could lead to burnout. This reflects the qualitative study by Hunter (2004) which highlighted the emotional implications for midwives working in an environment which had a conflicting ideology to their own.

2.7 Conclusion

This systematic review synthesis identifies midwife experiences of providing continuity of carer and how these experiences relate to sustainability of the model. There is now sufficient evidence to show that midwives find the experience of providing continuity of carer both fulfilling and challenging. This evidence synthesis offers insights into the positive and challenging aspects of continuity of carer practice, the barriers to a satisfying and functioning model from the perspectives of midwives and the strategies which are effective at sustaining them in this model of care. Given that sustainability

of MCoCer is key for women and midwives, it is imperative that these findings are used to develop strategies to support midwives in practice (Young, Smythe and McAra-Couper 2015).

While relationships with women were a key reason for the midwives wishing to practice in continuity models, they were also responsible for overcommitment and potential burn out. Effective structure in practice which supports the development of mutually reciprocal meaningful relationships as a positive aspect of the model, while maintaining work- life balance for the midwives is a necessary element of sustainable practice. This includes regular and scheduled time off, protocol for covering on call, sick leave and safe working hours, shared expectations and philosophy of care with women, colleagues and the wider maternity team, effective financial arrangements and agreed caseload size, allocation and make up.

The midwives valued autonomy to develop strategies to negate the challenges they faced working in continuity of carer models. Support of professional autonomy and personal flexibility by colleagues and the wider institution were necessary for the midwives to achieve this. Midwives who were supported to develop solutions to practice issues felt in control and expressed positivity towards their professional role and personal life balance. The solutions created by midwives were also more relevant in context and therefore more useful for sustaining practice. These insights provide key considerations for the design, implementation and sustainability of continuity of carer practice from midwives' perspectives.

2.8 Recommendations for further research

The review has identified and synthesised evidence regarding midwife experiences of continuity of carer models and the strategies which support its sustainability. The findings recognise that midwives can experience positives and challenges working in this way and highlights the areas for consideration by policy makers and management for the development and implementation of continuity of carer models in the UK and worldwide.

Significantly the review identifies that the knowledge generated through qualitative research into midwife experiences of continuity of carer has not typically been used to implement changes in practice. Equally important is the finding that midwives who are able to dictate their own working practices and are engaged and supported by institutions to do so experienced more positives in their professional role and were able to sustain their practice. Further research is required to establish ways to incorporate midwife views into practice development and practice change in a tangible way for continuity of carer models. This research study therefore aims to address this gap between knowledge generation and use in implementation through a cooperative inquiry (CI) methodology.

The aim of the CI was to determine the perspectives of the CI midwives and develop strategies to mitigate perceived challenges and support the positive aspects of MCoCer practice as they approached implementation of this model. The following chapter describes and justifies the use of cooperative inquiry and the research design used.

CHAPTER THREE

METHODOLOGY AND STUDY DESIGN

Tell me, and I will forget. Show me, and I may remember. Involve me, and I will understand (Confucius 450 BC).

3.0 Chapter Overview

This chapter explains and justifies the study methodology and research design. The first part describes cooperative inquiry, its origins and relevance as a methodology for this study. The second part of the chapter discusses the study's trustworthiness, rigour procedures and ethical considerations. The final part of the chapter outlines the research design, data collection methods and process of meaning making without traditional data analysis.

3.1 Using Action Research Methods to Support Effective Change

Cooperative inquiry (CI) is a branch of action research which has been chosen for its congruence with the research philosophy, conceptual framework and study aims. CI supports the development of meaningful knowledge and actions generated by those involved to establish effective change in context (Koshy, Koshy and Waterman 2011). The findings from the qualitative systematic review of the literature highlighted that sustainability of continuity of carer model relies on midwives determining their own work structures within their specific context. With this mind it is crucial that any research desiring to effect system change needs to actively involve the stakeholders who will be directly influenced in the outcomes (London Strategic Clinical Networks 2015). Action Research methodology originates from critical social science and operates within a radical epistemology, with the purpose of producing practical knowledge that is useful to those involved (Reason and Bradbury 2001). Without contextual understanding it is challenging to develop relevant and sustainable solutions. The strengths of action research methodologies lie in their focus on looking at the whole person to develop unique contextual understandings and solutions (Hughes 2008).

Koshy, Koshy and Waterman (2010, p.2) define the features of action research as;

  1)A method for improving practice (in a participatory and collaborative way)

  2)Knowledge created through action and reflection

  3) A shared interest or goal

  4) Situation and context specific

<u>1) A method for improving practice</u>

Stringer (2013) identifies a continuum of action-based research methodologies, at one end the researcher identifies an area for study and gathers data to determine possible solutions for the participants to implement. At the other end of the continuum the researcher works *with* a group of people, helping them to identify problems, generate solutions and implement them. Cooperative inquiry operates at this end of the continuum, being described as research 'with' not 'on' people by Heron and Reason (2007). Cooperative inquiry identifies participation as a way of knowing, honouring human rights through involvement to develop understandings and facilitate change simultaneously through participant led dialogue and solutions (Heron and Reason 2001; Reason and Heron 1995). The methodology functions within the interpretivism paradigm, recognising that the way we relate to the world is subjective, that people and events cannot be fully understood in isolation from their interconnections with the world and therefore that meaningful knowledge is always contextually embedded (Klein and Myers 1999; Reason and Heron 1995). Thus, it is a method is aligned with person-centredness.

<u>2) Knowledge created through action and reflection</u>

Unlike traditional research which is often theoretical rather than practical in nature, the inquiry process can be both informative and transformative. For a cooperative inquiry to be truly transformative and emancipatory each phase should start with reflection and lead to action based on understandings developed through discussion as a group (Reason 1999). Figure 4 shows the cycle and sequence of successive cycles of reflection and action phases. The inquiry cycles are an iterative process which develop knowledge and support transformation progressively.

Figure 4. Sequences of action-reflection cycles (adapted from McNiff and Whitehead 2011, p.10)
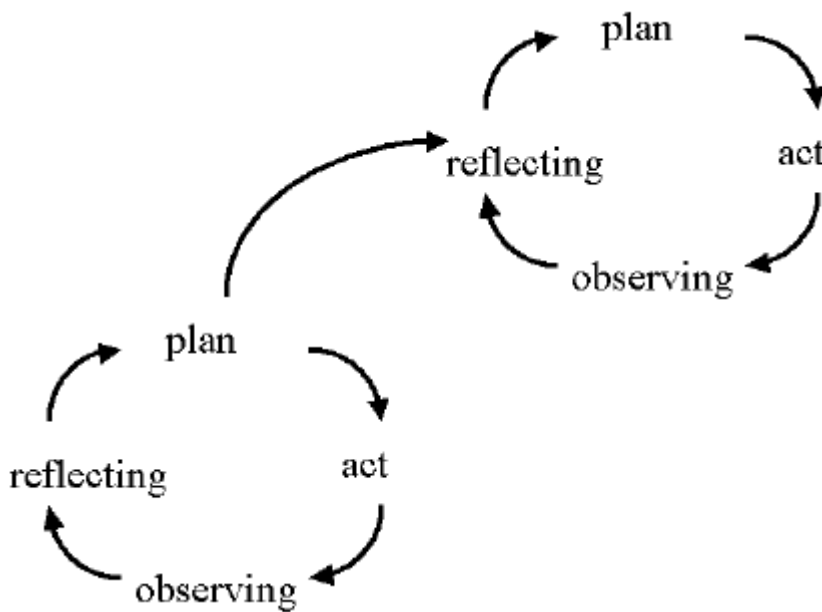
The knowledge developed during each reflective phase of the inquiry transforms through new understandings and subsequent actions. This process is evidenced in the Inquiry Process Chapter through the chronological reporting of the outcomes development.

3) Shared interest or goal

Ideally decisions about a cooperative inquiry involve collaboration with all the participants, including the development of the study aim and protocol (Heron and Reason 2001). However, to satisfy the research process within the constraints of masters research study timeline, the need for ethical approval from the Robert Gordon University (RGU) School Ethics Research Panel (SERP) and NHS Grampian Research and Development (NHSG RandD), approval a pragmatic approach was adopted and a modified version of a cooperative inquiry was employed. This meant that the research framework and aims were designed by the research team prior to the inquiry start. Feedback from midwives in Scotland regarding the recommendations for continuity of carer were used to develop the aim of the research study (Craig, J., NHS Tayside Head of Midwifery personal communication by conversation 13 February 2018). This was to assist the development of a study which was congruent with the current local thinking of midwives in NHS Grampian practice and would legitimately address their concerns. Other aspects which assured that the midwives identified with the area and aim of the research study included self-identification for participation which is further discussed in the Ethical Considerations section.

As stated by Hughes (2008, p.381):

> *we must see ourselves as inter-dependent with human and non-human elements*
> *in the systems in which we participate.*

This inquiry sought to bring about contextual practical understanding of how midwifery continuity of carer can be implemented for this group of midwives practicing within the environment of NHS Grampian, situated in North East Scotland. Thus, central to this study are the participant's everyday experiences and perceptions that take account of the influencers on their daily professional practice.

3.3 Trustworthiness and Rigour

While there continues to be debate about how best to judge the quality of qualitative research, there are procedures which promote trustworthiness and rigour of the research process to support the validity of the findings (Rolfe 2004). These recommended procedures and how they were applied in the research study are outlined below.

3.4 Validity Procedures

Ten validity procedures were applied:

1)Balance: reflection-action

2)Balance: order-chaos

3) Research cycling

4) Critical subjectivity

5) Equitable collaboration

6) Authentic participation

7) Member checking

8) Audit trail

9) Authentic representation

10) Evaluation: the process and outcomes

1) Balance: Reflection/Action

The aim of the study is to be both informative and transformative, requiring a balance of reflection and action within each phase. It is vital that any CI has both reflection and action for it to be

transformative and emancipatory (Heron, J. personal communication January 2018). Therefore, each meeting held with the midwives was reflective in nature and followed by an action phase (Rolfe 2006). The direction of the reflective discussions was guided by the data we co-created, these are further discussed in *Research cycling* below. An action phase followed each reflection phase, with the specific actions aimed to facilitate transformation on a personal, group and organizational level. The actions were co-decided as a group to address the key findings and direction of interest in each reflective session.

2) Balance: Order/Chaos

An effective inquiry will have elements of order and innovation and will use both Dionysian (more chaotic, unstructured) and Apollonian (ordered and structured) inquiry cultures to ensure balance between expressive, diffuse exploration and explicit, controlled, systematic (Heron and Reason 2001). As facilitator of the CI I was both co-inquirer and facilitator and was required to maintain the balance of order and chaos throughout. The apollonian elements of the inquiry were defined by the use of exercises and facilitation techniques (outlined in Appendix E) to ensure rational structure to the process of cycling between reflection and action (Allen 2018). The Dionysian element of the inquiry ensured the CI midwives shaped the inquiry according to their interests (Cook 2012). This was enabled through periods of unstructured dialogue where the co-inquirers were encouraged to have discussions based on an open question, often choosing to use stories from their own professional practice to illustrate and support their viewpoints. The use of storytelling as a presentational method of knowing connected the theoretical concept with the reality of living and engaged with the epistemology of CI (Heron 1996).

3) Research cycling

Cooperative inquiry cycles can be flexibly convergent or divergent, providing the opportunity to revisit a line of thought or different issues on successive cycles (Heron and Reason 2001). Divergence, in this context, does not imply conflicting 'wrong or right' ideas and approaches, likewise, convergence does not necessarily imply agreement, 'rightness' or consensus. Instead divergent themes referred to alternative avenues of exploration and knowledge generation. The inquiry was guided by the initial themes outlined by the midwives in the first session. My role was to collaborate the discussions and feedback the data to the midwives at the subsequent meeting to confirm and re-explore findings. This was the convergent element of the inquiry process. However, the use of open questions and the free flow of conversation enabled discussions to move flexibly according to the thought processes of the midwives at the time, allowing for introduction of new and divergent topics. While divergent thoughts were established and explored as a group, discussion naturally

flowed back to the initial topics outlined in the first session by the midwives, reaffirming their significance and the focus of the inquiry.

4) Critical subjectivity

For cooperative inquiry to be successful co-researchers must develop awareness of self or 'critical subjectivity' of their contextual basis of ideas and theories (Reason and Heron 1995). This can be achieved through reflection of the participants and effective facilitation. Effective reflection requires a means of reflection and a critical awareness of the co-inquirers of themselves and the specific topic of focus (Lash 1993). The reflective sessions provided a safe environment for the midwives to explore their views and feelings about their roles and practice change to provide continuity of carer, while the convergent nature of the inquiry through the phases of reflection and action allowed the midwives to develop deeper understandings and awareness of each topic. The language and approach to discussions with their co-inquirers evidenced the development of critical subjectivity of the participants. This strand of transformation is discussed further in Chapter Five, *Perspectives* (p.125).

5) Equitable collaboration

Authentic and equal engagement of participants can be a challenge when using cooperative inquiry and focus group methods (Savin-Baden and Howell Major 2013). This can be due to assumed or actual power of participants or different or dominant personalities (Somekh 2002). In her work Davies (2017:52) highlighted a 'spectrum of participation', signaling that the reality in cooperative methodologies is a range of input from those engaged. Expectations of engagement should therefore be approached on an individual level and assisted by person-centred facilitation. We began the inquiry with the aim of equitable collaboration and an awareness of individual factors which may affect this process.

The selection of the participants was the first step in creating an egalitarian philosophy, with no managerial staff members invited to participate in the inquiry and all midwives practicing in clinical midwifery roles. This was challenged at the start as one of the midwifery managers was eager to be part of the CI. As the researcher and creator of the project I was mindful of my potential power to influence equitable collaboration from other members of the group. Following discussion with the supervisory team the decision was made to maintain the initial criteria for inclusion and the manager was informed that they did not qualify to participate. An alternative opportunity was made available for NHSG maternity managers to join the group towards the end of the inquiry as part of the study's

final stages to support the collaborative nature of the inquiry as reported in Chapter Four: Inquiry Process.

Co-decision of meeting place and time for each reflective meeting initiated the self-determination and autonomy of the midwives. The university campus was co-decided as the site for the meetings by the midwives in order to be separate from their place of work. The meaning of this choice was further explored through the inquiry and reported in Chapter Five.

Co-design of ground rules in the first meeting further emphasized the importance of the equal value of experiences, perspectives and input (Heron and Reason 2007). Equitable contribution and power distribution were addressed through open acknowledgement and discussion to create awareness. Use of exercises facilitated equitable participation (Appendix E). Decision making was a participative process, with everyone's views heard and considered with the goal of total agreement as the ideal outcome. Reason (1994) suggests that true consensus is rare and that for the practical purposes of a research inquiry that participants should contribute to the decisions about process and outcome. This was assured through turn taking and each member being responsible for noting their neighbour's contributions, encouraging both equitable participation and engagement.

6) Authentic Participation

Aasgaard, Borg and Karlsson (2012) highlight that authentic participation requires awareness of everyone involved and critical reflection of self. Loewensen et al. (2014) suggest a set of reflective questions which assess the power dynamic in a research study with the aim to strengthen participation in the inquiry process. Figure 5 presents these questions which were used as a basis for determining the authenticity of participation.

Figure 5. Establishing authenticity in PAR (Adapted from Loewensen et al. 2014)

-Are the right people involved and 'at the table?'

-Who initiated the participation? Was it top down and external or organic and self-determined? Was it invited or claimed? What were the different interests and motivations of those involved? what were the risks and benefits of taking part?

-Does the process allow for all voices to heard and equally valued?

-How is participation organised? How are the members involved in conceptualising, establishing the aims of, planning, implementing and reviewing the project?

-What are the levels of participation- from manipulation, informing, through to consultation, to partnership and delegated power through co-determination?

-How has power changed in form or distribution in the process?

-How sustained and durable (or temporary and one off) are the processes, spaces and mechanisms?

-What spaces are being used- are they formal or informal; open or closed?

-What learning or co-learning has occurred for whom?

-What changes have taken place in people's confidence in their ability to analyse and bring about positive change and in their belief that decision making can be influenced?

The facilitation style and techniques applied for the inquiry to promote these procedures is discussed in detail in Chapter Four: Inquiry Process.

7) Member Checking

Member checking of themes is understood as an intrinsic part of cooperative inquiry to ensure authenticity and credibility of findings and improve validity (Thomas 2017). Member checking was discussed with the cooperative midwives and it was co-decided that my action as the researcher would be to collaborate and feedback findings from the reflective sessions to facilitate this process. Collaborated findings were presented during each subsequent reflective session to ensure the findings were truly representative of the midwives' views (Bergold and Thomas 2012). The member checking procedure was performed through dialogue as promoted by Harvey (2013) for its grounding in effective reflection. Examples of this reflective process are provided in Chapter Four. The process of member checking ensured findings were grounded in the data and assists a reflexive stance of myself as the researcher and the CI midwives (Akkerman et al. 2006).

8) Audit Trail

Transparency of data management demonstrates trustworthiness and reliability of the study process and findings (Akkerman et al. 2006). The following records were maintained to exhibit this:

- Reflective Research Diary regarding interactions with management, recruitment processes, the inquiry meetings and actions and contact with the midwives. These included field notes about the logistics of contact, organizing and meetings

- Audio recordings of the reflective meetings with consent

- Notes and progress logs from Supervision sessions outlining our discussions and support

- Current curriculum vitae evidencing any training in relation to the research study

- All data generated with the CI midwives during the reflective sessions

- Email communications with the CI midwives during the Action Phases for collaborative purposes

All primary data is stored according to data protection and management protocols (The Stationary Office 2018; Health Research Authority (HRA) 2017; European Parliament and Council 2016; UK Government 1998). All data generated within the study reflective meetings were photographed and stored electronically as a transparent record of the research process. Data protection procedures and data storage were all agreed when obtaining ethical approval and discussed again within the CI as part of establishing the ground rules. This ensured that midwives were consulted and co-decided the ground rules for identity and data protection. No additions to the ethics approval were requested in the CI itself. The co-created data from each reflective session and my own reflections on the CI process are evidenced in Chapters Four and Five.

9) Authentic Representation

The data collected at each meeting was collated by myself as the facilitator following each reflective phase and fed back to the midwives at the next meeting for discussion and clarification. The CI midwives were encouraged to provide feedback to ensure their voices were honestly represented in the final write up. The convergent cycling of the inquiry enabled the midwives to revisit the same themes, thus refining and confirming them further than with traditional qualitative methodologies. The CI midwives were classed as co-researchers in this study and were asked for permission to share findings and given the opportunity to be named in publication to acknowledge their contribution in accordance with PAR methodology practice (Löfman, Pelkonen and Pietilä 2004).

10) Evaluation: the process and outcomes

Evaluation of action research projects and the outcomes are necessary to ensure the trustworthiness and validity of the findings. The evaluations of the sessions evidence the midwives' individual transformations, and regulated the facilitation. The feedback indicated that each reflective session

boosted individual and group positivity in approaching practice change, while the actions provided tangible evidence of their investment. This is discussed further in the Inquiry Outcome Chapter.

3.5 Ethical Considerations

This section outlines the ethical considerations which have been addressed to ensure the research has been conducted to the standards required;

1) Informed and Voluntary Consent
2) Confidentiality
3) Wellbeing of the Cooperative Midwives

<u>1) Informed and voluntary consent</u>

Ethical approval was granted by Robert Gordon University School Ethics Review Panel (RGU SERP), SERP Number: 18-07 date: 06.03.2018 (see Appendix F for letter of approval) and NHS Research and Development prior to commencing the study (see Appendix G for letter of approval) recruitment or disseminating information.

Transparency and understanding are required for independent informed consent (HRA 2017). A clear understanding of the methodology, the structure and phases and data collection methods were important to establish informed consent with the participants. Information was disseminated to the selected population of midwives by letter to allow them time to consider the nature of the inquiry and enable self-selection without coercion. The Participant Information Sheet (Appendix H) outlined the nature and process of cooperative inquiry, the aim of the study and the potential benefits and risks of taking part. The information sheet also clearly communicated that participation was voluntary and the midwives were free to withdraw at any time from the inquiry. Potential participants were provided with the opportunity to questions of the research team by email, phone or individually in person at a mutually decided place. The midwives were provided with a period of four weeks from receiving the recruitment material to notify their interest. A face to face visit by myself as the researcher and facilitator was made to the locations agreed with NHS Grampian management in order to provide the midwives with the opportunity to further assess whether the inquiry topic and methodology were interesting to them. Following this, midwives interested in participating were asked to contact a member of the research team with a signed consent form (see Appendix I). This was to further ensure self-selection without coercion (Cook 2012).

<u>2) Confidentiality</u>

Due to the nature of cooperative inquiry the midwives were known to one another which was identified on the Participant Information Sheet (Appendix H). The Consent Form (Appendix I)

stipulated the need to protect the identities of the group members to others outside of the inquiry. An agreement for confidentiality procedures were co-decided and written as a contract during the initial meeting which included the following:

- Any confidential or identifying information was to remain between the inquiry participants

- The CI midwives wished to use first names on the final publication, which was confirmed again prior to final report (thesis) write up

- This ensured acknowledgment of contribution whilst protecting the midwives' identities within the wider context

3) Wellbeing of Cooperative Inquiry Midwives

Cooperative research is by its nature focused on personal transformation and can be emotionally and physically demanding for participants (Nurick and Apgar 2014). This must be recognised and supported through creation of a safe space through mutually agreed ground rules and choice of time and setting of sessions by the cooperative midwives and effective facilitation by the researcher (Löfman, Pelkonen and Pietilä 2004; see Appendix E). Support was available for all participants including the researcher through the supervision team and clinical supervisors.

3.6 Research Design

The first part of this section describes the cooperative inquiry design, data generation and meaning making without traditional data analysis. The second part outlines the inquiry setting, recruitment, structure, facilitation style and introduces the inquiry participants.

3.6.1 Setting

Figure 6. Map of Grampian Region in Scotland, UK (National Records of Scotland 2016)

Aberdeenshire is a county in North East Scotland with a rural population of 261,960, fertility rate of 60.9 per 1000 women aged 15 to 44 compared to the national average of 54.7 in 2014 (National Records of Scotland 2016). An assessment of midwife demographics in Scotland shows that 42% are over the age of 50, birth rate continues to rise and population demographics are becoming more complex (RCM 2015). The remote and rural geography of the area, staff recruitment and retention are significant workforce challenges (NHS Education for Scotland 2013).

3.6.2 Recruitment

A purposeful recruitment strategy was employed using group characteristic sampling to generate information rich cases for in-depth study (Patton 2015) by identifying midwives with interest in continuity. Group characteristics for participant inclusion/exclusion were decided as follows:

Table 17: Group characteristic sampling criteria

Inclusion Criteria	Exclusion Criteria
NHS employed midwives currently working in Grampian	Midwives under investigation by the NMC or under practice supervision.
Working Full Time or Part Time (FT/PT) clinical midwife, no minimum experience required	
Interested in continuity and wishing to practice in this way.	
Wishing to work across the scope of midwifery practice (antenatal, intrapartum, postnatal care) in home or hospital settings.	

Following conversations with NHS Grampian midwifery managers the Aberdeen City Community Midwife Teams and Midwife Led Unit (MLU) were identified as potential populations for recruitment. The total number of midwives (n=34) were provided with a letter and information sheet to facilitate informed consent (Appendix H). The midwives were asked to self-refer to the research team with any questions and to notify interest with the first respondents recruited to participate. The size of the group was decided as an ideal of 8 as an ideal number for group discussion, with a minimum of 5 including myself required to commence the inquiry and a maximum of 12 to allow for potential participant withdrawal (Savin-Baden and Howell-Major 2013). Midwives were asked to commit to attend the four reflective meetings and participate in the co-decided actions between meetings. Time taken for participation was counted as working hours and continuous professional development (Nursing and Midwifery Council (NMC) 2018) as agreed with NHS Grampian. This was to honour the midwives' commitment to participate, and to develop a positive environment for the inquiry (Savin-Baden and Howell-Major 2013).

3.6.3 Communication strategies

The midwives were provided two weeks from receiving the recruitment packs initially to respond. Three midwives came forward initially from the city team so a visit was planned to the areas decided

to address any questions the potential participants might have. While it was not possible to meet all of the potential midwives due to working patterns and annual leave this provided the opportunity to disseminate the aim of the study in a more informal way. A further three midwives came forward from the city team following the face to face meeting. A Doodle poll was created to co-decide the date of the first meeting according to the availability of the midwives who had come forward. Dates were given for two weeks in June with the flexibility of any 2 hour time slot from 9am-9pm each day. After two weeks, three of the midwives had responded with two possible times and three were left to vote. An email was sent to the midwives to remind them that time taken for the study would be classed as work hours regardless of time in an attempt to create more flexibility in scheduling the first meeting. After a week there were no further suggestions from the midwives and the decision was made to set the most applicable date. Five of the midwives confirmed the date with the other midwife unable to change work commitments.

To improve recruitment the decision was made as a research team to extend the invitation to midwives working in the Labour Ward and the rural community teams. A poster was designed and disseminated along with the participant information sheet with the set date decided with the original recruits. A further three midwives came forward from this line of recruitment, two from Labour Ward and one from a rural community team.

3.6.4 The Inquiry Structure

Group meetings were chosen as an effective method to support authentic reflection as proposed by Bolton (2010). These reflective meetings provided a space and time for the cooperative midwives to question assumptions, values and attitudes in order to develop insights into continuity of carer. A time management plan was produced and agreed with my supervisors, NHSG managers and confirmed with the cooperative midwives through the recruitment and consent process. The inquiry took place between June and August 2018, with a total of four reflective meetings spaced two to three weeks apart, according to the availability and choice of the midwives, to maintain momentum and impetus for the project (Charles and Glennie 2001). Each meeting was two hours long which were scheduled at a mutually agreed time and location off NHS campus as requested by participants. The group agreed that the time allowed for the reflection meetings was not sufficient, however, due to the constraints of family and work commitments and the agreement with NHS Grampian this could not be extended.

An agenda for the first phase meeting was constructed prior to the meeting with the CI midwives to provide structure and lines of inquiry. The ideas for this were confirmed as a group as part of the introductions. The agenda for each subsequent reflective meeting was informed by the nature of

our conversations and the previous phase themes and actions, ensuring we continued to follow lines of enquiry pertinent to the group. The time between reflective sessions was an opportunity to further build on knowledge through mutually agreed actions. Figure 7 provides an overview of the phases of the inquiry, the content of the reflective meetings and the actions undertaken.

Figure 7. Agenda of the Inquiry

Phase 1: Establishing the inquiry

- Welcome and introduction of CI methodology and data collection methods by Professor Crowther.
- Co-decision of ground rules and inquiry aims.
- Introductions of selves, our backgrounds and motivations for participating in the CI
- Exploration of our personal philosophy of midwifery.
- Collaboration of our individual philosophies.
- Identifying our views about the Positives and Challenges of MCoCer.
- Co-decision of group action: Completion of Action worksheet informed by RCM toolkit (2017).
- Agreement of next meeting time and place.

Phase 2: Exploring themes and developing action

- Reflection on our views of MCoCer and the inquiry so far.
- Co-deciding a group definition of continuity.
- Confirmation of group philosophy themes identified through my collaborations of Phase 1 data and co-creation of a Shared Philosophy of Care.
- Exploration of Positives and Challenges in relation to Action Worksheet.
- Co-decision of group action: Research and reading about midwife experiences of MCoCer.
- Agreement of next meeting time and place and actions to be undertaken before next session.

Phase 3: Contextualising

- Reflection on what we have each read and our developed understandings.
- Exploration of Framework in context (geographical, economical, social).
- Co-decision to create a separate Team Charter composed of elements important to the midwives for good team working.
- Decide on what actions to be undertaken before next session.

Phase 4: Confirming and Concluding

- Reflection on action meeting with managers and inquiry as a whole.
- Confirmation and refinement of co-created Team Charter and Framework and final decision about dissemination preferences and acknowledgment.
- Co-deciding ongoing action and conclusion of study.

As the principal researcher I was both one of the cooperative midwives and undertook the facilitator role. This is a different approach to the role of the researcher compared with traditional research methodologies. Heron and Reason (2008) assert that researchers must participate alongside and with those who are engaged in the area of interest in order to accurately understand their views and meanings. As one of the cooperative midwives I participated in the inquiry, adding my own personal beliefs to the findings and development of solutions for practice.

Heron (1999) describes an effective facilitator as flexible and responsive to the needs of the group, individuals and inquiry purpose. Awareness of the groups needs and ability to react to this by altering facilitation style are key to an effective inquiry. Prior to the inquiry starting I took two courses in facilitation to improve the quality of the inquiry and to support the midwives in the process of transformation. Table 18 outlines the six stages of learning and three facilitation approaches described by Heron (1999).

Table 18: Dimensions and modes of facilitation adapted from Heron (1999)

	Hierarchical	Co-operative	Autonomous
Planning	Plan and decide the agenda for the group what they will learn	Planning agenda with the group through negotiation and integration of ideas	Planning is delegated to the group
Meaning	You draw meaning for the group	Collaboration of the group to generate understanding	Interpretation reflection and review of meaning delegated to the group
Confronting	Highlight rigid behaviours and direct people to address them	Work with the group to raise consciousness of avoided issues and defensive behaviour in a collaborative way	Create a safe space to enable members to practice self and peer confrontation

Feeling	Management of the group members feelings and emotions	Discussion and collaborative management of feelings and emotions	Management of feelings and emotions delegated to group
Structuring	Structured learning exercises directly supervised	Learning processes devised cooperatively with group	Self and peer directed control over learning process
Valuing	Facilitator invests in and takes responsibility to care for the group	Development of an inclusive, collaborative environment of mutual respect	Space provided for the group to develop and celebrate their own self-worth

My facilitation style was dynamic and reactive, changing through the inquiry process, to assist the midwives in their transformation individually and as a group (Heron 1999). Evaluation of the reflective sessions were requested from the midwives to provide feedback of facilitation skills and style and develop insight to enable growth and progression for an effective inquiry (Heron 1999).

The facilitation style was aimed to be cooperative as described above, to support the nature of CI methodology. However, due to the initial engagement style of the cooperative midwives my role began started as more hierarchical in nature. The need for directive facilitation was gradually phased out as the midwives became more confident and autonomous in the process of inquiry. My own role transformed to become one of the cooperative midwives as the group and myself engaged with the process and became more collaborative. This journey was included in my reflective diary and discussed in further detail in the Inquiry Process Chapter in relation to the transformational outcome.

3.7 Data Generation

Data was generated and collected during the reflective phase meetings. The participants and myself were co-researchers in the project, and as such were all involved in the generation and development of understandings in each phase. The inquiry process is dynamic and creative, therefore data emerged in different ways according to the mood and flow of the inquiry. These included written sources in the form of mind maps, post-it notes, posters, flipcharts and any completed exercises from the RCM worktool (2017a). In addition, audio recording of the reflective sessions were taken with consent and written evaluations of the meetings provided feedback for the inquiry process. Any

action taken between the reflective meetings was discussed at the following meeting, and was therefore included in the data generated during the next reflective phase of the inquiry.

3.8 Meaning Making

Unlike traditional research cooperative inquiry does not rely on data analysis following data collection but occurs within the reflective phase of the cycle (Heron and Reason 2001). As commented by Bruning (2009, p.1)

> *Co-operative inquiry is not a process which is not meant to be analysed. There are no theories or hypotheses to prove or disprove.*

To analyse the data generated by the midwives would have undermined the defining characteristic of cooperative inquiry methodology which aims to emancipate the participants. To externally analyse the midwives' views would imply a lack of respect for the conclusions and transformations they underwent and the validity of their own lived experience which is fundamental to the action research paradigm (Heron 1996).

The data analysis and findings created in a collaborative way during the reflective phases represented the views and understandings of the participants most effectively. The reflective sessions were audio recorded with consent but not transcribed verbatim as they were not required for data analysis, which is justified by the process of meaning making in cooperative inquiry (Heron and Reason 2001). The audio recordings were a useful aide memoir when collaborating data, to assist critical reflection of facilitation and genuine contribution to the outcomes.

The creation of meaning occurred through the process of reflection and critical reflection of our ideas and the data we generated within each reflective cycle. This was supported by the validity processes described above. In particular member checking and research cycling were applied to confirm our meanings and deepen understandings. The findings of each phase were used for this process rather than transcriptions of the reflective meeting to ensure the outcomes and not the process were the focus of research cycling. Due to the time restrictions of the Masters it was agreed that as the facilitator I would collaborate the findings from each reflective session for member checking, to share these with the group for reflection, refinement and consensus. This process was not analytic or interpretive but reflective, using the audio recordings to immerse myself in the experience and journey of each reflective phase as it occurred with the aim of authentically presenting the midwives findings. All the collaborated findings were fed back and discussed with the midwives in the subsequent reflective phase to ensure the findings were truly representative of their

understandings and views. The audio recordings provide evidence for the discussions held and were available for the midwives to listen to at any time.

The supervision sessions with the research team allowed for my own personal reflections on each meeting with the midwives, the actions they had undertaken and the findings generated in each phase. These personal reflections were an important stage in critical reflexivity to ensure validity of the inquiry process and my role in it both as the facilitator, and CI midwife.

To satisfy the need for critical analysis at a master's level Chapter Six critically reflects on the findings co-created by the midwives alongside the findings from the systematic review. This is not to analyse the findings of the CI itself, as this would be counter-intuitive of the emancipatory goal of the methodology, and contradicts the theoretical framework of person centeredness, but to assess the similarities and differences between the various contexts. My own reflections on the process and validity of the inquiry are included in this discussion.

3.9 Summary

This chapter has presented the methodological underpinnings of CI and describes the ethical considerations, study design, recruitment and data collection procedures. CI requires an openness and willingness to engage with development of knowledge and generate data in different ways. The rationale for the approaches adopted has been provided and how transparency in the study processes was assured. I have highlighted how this approach to research is unique in its collaborative data analysis strategy and subsequent presentation of findings. The next chapter introduces the participants in this co-operative inquiry and describes and reflects on the study process in more detail to provide context for the Findings.

FINDINGS RELATED TO THE INQUIRY

As with all CI, this project was concerned with a journey of meaning making as a group which does not involve traditional data analysis. The iterative and reflexive process of CI challenges the often-linear scholarly prose typical of research study reporting. Both the process and outcomes are equally important in the development of significant meaning through CI methodology as they tell the story of the insights we developed. The rationale and justification of this approach is set on Patton's (2015) four premises of participatory research designs: 1) to ensure that participants in the study were not worked on but worked with, 2) that all co-inquirers were willing and understood the importance of the study and significance to their own professional and personal lives, 3) that reciprocity was at the heart of what outcomes were derived from the inquiry and that the focus remained on benefits to them individually and collectively through presentation of the outcomes of the inquiry. 4) That the outcomes of the inquiry have utility, likely to be useful and are mutually agreed. These four premises have been ensured in the write up by reporting both the process of the inquiry, to signpost how we approached the aims and objectives and understand the context of the midwives which is central to the outcomes we co-developed.

Although this thesis was authored by myself, to ensure that each midwife's views have been accurately represented the co-created findings were discussed within the supervisory sessions and have been reviewed and confirmed by each member of the CI group.

 Due to the unique style of CI methodology the findings of this thesis are presented across two chapters: Chapter Four: Inquiry Process and Chapter Five: Inquiry Outcomes. This provided adequate form and structure to ensure the inquiry process was understandable from an outside perspective and followed reporting convention for CI as outlined by Heron (1996);

- The inquiry process which reports the journey of the group and how they approached the topic, to relay the significance of their meaning-making and its relationship to the final outcomes (presented in Chapter Four-Inquiry Process)

- Presentation of the Informational and Transformational Outcomes of the inquiry which developed as a product of the process (presented in Chapter Five- Inquiry Outcomes).

- Reflection on the quality and validity of the inquiry (Chapter Six p.148).

The structure of Chapter Four and Chapter Five are outlined in Figures 8 and 9.

Figure 8. Inquiry Process as presented in Chapter Four
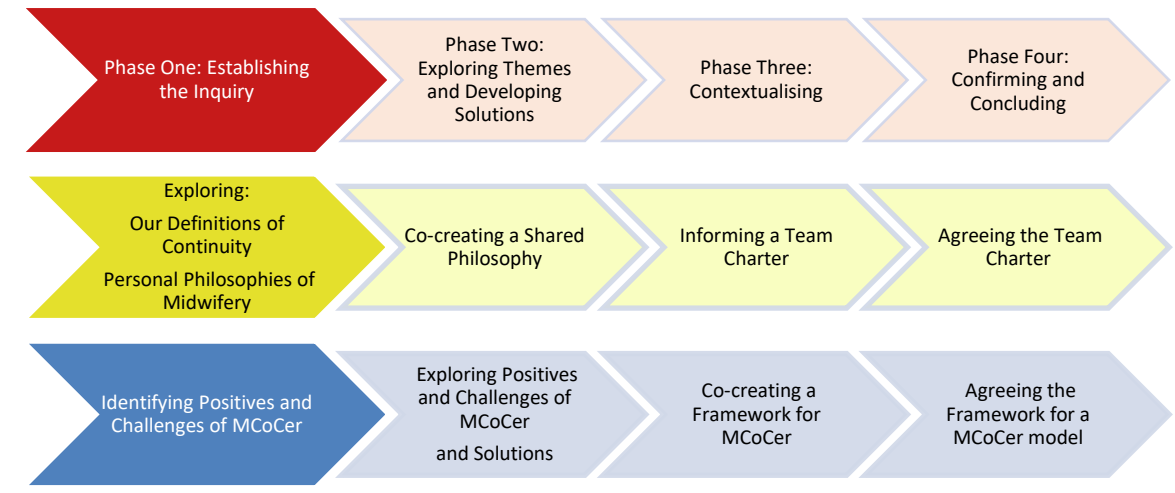
Figure 9. Transformational outcomes of the inquiry presented in Chapter Five
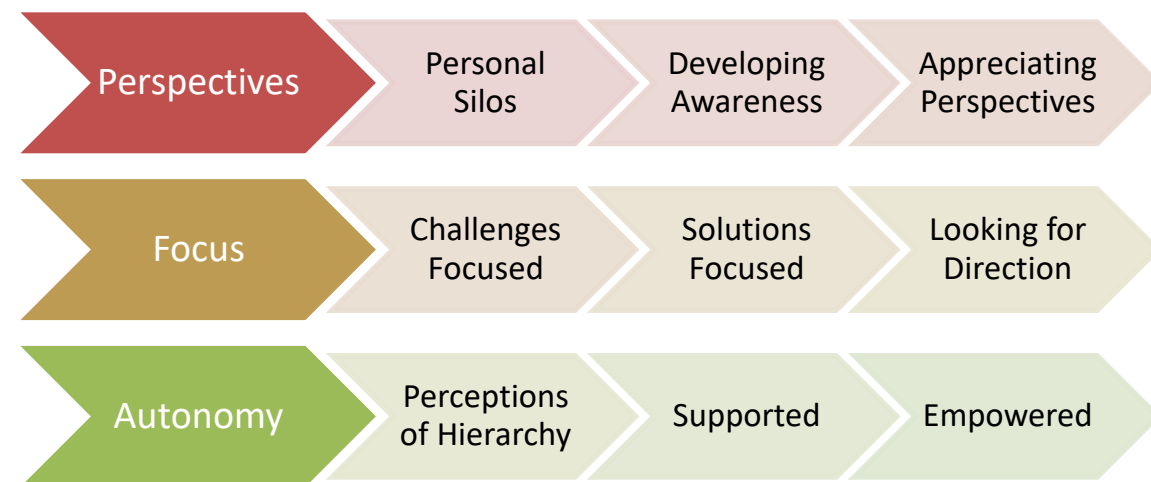
CHAPTER FOUR

INQUIRY PROCESS

4.0 Introduction

This chapter documents the process of establishing the inquiry and the reflection and action phases which supported the development of meaning. Recruitment and why participants joined the inquiry and how we established it together are significant to the process and outcomes as a whole and so are also reported here. The process is reported chronologically as it occurred, presenting the reflection meetings, facilitation methods, co-decided actions and evaluations of each phase. Figure 10 has been included to signpost this chapter and the writeup of the inquiry process.

Figure 10. Inquiry Process as presented in Chapter Four
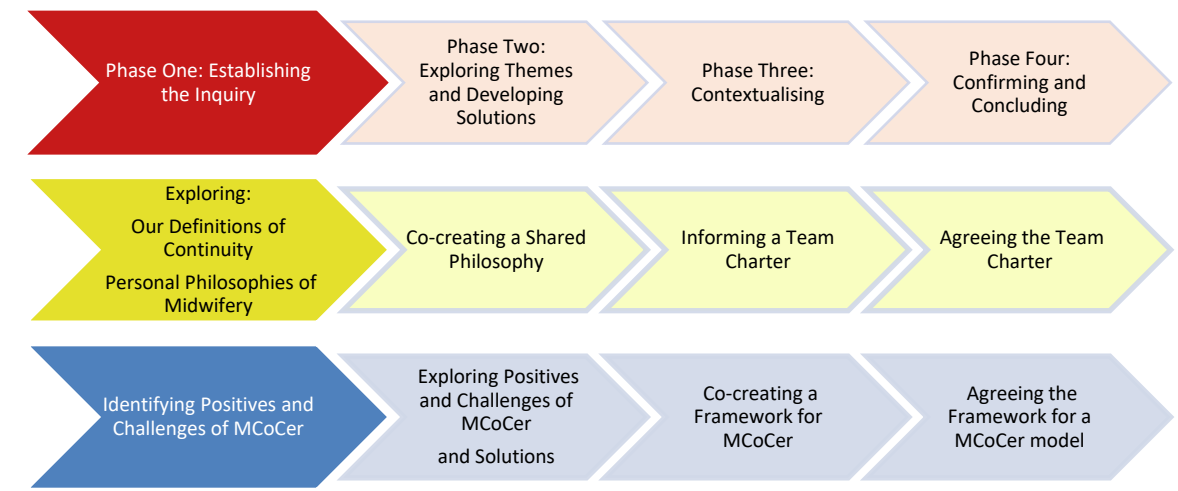
4.1 Recruitment Process

Recruitment to the study was initially slow, with only three midwives self-identifying to participate with the distribution of invitations to participate and the information sheets. Changes to the recruitment strategy, as described in the Chapter Three, were undertaken following an initial lack of response from the midwives approached. A decision was made with my supervisors to involve the team leaders to explain the study aim and structure. Following correspondence with the area team leads, and further clarification for the midwives five more midwives applied to take part. Following this I was invited into each of the areas to discuss the study further. This strategy resulted in the

eight midwives coming forward to participate in the inquiry. The recruitment process highlighted the status quo of the maternity services structure in Grampian and the midwives' expectation that change was enforced rather than a self-directed choice. This trend was noted throughout the inquiry process and documented in the Transformational Outcome thread *Autonomy* (p.130).

4.2 Introducing the cooperative midwives

Figure 11 provides the biographies of the cooperative midwives. All the information included in the personal descriptions was written by each midwife in response to a request to introduce themselves to each other in the inquiry.

Figure 11. Biographies of the CI midwives

Charlie

Trained in Scotland, qualified in September 2016, experience working in caseloading as a student midwife abroad, integrated team working in two UK areas and worked as a caseload continuity midwife for women of mixed complexity in an urban/semi-rural area of England when qualified. Passion for relational continuity and informed choice and personal interest in midwife job satisfaction, wellbeing and retention were all reasons for starting research into continuity of carer models and practice change.

Kayleigh-Anne

Trained and working in Scotland, 18 months experience as a qualified midwife working as a rural community midwife. 80% continuity currently in team and experience with home births. Joined the inquiry due to passion for developing the continuity model of care and desire to be involved wherever possible during its conception and implementation.

Gayle

Experience of continuity includes working in a rural integrated unit accommodating women of all complexities as part of a small team of midwives and current post as a community midwife in an urban area. Reason for joining the inquiry was interest to see how continuity if carer might be facilitated.

Lauren

Trained and working in Scotland, 18 months experience in semi-rural community midwifery post. Achieving good continuity in the antenatal/postnatal periods, intrapartum care home births which are covered as a team of 34 midwives. Interested in the inquiry as it is important to take an active role in career and where and how it might be in the future.

Bev

More than twenty years experience as a qualified midwife with experience of continuity in domino care before the team model was introduced and more recently following move back to a community after ten years in hospital. Currently providing antenatal/postnatal continuity and participating in the inquiry to grow understandings about providing continuity of carer and have an active role in moving forward with Best Start recommendations.

Lisa

Trained and working in Scotland as a community midwife in an urban practice since qualifying nine months ago. Experience of continuity of carer as a student working in an integrated model with midwives carrying caseloads of 35 women and staffing the unit to create some intrapartum continuity. Taking part in the inquiry to have a say in how continuity would be implemented in practice.

The participants in the study are referred to as the Cooperative or CI midwives from this point onwards to provide clarity and differentiation when discussing data and findings in relation to those external to the inquiry.

4.3 Motivations for Joining the Inquiry

The cooperative midwives cited various reasons for joining the inquiry, most of these focused on a joy for relational continuity and a desire to be involved in the development and implementation for continuity of carer as it directly affects their working practice and lives. Figure 12 shows direct quotes from each midwife about their personal motivations for taking part.

Figure 12. Reasons for Joining the Inquiry

Zoe
To help midwives feel passionate, supported and enjoy a new model of care providing continuity to increase satisfaction for women and midwives

Gayle
Interested in how continuity of carer might be faciliatated

Bev
Wanting to grow understandings about continuity of carer and have an active role with Best Start

Charlie
Passion for relational continuity and personal interest in midwife wellbeing, job satisfaction and retention.

Kayleigh-Anne
Passionate about developing a continuity model of care and want to be involved in its conception and implementation

Hayley
Passionate about midwifery and continuity and belief in the benefits for women and midwives. Understanding the importance of a supportive system

Louise
To improve job satisfaction and work with likeminded people who share the same philosophy of care

Lauren
Wanting to take an active role in career and how that might look in the future

Lisa
To have a say in how continuity would be implemented in practoce

The midwives cited ability to influence the development of MCoCer models to improve maternity services for women and midwives as their core motivation. I felt positive that their reasons resonated with the aim of CI methodology.

4.4 Phase One: Establishing the Inquiry

Phase one of the inquiry was focused on establishing the cooperative nature of the meetings with the midwives and generation of data and meaning from their perspectives. The inquiry began by creating an environment which would support an authentic inquiry. The midwives chose the university as the site for the reflective meetings, I set up the room providing refreshments and a circle of chairs towards the back of the room. Both of these acts were aimed to create a welcoming and open environment advised by Heron (1996) to create 'human equality and presence' (p.129). These comfort provisions were welcomed by the CI midwives:

Following written and verbal consent to participate and to audio record the sessions, the initial cooperative meeting began by establishing ground rules cooperatively with the participating midwives. Application of the four principles of partnership, mutual respect, proactive and dynamic leadership and critical reflection enabled a safe and open environment for discussions (West et al. 2015). Co-decided ground rules based on these principles were written up and placed for the group to see throughout (Figure 13)

Figure 13. Engagement guidance agreed with the CI midwives

Engagement Guidance
- *Phones on silent, calls outside*
- *Respect- one person to speak at a time, everyone's views to be valued and respected*
- *Equal value- everyone to speak and be heard*
- *Commitment- to engage and participate in 3-4 sessions*
- *Wellbeing of the group- take refreshments and breaks when you need*
- *Confidentiality- first names to be used in writeup and publication, no identifiable information about women will be used*

Confidentiality was discussed and confirmed with a group regarding material which was to be shared and the use of real identities for dissemination. All the CI midwives stated that they wished for their first names to be used in the final thesis and that any publications would acknowledge them as co-inquirers. Group roles were then discussed and outlined together. This included my role as facilitator and equality of each member of the group through respecting, affirming and encouraging their input. Following detailed description and discussion of the ongoing inquiry process the participants agreed to attend four planned reflective sessions and complete the co-decided actions in each phase.

4.4.1 Exploring: Our Definitions of Continuity

To support a meaningful inquiry, it was important to explore the midwives' understandings of continuity and agree on definitions together (Figure 14). The midwives were asked to outline their experiences of continuity to begin the process of determining what the term meant to them. Initial descriptions focused on the concept of relational continuity, in terms of the midwife's successive contact with a woman across different episodes of care. For the community midwives this involved antenatal and postnatal continuity, for the hospital midwives it was the opportunity to care for a woman on a one-to-one basis through a specific event such as labour and birth.

Figure 14. Defining our meaning of continuity
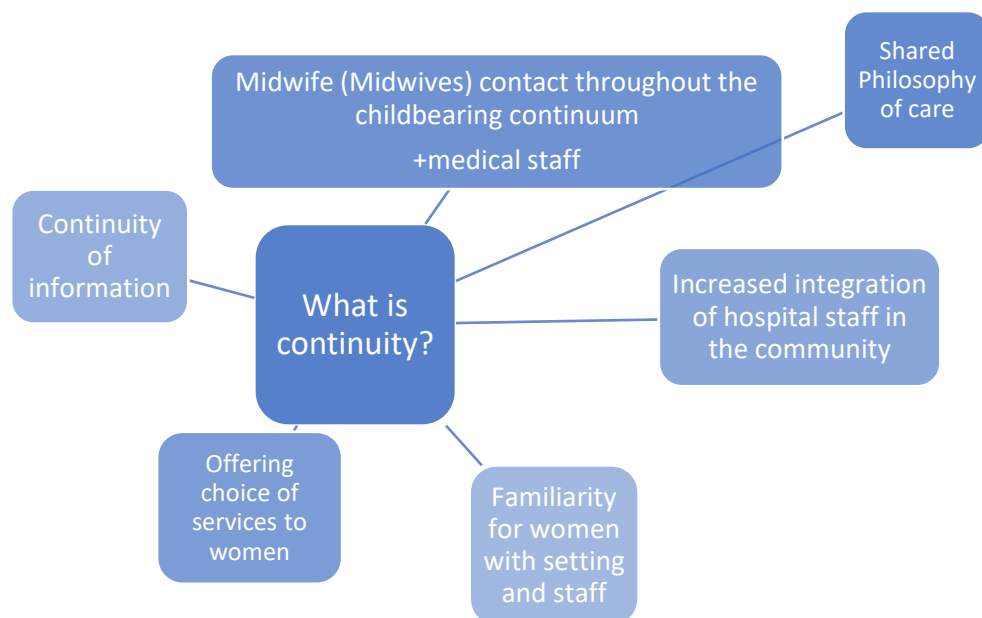
The midwives' definition and understanding of the core values of continuity of care and carer formed the basis for the inquiry and gave meaning to the discussions and ideas generated. The midwives identified that for them 'continuity of care' included consistent provision of information

for women, familiarity and confidence in the place that they accessed care and a consistent and shared philosophy of care which supported effective wider team working to support woman centred care. Continuity of carer was viewed as a midwife being in contact with a woman through all care episodes throughout the childbearing continuum. For example, the notion of being with woman on a journey was emphasised,

> *You're just with them on that journey, to stay and support, encouraging their laughter and listening when they're crying...[Zoe]*

Through this discussion the midwives identified that while the gold standard of care, total continuity of carer was not always possible or practical,

> *The time element means there's not quite the same chance to build relationships, it depends when you're working, postnatally you might not see them at all. [Gayle]*

Through discussions the CI midwives identified that continuity of carer was a facilitator for informational continuity, relational continuity and improved informed choice for women.

4.4.2 Exploring: Personal Philosophies of Midwifery

The importance of a shared philosophy with colleagues was highlighted by Louise as an important factor in job satisfaction which was agreed by the whole group. As the facilitator for continuity of carer. We began by exploring our own personal philosophies of midwifery using the exercise outlined in Figure 15.

Figure 15. Personal philosophies of midwifery exercise
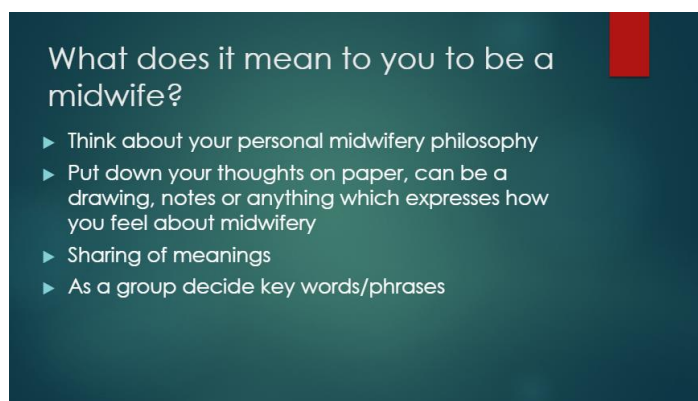
The midwives were provided with mixed media and paper and asked to represent their philosophy in any way they chose (Figures 16-21). Lauren, Bev, Kayleigh-Anne and Lisa chose to create mind maps using key words they each identified with their personal philosophy of midwifery. Figure 16 shows the creative representations of their personal philosophy as the initial outcomes of this process.

Figure 16. Personal philosophies posters for Lauren, Bev, Kayleigh-Anne, and Lisa
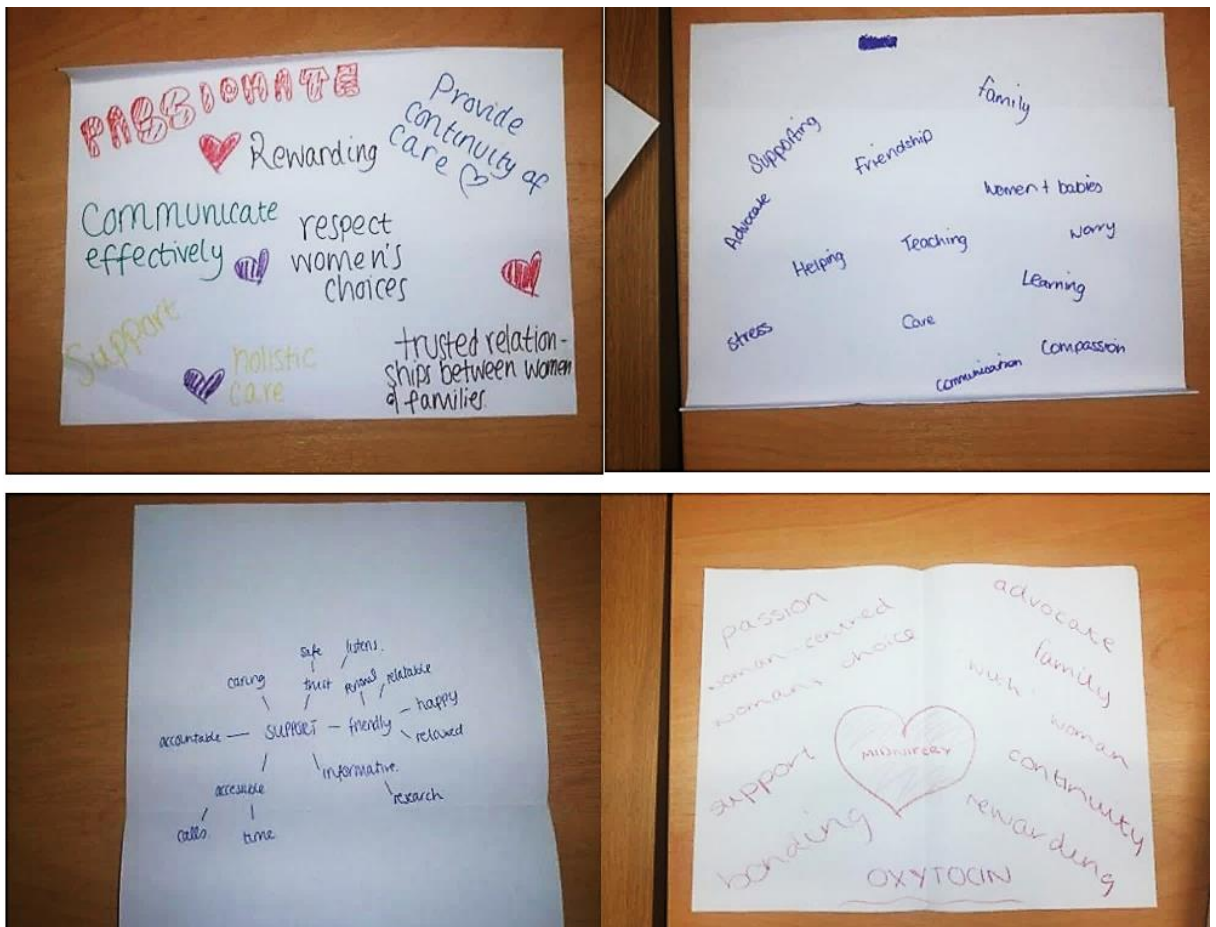
Support, Bonding, Woman-Centred, Friendly, Caring, Compassion, Trusted, With-Woman, Advocate, Happy, Rewarding, Continuity, Bonding, Friendship, Family, Respected, Woman's Choice, Holistic, Learning, Teaching, Worry, Stress, Communication.

The use of the same or similar words by the four midwives who adopted the mind maps method highlighted the convergence of their views of what it meant to be a midwife.

Gayle and Louise created posters (Figures 17 and 18) which focused on the challenges in their current practice. Gayle description outlined the stressors she faced in her daily practice which were barriers to the care she wanted to provide;

> *Everything is always against the clock, always feeling like you just have to fit everything in to your day...I just feel that there's constantly things to sort out, phonecalls that need to be sorted out constantly so you can't ever quite get on top of things [Gayle]*

Figure 17. Personal philosophy poster Gayle

Louise's poster depicted herself alone on one side of a set of scales and several other people on the other side to represent the imbalance she felt in her professional balance in her life due to the constant pressures of her job.

Figure 18. Personal philosophy poster Louise
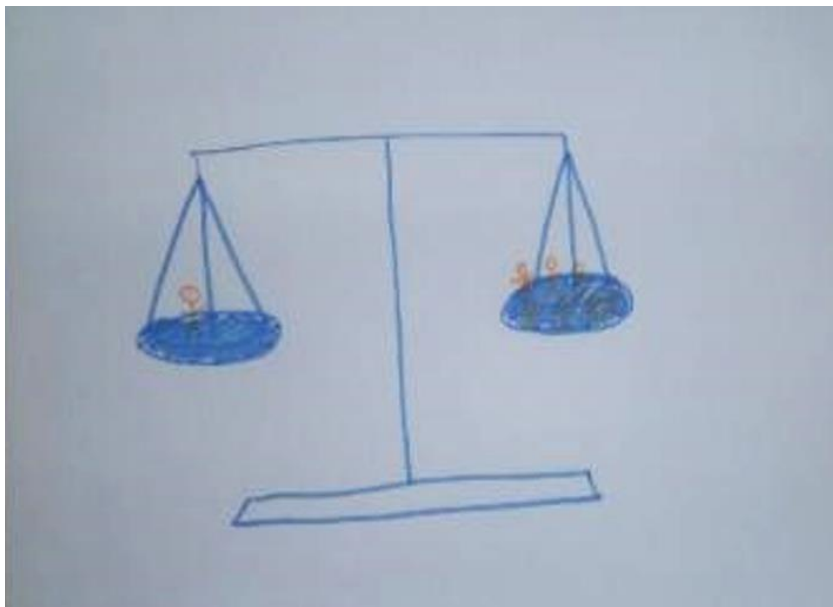
Zoe, Hayley and Charlie described their personal philosophy of midwifery in terms of a journey which centred round the woman and her family and involved them as the midwife (Figures 19, 20 and 21). This was seen as an inclusive and transformative partnership by all three midwives. Hayley commented;

> *I don't know who these people are, I don't know if it's me and the woman, the woman and her family or everybody, we're all sort of together. [Hayley]*

Figure 19. Personal philosophy poster Zoe

Figure 20. Personal philosophy poster Hayley

My own poster involved the feeling of 'getting it right' for each woman, the feeling of euphoria at the birth of a woman you know after you have built a relationship with them and been on a journey with them.

Figure 21. Personal philosophy poster Charlie

This exercise was an important step in recognising and honouring individual beliefs. It also highlighted the need for common ground or a shared philosophy between the midwives to begin the development of respect and support their work together. Creating a thematic map incorporating our individual philosophies to begin to understand convergence and divergence of perspectives in the group was the first step in co-creating the shared philosophy. Collaboration of the groups individual philosophies led to the identification of six key themes for our Shared Philosophy of Care as outlined in Figure 22.
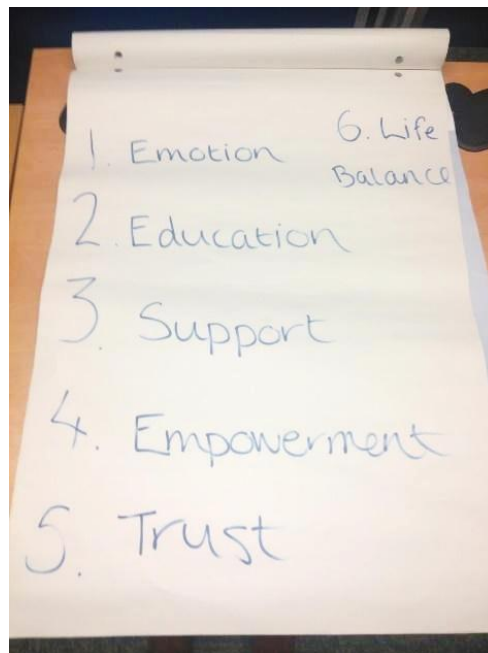
These initial themes incorporated the individual perspectives of the CI midwives and began acknowledgment of the common ground between them. The themes were revisited in Phase Two when we established our Shared Philosophy.

4.4.3 Identifying Positives and Challenges of MCoCer

The next part of the first reflective phase was to explore the midwives' views about the proposed practice change to MCoCer. This was approached through a creative thinking exercise to identify the perceived positives and challenges the midwives associated with working in this way. Figure 23 shows the slide describing the exercise we completed together.

Figure 23. Positives/Challenges exercise
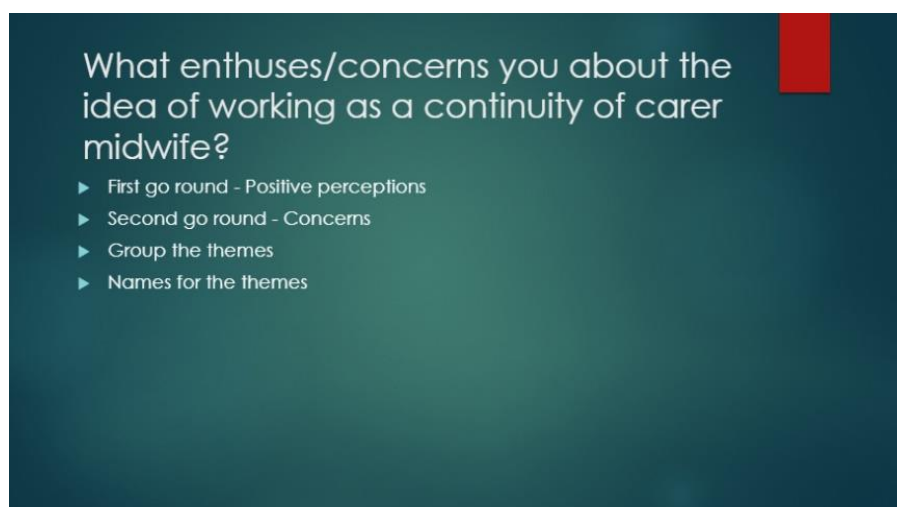
The midwives identified their own personal views through this process in a group idea generation exercise. Their individual ideas were used to form posters outlining the Positives and Challenges. Figures 24-34 present the collaborated 'Positives' and 'Challenges' themes of MCoCer in Phase Two of the inquiry.

4.4.4 Phase One Co-Decided Action

Suggestions were made for the Phase One action as part of the facilitation process as none were volunteered by the group. Out of three options regarding the work we co-created in Phase One. The co-decision was to complete a worksheet (Appendix J) informed by the RCM work tool for MCoCer (2017a). This concentrated on the more practical elements of a MCoCer model was co-decided as a group following the 'Positives and Challenges' exercise. My own action was to collaborate the themes we generated together in the meeting to confirm with the midwives in Phase Two.

4.5 Phase Two: Exploring Themes and Developing Solutions

Phase Two of the inquiry involved reflection on the themes generated in Phase One. This was to confirm the initial themes and the continued direction of the inquiry and reflect on Action One. At this stage there were two distinct threads of the inquiry, the philosophy of midwifery and the development of practical solutions to the positives and challenges identified for a MCoCer model.

4.5.1 Co-creating a Shared Philosophy

The initial theme map developed from the midwife philosophy exercise was revisited in the second phase of the inquiry to build upon CI midwives' individual philosophies and foreground the meaning making that surfaced throughout the inquiry. The importance of the interconnection of all the elements for the midwives is reflected in the final thematic diagram (Figure 24). As stated by Lauren;

> *I think it all links in to each other. I don't think it can be one without being all of the others. [Lauren]*
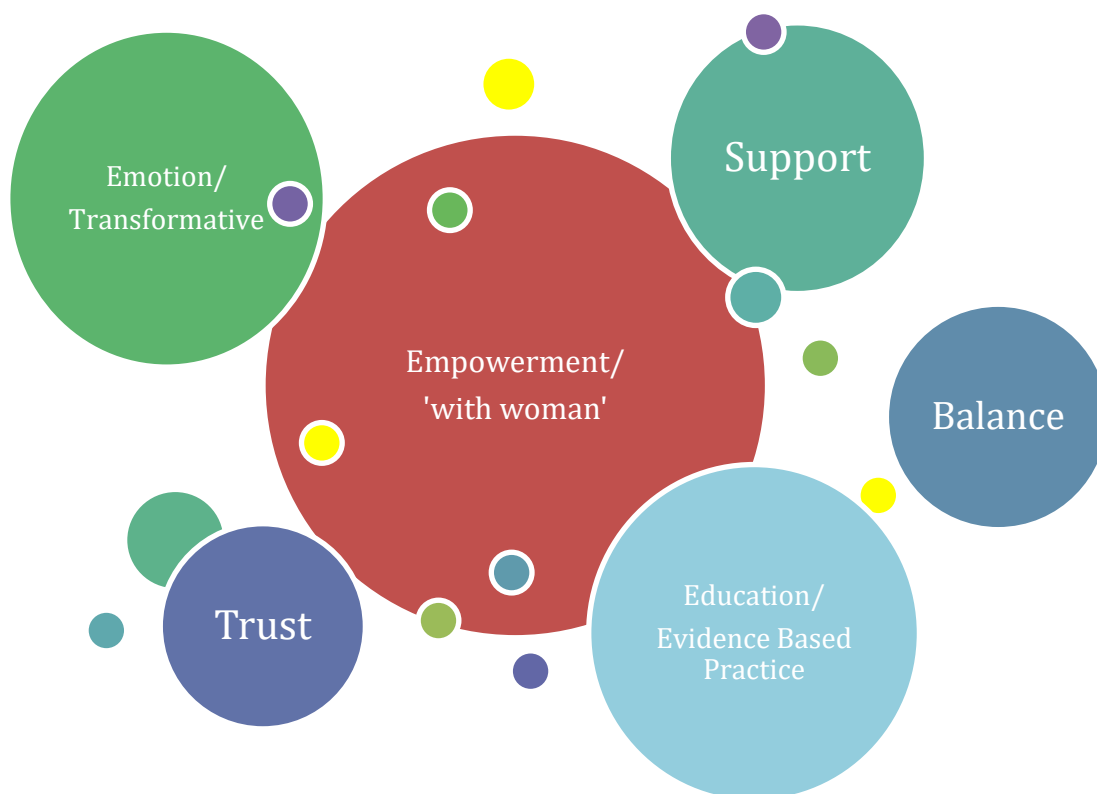
Figure 24. Thematic diagram of the Shared Philosophy of Midwifery themes

The theme of empowerment seemed to run through all of the themes for midwives, women or both within the philosophy. While the core theme described by the CI midwives was 'with woman' the concepts of balance and support spoke of a person-centred philosophy which incorporates the needs of women and midwives working in harmony to achieve empowerment, self-determination and autonomy which included leadership and management.

Understandings and meanings of the key themes of our shared philosophy were developed through discussion which built upon the CI midwives' individual understandings. Table 19 presents these meanings ascribed by the CI midwives based on these conversations and critical reflections on the philosophy theme map. The midwives felt that each theme was better described in a sentence rather than a single word due to the complexity of meaning developed through collaboration.

Table 19: Shared Philosophy of Midwifery

Theme Name	Final Theme Description	Supporting Quotes
Empowerment/ 'With Woman'	To be 'with woman' in an individualised, supported, holistic and compassionate way to empower them to make informed decisions about their own care.	*Individual for everyone, so everyone's care is individual, everyone has an individual experience [Kayleigh-Anne] it's about listening to them (the woman) and providing what they need and developing that relationship with them so we do get it right [Charlie]*
Emotion/ Transformative	Joy in midwifery and protection of the natural physiological aspects of pregnancy and birth space to support positively transformative experiences for women.	*that sort of joyful moment when somebody who you've gotten to know and has spoken about what they need and what they want in their pregnancy with you all the way through suddenly has that. [Charlie]*
Education/ Evidence Based Practice	Awareness of the best evidence and skills and competence to be an autonomous practitioner and ensure safe practice and provide informed choice.	*It's trust, we advocate, it's a holistic approach, we're listening, we're building up a relationship, we're educating, with respect for each other what we do for women and their families [Bev]*
Trust	Familiarity banishing fear through the building of relationships and trust with women and colleagues.	*Yesterday I bumped into one of my ladies who was on her way into the hospital, she looked like a total rabbit in the headlights and I thought, what a shame, that if we could actually be involved in that process, I think that takes away such a huge amount of the unknown for them if you've built up that relationship. [Gayle]*
Support/Inclusive	To be inclusive with women and colleagues and create a friendly and approachable community of practice.	*Happiness for all [Louise] Happy-like the song by Pharrell Williams [Bev]*
Balance	The importance of reciprocity and supporting each other to achieve balance (between midwives, management, women)	*This is how I'd like to feel, there's more balance with everything, time, life, everything. [Louise] It's mutual, a two-way relationship [Bev]*

4.5.2 Exploring Positives and Challenges of MCoCer

The collaborated data from the Positives and Challenges exercise and the Action Worksheet from Phase One were revisited as the next stage in co-creating solutions for MCoCer. The next part documents the confirmation of the themes in the Positives and Challenges.

The theme of **Meaningful Relationships** was identified as a significant positive for women and their families experiencing MCoCer. The ability to develop close professional relationships with women through continuity was also viewed as a positive by the CI midwives (Figure 25).

Figure 25. Theme 'Meaningful Relationships'

Relational Joy	Family feels included

Women will know their midwives
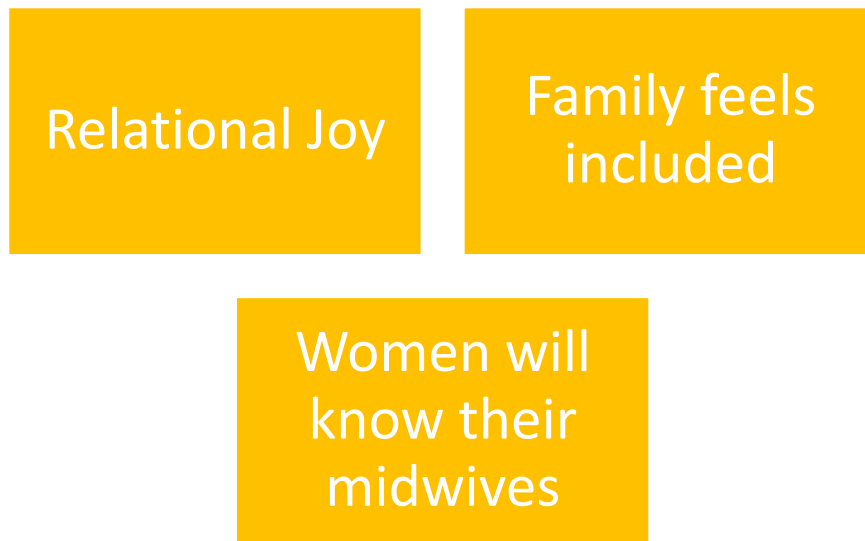
The midwives identified knowing women better through MCoCer practice would provide a better environment to support **Individualised Woman-centred care** (Figure 26).

Figure 26. Theme 'Individualised Woman-centred care

Better for women and family	Individualised care plan agreed in partnership with woman and midwife	Personalised care
Care for women in a unique way, personal to them	Flow of care and conversations	Woman centred
	Easier to be advocate. Ease of info	
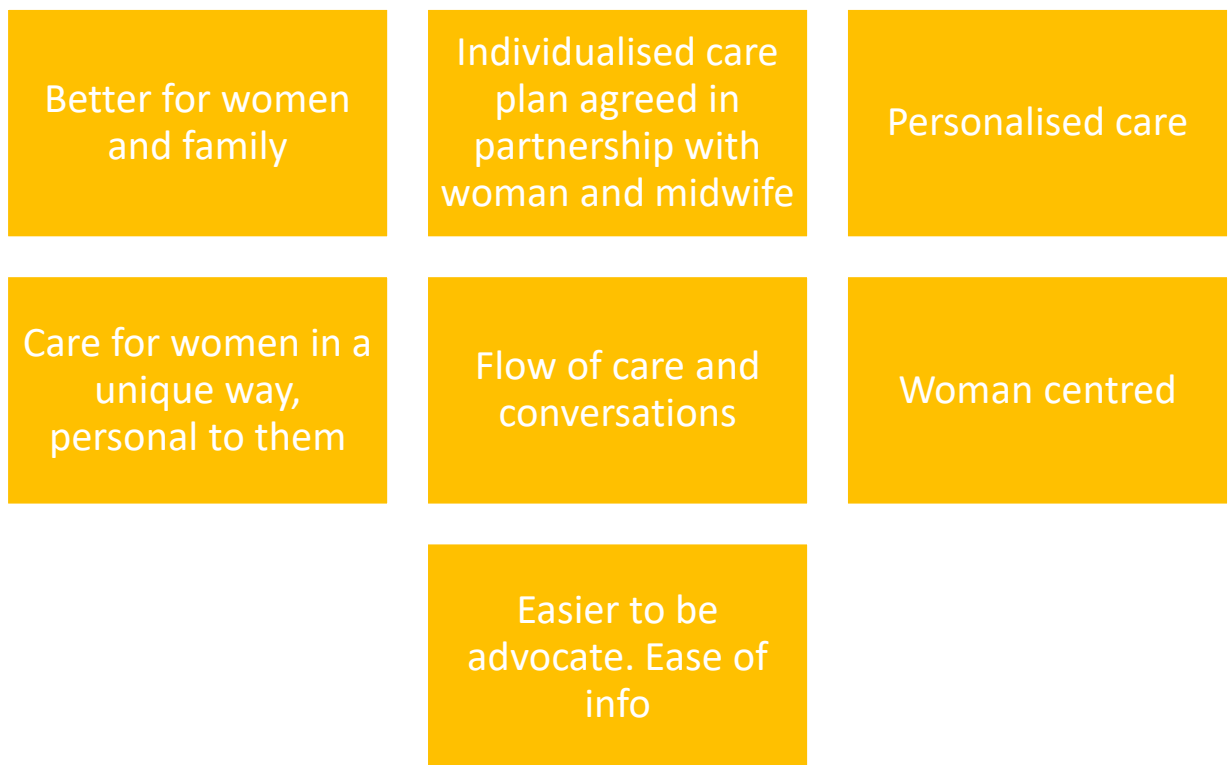
The midwives felt that MCoCer would improve **Safety** for women and babies, in comparison with current fragmented practice in which midwives felt key components of care could inadvertently be overlooked (Figure 27).

Figure 27. Theme 'Safety'

The midwives felt MCoCer models would enable more cohesive teams and **Shared Philosophy of Care** with colleagues which is something they expressed was lacking in their current workplace experiences (Figure 28).

Figure 28. Theme 'Shared philosophy of care'

The midwives linked MCoCer to improved autonomy and **Improved Job Satisfaction.** This included the concepts of increased competence and confidence in midwifery skills and through knowing women (Figure 29).

Figure 29. Theme 'Improved job satisfaction'

Job satisfaction	Full set of skills used. Confident in all areas.

Relaxed midwives because they know their women and are not meeting new women all the time

Improved Work-Life Balance was identified as a benefit of working as a continuity of carer midwife. This was associated with the reality of smaller caseloads and being more likely to be able to complete working tasks in a timely way was key to this as well as the ability to work flexibly around personal commitments (Figure 30).

Figure 30. Theme 'Improved work-life balance'

Better work-life balance	Flexible working hours
More time to do what you need to do (smaller caseload)	Smaller caseloads

The collaborated themes from the challenges exercise were defined as; **Conflicting Ideologies, Increased Expectations, Work-Life Balance and Logistical Concerns.**

The midwives expressed concerns about **Conflicting Ideologies** and philosophy of other colleagues within the wider maternity environment. This included selecting immediate midwife colleagues to work with, differences in personalities and beliefs and understanding and trust between core and caseload working and from management (Figure 31). They clarified that as a caseloading midwife you must be supported to be autonomous, but that this would require a significant change to the organisation of maternity services from the current situation to facilitate this.

Figure 31. Theme 'Conflicting Ideologies'

Justifying midwifery care when liasing with other staff	Trust of management in your capabilities/work ethic	Attitudes of other staff
Medical staff (not) trusting midwives	Lack of trusting relationships between staff members	Not a shared philosophies with medicalised staff
Situational awareness between core/community	Lack of protocol for care package-not working the same way	Inability to choose team members
Clash in personality	Resistance to change	Mutual Respect (lack of)
(not) valuing emplyees		

The midwives perceived that MCoCer would mean **Increased Expectations** on them in their professional role (Figure 32). This incorporated ideas about women expecting them to 'know everything' and be available at all times and management creating an extended role that was out with their comfort and skill level, while not being supported or trained to provide this type of care.

Figure 32. Theme 'Increased expectations'

Time management- stress!	Unrealistic expectations of women
Woman's expectations- needs to remain professional	Increased pressure to know everything
No choice in skill set	Staff (midwife) commitments increasing
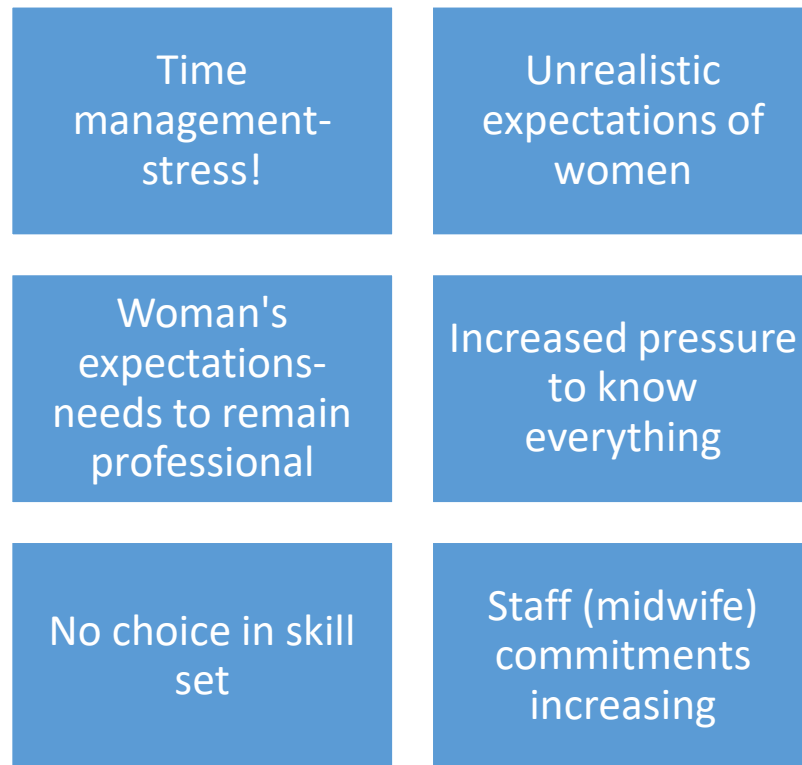
Although flexible ways of working were identified by the midwives as a positive, the midwives also raised concerns that working in MCoCer models could erode the definition between work and personal life and could threaten their **Work-Life Balance** (Figure 33).

Figure 33. Theme 'Work-life balance'

Lack of life-balance	Impact on personal life	On call stress-restrictiveness of this
How are women allocated?	Caseload size/caseload cap? (no choice)	Feeling overwhelmed by women/caseload
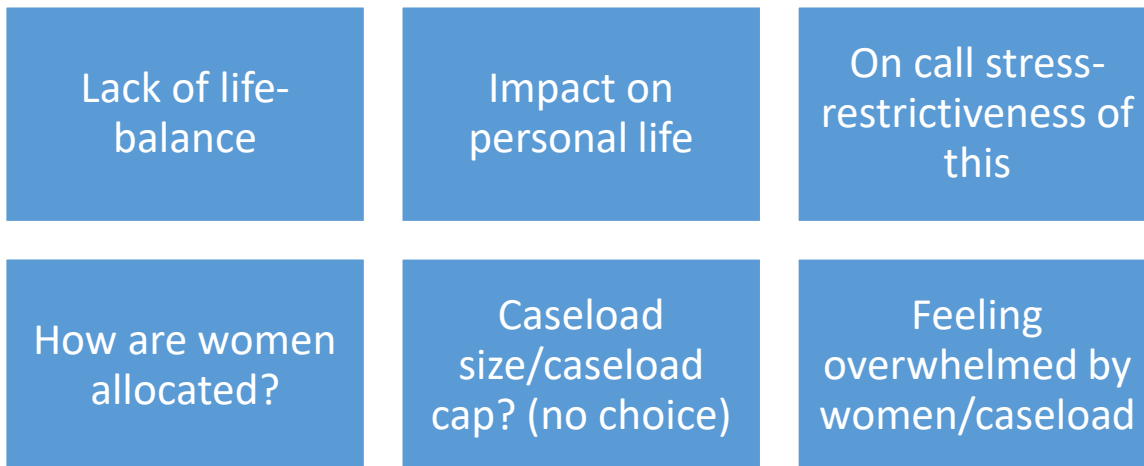
The midwives voiced concerns about how continuity of carer would be provided with a lack of midwives and the associated cost of increased on call and extended midwife roles for the NHS. Continuity of medical care was also perceived as an important element of MCoCer which they did not feel was addressed in the current model and would be overlooked in the future design and implementation of new maternity care. This theme was collectively titled **Logistical Concerns** (Figure 34).

Figure 34. Theme 'Logistical concerns'

How do midwife students learn/shadow?	Continuity of carer with medical staff?	Finances-cost of on call?
Not the allocated consultant which women see currently	Lack of midwives	
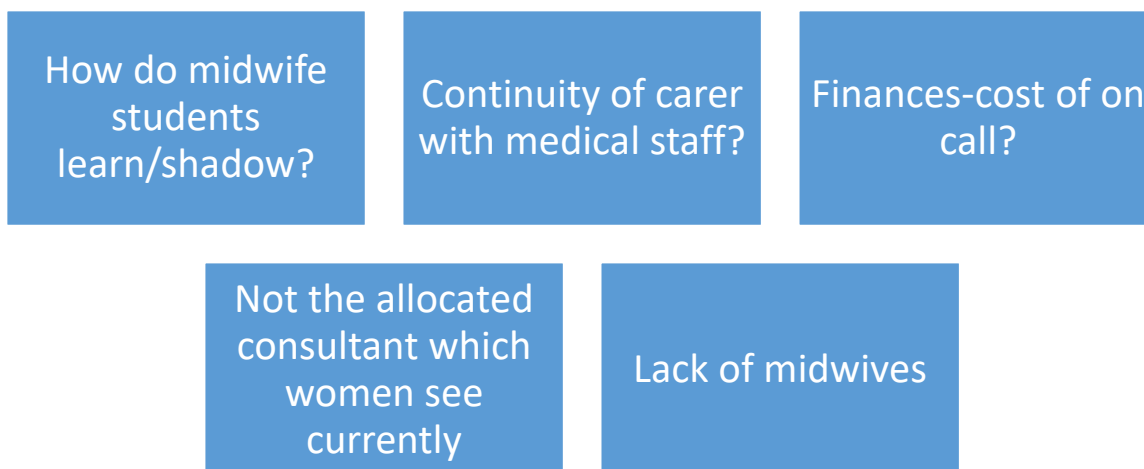
Overall the midwives noted more perceived challenges than positives of working in a MCoCer model, which reflected the uncertainty the midwives felt for practice change. Each of the midwives often participated in both the view of positive and the reflecting challenge of the same theme, highlighting personal conflict with the concept of MCoCer, rather than conflicting ideas between members of the group. Through discussions the midwives identified that the proposed practice change caused them to feel a great deal of uncertainty and lack of control about their own working practice and the future;

> *I've had a few of those moments when I've thought, how is it going to work? Is it actually going to change things in the way they say it's going to? [Gayle]*

As such it was a difficult exercise for the midwives to separate and identify specific positives and challenges. Many of the Positives and Challenges themes reflected the same topics, depicting the opposite aspect of each key factor. As such the themes identified were simultaneously convergent, as they addressed the same topics, and divergent as opposite elements of the same key factors were raised by the midwives. Figure 35 depicts the relationships between these themes that developed from themes in Figures 25-34.

Figure 35. Summary of Positives/Challenges themes

Positives	Challenges
• Meaningful Relationships • Woman-Centred Care • Safety • Shared Philosophy of Care • Improved Job Satisfaction • Improved Work-Life Balance	• Increased Expectations of Midwives • Logistical Concerns • Conflicting Attitudes • Lack of Work-Life Balance

While we did not specifically return to the Positives and Challenges exercise again during the inquiry, the exercise did help inform the development of relevant co-created solutions as reported in the following two sections.

4.5.3 Collaborating Solutions for MCoCer

Reflection on the personal practicalities developed through the Phase One Action Worksheet (Appendix J) informed by the RCM workbook (2017a) initiated the process of developing collaborative solutions to the practical elements of an MCoCer model. Appendix I shows one of the completed worksheets.

The CI midwives shared divergent and convergent ideas that coalesced into a mutual appreciation of what the model would eventually contain. Consensus on ideas was formed through discussion and critical reflection, with agreement written up together to form the initial Framework for MCoCer depicted in Figure 36.

Figure 36. Consensus of practice elements for MCoCer Framework

1. Base / Home AN/PN joint decision
2. ½ to -1hr depending on need / AN appt.
3. Organisation, shared diary, communicate app?
4. protected admin days / every 2 weeks
   integrated unit MUST - consultant clinic
   joined up working.   team members
   covering women + needs.   CTG.
5. self roster, manager sign off.
6. Basic salary, unsocial hours - on call
   Band 7 - additional role on top of (needs to be addressed)
7. Buddy system, taking turns
8. Communicate, swapping, trust, friend.
a. Calendar, roster, joint decision
   10. 35 at time

11. as an organisation, in contract, not requested
    over 35 women. Fluctuating but not higher
    lower according to need. Quality care.
    Sharing + conversations, due dates.
    Grading system for midwife only. not red
                                      green.
12. Based by area (general) for driving. A guide
13. building caseload over few months
    PT learning days for everyone
14. Teamwork, support system, shadowing.
15. Team meeting 1/week social, reflect, debrief
16. Badgernet.
17. Named obstetrician
18. Team decisions, Communications
    dress code - not uniform (decided between team?)

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The midwives were able to voice their individual concerns about their personal views within the group, which were all considered respectfully in the creative process. The development of reflective and open language was part of the transformation thread of *Perspectives* (p.125).

<u>4.5.4 Phase Two Action</u>

The aim for actions to be transformative at individual, group and wider midwifery community levels was discussed with the CI midwives (Figure 37).

Figure 37. Co-deciding action for Phase Two

The co-decision was made to increase our understanding of continuity models and effective implementation. Each CI midwife individually chose how to proceed individually which ranged from reading and reviewing an article to contacting experts in MCoCer. The midwives were encouraged to share their findings with the other CI midwife and colleagues outside of the inquiry as part of this action to support transformation at a personal, group and wider midwifery community level. We reflected on the midwives' actions at the following meeting. My own action, as agreed with the group, was to write up the collaborated solutions.

Hayley took the opportunity to contact midwives in Canada for information and ideas about how they structured their model of care (Figure 38). This was a good example of taking action towards transformation in the group.

Figure 38. Email correspondence from Hayley to MCoCer midwives in Vancouver, Canada

> I've recently been involved in research to support a change with midwifery services and creating a new model.
> I was hoping you might be able to send me some information regarding your model of care and responsibilities of midwives and women and what the role of the midwife is within the case loading model.
> It's really all the things I should've spent the time to write down when I was in Vancouver!

4.5.5 Evaluation of Phase Two

Evaluation of methodology and methods is an important step in all qualitative research, and ensures the validity of process and improves the trustworthiness of findings in action research methodologies (Lowensen et al. 2015). Evaluations of the inquiry were requested at Phase Two, Three and Four to document the transformative journey of the midwives from their perspectives and enable anonymous feedback on the facilitation and CI process. Figure 39 shows the PowerPoint evaluation slide with the questions posed at Phase Two and Three.

Figure 39. Evaluation questions Phase Two
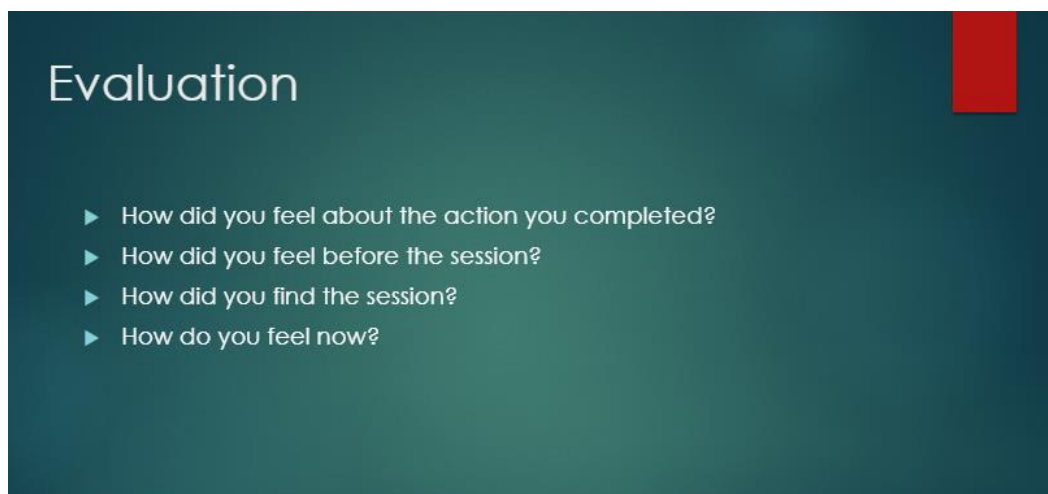
The evaluations provided useful feedback on the facilitation of the CI which assisted critical reflection and adaption of methods to assist genuine participation and validity of the outcomes. The Inquiry Outcomes Chapter documents the transformations both as individuals and as a group.

4.6 Phase Three: Contextualising

As the inquiry progressed the philosophy of midwifery co-created as a group framed the discussions around two key concepts which were important to the midwives; working together to provide continuity for women, and maintaining work-life balance that the midwives highly valued. As commented by Gayle;

> *Moving forward with continuity of carer, anyone who's been involved in it, even my own experience here, or for people who have worked in New Zealand that balance of work and life can be so hit and miss. [Gayle]*

This quote identified a key motivation which was shared by the CI midwives in developing a MCoCer which was responsive to their needs.

4.6.1 Co-creating a Framework for MCoCer

Phase Three of the inquiry focused on the emerging framework for a MCoCer model. An initial framework was formed using the discussions in Phase Two reflective session of the inquiry using data generated from the Action Worksheet (Appendix I).

All of the elements present in the document were conceived in Phase Two, additional questions were added for the reflective process in Phase Three to improve clarity and confirm each element of the framework. The meeting focused on critically analysing the document and confirming each aspect as a group, to define and justifying their inclusion or exclusion. At this stage of the inquiry we had begun to question our own preconceptions and views as well as those of other members of the group. This developed the groups critical reflection skills and created a new openness in the reflection meetings enabling the generation and discussion of new ideas in a broader sense. This transformation is reported as part of the *Perspectives* thread (p.125).

4.6.2 Informing a Team Charter

During the critical reflective process the midwives identified both elements which related to the day to day practicalities and group working as well as the design and implementation of a MCoCer model itself within the initial Framework. The midwives felt that the elements related to their group philosophy and working should be contained within a separate document. I clarified what the midwives meant by this using reflective questioning techniques;

> *So (you feel) some of the elements describe the role-sort of like a job characterisation? And the rest should be in a separate document? [Charlie]*

The group felt this was needed and we discussed how this could be done. This led to the development of two separate documents, A Team Charter guided by the Shared Philosophy and a

Framework which contained the named logistical elements of MCoCer practice arrangements. Figure 40 shows the process of annotating the framework document as part of our collaborative discussions.

Figure 40: Annotated page of Initial Framework

The co-decision to separate the emerging framework into the elements relating to the midwives shared philosophy and those relating to the design and structure of the model itself.

In summary the outcomes from Phase Three included:

i)   A Team Charter informed by the shared philosophy of care to support effective and positive team working

ii)   A Framework for MCoCer outlining the design and structure of a model of practice

4.6.3 Action Phase Three

The co-decided action for this phase was to meet and discuss the Framework with NHS Grampian midwifery managers and team leaders to share their views and raise awareness. It was important to produce documents which were representative of the midwives' views prior to the action meeting with the managers. Figures 41 and 42 were included to evidence these conversations and show the nature of these email exchanges. The respect for the other CI midwives was evident through these exchanges, highlighting the journey of transformation.

Figure 41. Email correspondence Gayle confirming the Framework practice elements

> Thanks for the clarification. I think I am just struggling to get my head around how to marry the idea of the philosophy with how that might work in reality. I think having been involved in a change of service I have seen first hand how careful you need to be with what is offered.... Two on calls quickly can become 3 or four!
> Thanks for clearing up where the £17 came from. My only concern with linking this to the role of junior doctors would be, do midwives truly want the responsibility which comes with this increase? Personally I would rather we were trying to secure a reasonable boundaries of working for midwives, the limitations of which is supported by management in order to keep our profession safe and our work life balance in tact. Continuity can be a very rewarding way to work, as a midwife. My fear would be increasing the expectations of the midwife leaves us open to litigation.

Gayle also raised a concern that they did not feel qualified to establish a framework for a MCoCer design for midwives.

Figure 42. Email correspondence Gayle group thread

> To be honest I also didn't realise that the plan was to take this to management to suggest it should be contractual changes for midwives. I don't feel I have the expertise or understanding of continuity or have had the time during this process to really be able to take this to such a level that it is looking for management to change contracts. It is such a huge area to look at we have barely touched the surface.
> I think there have been some great ideas banded about but without trialling such a working method I wouldn't want to be responsible for permanently changing the working method of many! I'm not that brave..... Lol!

This was taken as an opportunity to re-confirm the purpose and scope of the framework as a group. The following criteria were co-decided.

-     The framework should support the midwives but also provide them with the flexibility to be self-directed and adapt to a changing work environment in an autonomous way.

- The specific solutions co-decided as a group were relevant to the CI midwives, their views and contexts only.

- The completed framework can be used as a guide for groups of midwives looking to establish a continuity of carer model and the elements of practice to consider when designing models of care that are contextually and specifically orientated.

Following this conversation two other CI midwives decided to attend the meeting with the managers. The final Framework depicted in Table 22 (p. 120) was shared and discussed with NHS Grampian managers and team leaders. As the meeting with the managers included those outside the inquiry and was within the action phase, data was not explicitly collected. The CI midwives' views and understandings which developed through participation in this meeting were explored in the following reflective phase and their evaluations of the CI process which are reported as part of the transformational outcome *Autonomy* (p.130).

4.7 Phase Four: Confirming and Concluding

4.7.1 Agreeing a Team Charter and Framework for a MCoCer model

Only three of the CI midwives including myself attended the final meeting. From my own professional experience and having worked locally amongst these midwives I understood this to be connected with two principal issues:

1. The unpredictable nature of midwifery and amount of pressing work commitments

2. A lack of engagement with the inquiry

The first reason for lack of attendance was unavoidable due to the nature of midwifery practice. However, the two CI midwives present felt the lack of attendance was related to a lack of commitment or prioritisation of the study and potentially a lack of understanding of the inquiry aim and outcomes from the beginning. The two midwives also felt that MCoCer was still largely unknown and as a consequence felt anxious about being associated as a 'trouble maker'[Lauren]. This was evident from conversations in the practice areas which had created fear for some of the CI midwives.

The agenda of this final meeting of the CI midwives involved reflecting on the Phase Three action meeting with NHS managers and evaluation of the inquiry as a whole. The following questions were addressed through discussion in person at the final reflective meeting or requested by email if the midwife was unable to attend. Figure 43 outlines the final reflective questions on the inquiry.

Figure 43. Final questions posed to the CI midwives Phase Four

Final meeting reflections

1. Are you happy for the data we have created together in the reflective sessions to be used in the write up of the project?
2. For the purpose of protecting of your identity for quotations are you wishing for a pseudonym to be used in publication?
3. Do you wish to be named as a co-author of the research as is usual practice for cooperative projects?
4. What are your reflections on the action meeting with the managers? (if you did not attend please outline why and what might have made it possible for you to do so).
5. What do you think the transformations have been:
   - personally
   - as a group
   - at a wider Grampian level
6. What have you found positive and challenging about the Inquiry process?
7. What do you plan to do following the end of this project to maintain momentum and your own ownership of the progress with Best Start in Grampian?

Confirmation of the final frameworks through critical reflection and reference to the original 'Positives and Challenges' exercise to ensure the outcomes addressed the concerns of the midwives.

4.7.2 Action Phase Four

A final action was discussed with the midwives to maintain momentum and encourage their further involvement in the future planning and implementation of Best Start. Hayley and Zoe commented positively on their future plans while Lauren and Louise expressed uncertainty for the future and because of this unable to commit to an ongoing action. This is reported as part of the transformational threads of *Focus* and *Autonomy* (p.128, p.130).

4.8 Summary

This chapter has been concerned with the process of the inquiry. I have reported the recruitment and inquiry processes and transparently presented our journey through four phases into meaning making together. The following chapter presents the informational outcomes of the Shared Philosophy, Team Charter and Framework for a MCoCer model and the transformational outcomes of the inquiry.

CHAPTER FIVE

INQUIRY OUTCOMES

5.0 Introduction

This chapter now presents the informational and transformational outcomes of the inquiry which are interwoven with my own reflections as both investigator/facilitator and co-inquirer to highlight reflexivity and reciprocity in the process. The chapter is in two parts. The first part presents the three informational outcomes:

- Shared Philosophy

- Team Charter

- Framework for MCoCer model

The second part of the chapter presents the transformational outcomes as revealed through evaluation of the inquiry and critical reflection of the process. The transformational outcomes are reported chronologically to reflect their development over the course of the inquiry.

Figure 44. Transformational outcomes reported in this chapter
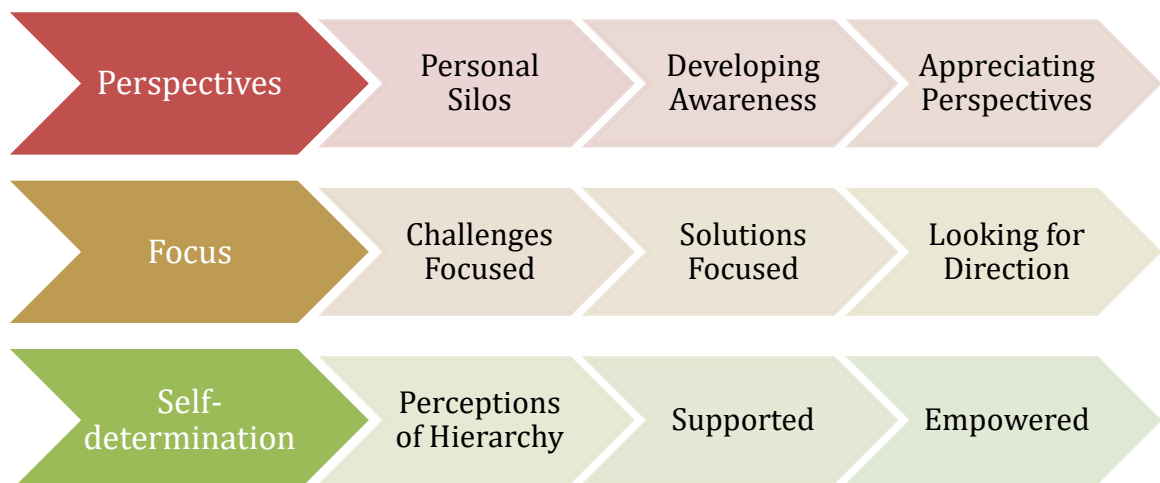
PART ONE: INFORMATIONAL OUTCOMES

5.1 Shared Philosophy of Care

The central theme of the Shared Philosophy of Care was **Balance** which identified the importance of addressing the needs of midwives alongside women and resonated with a Person-centred model of care. The remaining themes we identified all related to the central concept of person-centredness and an individualised and holistic approach to midwifery.

Table 20: The CI midwives shared philosophy of care

Balance	The importance of reciprocity between colleagues and women and support of each other to achieve balance between work and personal life
'With Woman'	To be 'with woman' in an individualised, supported, holistic and compassionate way to empower them to make informed decisions about their own care.
Transformative	Joy in midwifery and protection of the natural physiological aspects of pregnancy and birth space to support positively transformative experiences for women.
Evidence Based Practice	Awareness of the best evidence and skills and competence to be an autonomous practitioner and ensure safe practice and provide informed choice.
Trust	Familiarity banishing fear through the building of relationships and trust with women and colleagues.
Inclusive	To be inclusive with women and colleagues and create a friendly and approachable community of practice.

The shared philosophy care represented co-operatively agreed guiding principles which were central to development of the subsequent team charter.

5.2 The Team Charter

The aim of the Team charter was to support effective team working for a positive and welcoming midwifery environment. Table 21 is the culmination of our thoughts about collaborative team working in a MCoCer model. The first two columns outline the practice element and the discussion around this. The third column outlines the co-decided structure of each practice element.

Table 21: Team Charter

Practice Element	Discussion about the practice element	Co-decided design
Where are women seen for routine care	*In their own environment [Zoe]* For the midwives this meant where women felt comfortable in partnership with midwife workload	AN/PN at home or base/hub co-decided with women
Appointment timings	*Dependent on need [Gayle]* Midwives appreciated the ability to spend time with women but also saw the value of expected appointment times for work balance	Most visits assumed 30 minutes to 1 hour depending on need.
How to manage appointments	*Expecting your members of the team to input and share [Louise]* This supported self-directed autonomous working which the midwives desired	-Self management, electronic diary shared with team members -Use of clinics and group AN when appropriate
Team working	*You need to try and encourage that behaviour, that ethos- you're a team not just an individual person [Bev]*	Induction also includes introduction to the way the team work and discussions about any changes to this
Expectation setting with women	Midwives' felt that a shared way of working and setting expectations with women was a fair way to practice.	Shared group expectations regarding aspects of practice, (ie. on call, contact, appointments, birth) and philosophy of care
Schedule of information	Framework for AN/PN visits and Evidence Based packages for discussion at specific points	Framework for AN/PN visits and Evidence Based packages Agreed timings for discussions with women to ensure equitable care and safety

How to manage visits after call out overnight	*If you're in a team you'll obviously all speak to each other anyway [Louise]* Team work was an important factor for managing unexpected work	Shared diary/app for communication 'Hub'/Floating midwife for drop ins or rescheduled appointments
Managing hours and commitments	*I think you should be able to organise your own diary [Kayleigh-Anne]*	Self-rostering, with a buddy/buddies and signed off by team lead
Working style	*Decided by you rather than pre-determined [Charlie]*	Action based work depending on caseload needs Floating midwife every weekday without clinics or visits booked
Increasing continuity	*So by the time they actually to having the baby they have met everybody [Louise]* *Empowering women to not need you (their midwife) [Charlie]*	Fresh face appointments antenatally Group antenatals at busy times Meet the midwife events
Caseload Responsibility	*Taking a bit of the pressure off [Zoe]*	Caseload supervision from Lead midwife/Team member monthly Fresh eye appointment with buddy at set gestations (reciprocal)
Midwife biographies	Shared platform for knowledge base.	Sharing expertise between team members and across teams to increase competence and confidence
Welcoming Environment	*It has to be shared generosity, not just one person getting what they need [Charlie]*	A positive and supportive environment to work in Statutory and Mandatory training together with the multi-disciplinary team
Supported Environment	Important for team coherence and team philosophy, sharing knowledge and improving evidence base together.	Monthly evidence sharing meetings in teams, circulated between teams for updating evidence base and ensuring equitable care across teams.
Meetings	Share concerns, reflect, debrief and catch up. The midwives felt they need to	Weekly

	connect with their team often for cohesion.	
MSWs	*They are going to be part of the team [Louise]*	MSW integral to team Breastfeeding antenatal class and antenatal visit to increase continuity
Handover system	*You want to be considerate of your team [Bev]*	Electronic calendar Annual Leave Face-to-Face
Notes	Consensus across service about where and how to document events to increase safety and transparency	Paper light- A4 summary for midwives assisting handovers Badgernet

The Team Charter we co-created provided support for effective and positive team working. This complimented the Framework we co-created which contains the logistical details of a MCoCer model to support the CI midwives to mitigate the perceived challenges and emphasize the perceived positive aspects.

5.3 Agreed Framework for a MCoCer model

The framework for a MCoCer model was constructed through the process described in the previous chapter and involved group consensus for practice arrangements. Table 22 contains the details of the final co-created Framework. The first column states the practice element which was integral to the logistics of designing a model of care, the second column outlines our discussions as a group and the third column outlines the co-decided design.

Table 22 Framework for a MCoCer model

Practice Element	Discussion within the inquiry	Co-decided design
Caseload size	*Based on the complexity of women and their needs so it is individual [Lauren]*	35 women maximum at any time (FTE) including postnatal Caseload reduced according to complexity and/or geography Workload tool complexity grading
Allocation	*For equitable caseloads [Kayleigh-Anne]* *No requests to be made if midwife at capacity [Charlie]*	Women to contact central hub to book with midwife. Assigned according to geographical area, due dates and complexity. Women booked by named midwife

Caseload complexity	*Make sure you keep up skills [Lauren]* *Not segregating women according to coloured pathways but as individuals [Charlie]*	Mixed caseloading Midwife led, Multi-disciplinary Team supported
Hours worked and protected time off	*Same as we work now [Louise]*	37.5 hours/week FTE (logged with SSTS) 2 days off/week or 4/2 weeks to be arranged 2 months in advance with buddy and then decided as a team.
Care Period	*It still counts when they're (the women are) postnatal [Lauren]*	Booking until 28 days postnatal (remain on caseload until discharge) HV to visit from day 10 PN
Midwifery Base	*Sometimes you never know if someone has had that appointment [Louise]* Joined up working aimed to make care safer and reduce unnecessary workload for midwives.	Each team to have access and use of a maternity base which is accessible for the women in the geographical area covered. Rooms for AN/PN and IP Shared spaces for AN classes and admin
Contact method	*I feel that it should be added in here that the 'central hub' receiving the call from the women should be triaging the call and making the decision to call the on call midwife [Louise-email correspondence]*	Central contact as midwife base Triage and labour calls directed to most suitable midwife (named/base midwife during the day according to caseload, on call/base at night according to need)
Team Communications	*We use these already and it works {Kayleigh-Anne}*	Smart phones, shared electronic diary used as communication between colleagues and from central base.
Central Hub Role	Role to support caseloading midwives *We need someone to facilitate things [Louise]* *That needs to happen [Lauren]*	Central Admin Team (caseload allocation, first point of contact for booking women, non-clinical, correspondence, expenses etc.) Safeguarding team Specialist/experienced midwives
Experience required	Reflecting current roles for NHS grade 5 and 6 midwives.	Band 5-6 (including Newly Qualified) Band 7 including increased role (governance, audit, specialist etc).
Team Size	Team of 4- more on call nights, less chance of being called Team of 8-fewer on call but more likely to be called out.	4-8 subject to the decision in context by each caseload midwife team.

Recruitment	*...to work with likeminded people who share the same philosophy of care.* [Louise]	Choice of buddy Shadowing as part of interview, team to have say in job offers
Caseload Role	Importance of confirmed caseload role and equitable working *Not to be called in to staff the hospital when short [Kayleigh-Anne]* *Unless the traffic goes both way [Louise]*	Routine AN/PN Triage Home assessment Home Birth Midwife Unit Birth Newborn Infant Physical Examination Second midwife for women undergoing complex birth/Induction of Labour/Elective Caesarean section on individual basis Parent Education
Managing commitments	*We self-roster and it works [Kayleigh-Anne]*	Self-rostering, with a buddy/buddies and signed off by team
Off sick/Extended Leave policy	System to be included in contract to ensure that midwives caseloading do not exceed working hours on a regular basis.	Protocol for emergency staff to be drafted in to cover staff who are on long term sick or absence over a week Additional on calls to be taken by cover staff also.
On call	For larger teams of 8 with increased chance of call out that some of the on call hours counted as part of 37.5 *I think what we are saying as it needs to be dependent on the needs of the team? [Charlie]*	2 on calls/week FTE 10/12/24 hours on call subject to midwife choice One 10 hour on call counted as hours (FTE)
Midwife Safety	Safety of midwives should be paramount both physically, emotionally and professionally.	Lone working protocol to protect staff Clear communication between midwives to ensure safety of self and each other. (Check in/out) Asking Gender Based Violence question at telephone booking prior to attending
Professional Support	*we should be supported by management, by experienced practitioners and provided with training and supervision to support women in their choices. [Charlie- email correspondence]*	-Caseload supervision -Fresh eyes appointments from colleagues at set gestations in the pregnancy and when needs arise for care checking- according to the discretion of the primary midwife -Named mentor for NQ/ Newly employed midwives for 1st year

Escalation Protocol	Routine queries to team mates/Lead midwife Emergency requests to red phone in Labour Ward	Clear escalation pathways AN/IP/PN Primary midwife to declare to Lead midwife if/when they feel uncomfortable about care plan and receive full support to manage the situation.
Annual Leave	*No more than 2 FTE off in each team at anyone time for AL [Louise]* Aimed to reduce extra workload for midwives.	35 days/FTE Self-roster in pairs, confirmed as team in electronic calendar Routine AN organised around AL
Admin	Both admin work and 'floating' midwife role	8 hours protected time/week- also classed as 'floating' role for triage and labour care.
CPD	Global circular emails about updates, research summaries and guidelines from NHSG Maternity.	Designated CPD days 8hours/month Includes statutory and mandatory training with the remainder of the allocated hours to be used by the midwife to attend training and conferences of their choosing.
Value	*The junior doctors get paid £17/ hour for doing the same roles as us [Kayleigh-Anne]* Midwives should be valued according to their responsibilities	Basic pay £17/hour minimum Unsocial hours additional On call retainer as part of salary Car insurance/car scheme and mileage Continued incremental increase over time worked
Training	Additional training requested and facilitated by team lead according to the needs arising from caseload.	Statutory and Mandatory with caseload/core staff to strengthen professional relationships
Induction Programme	Detailed induction programme completed before starting and shadowing for all new midwives to the team.	10 working day induction programme before clinical Build caseload slowly from booking to ensure continuity Reduced caseload 3 months for NQ and RTP
Team leader	Support for midwives to self-direct working practices as autonomous practitioners.	Band 7 Reduced Caseload Support midwives with clinical concerns Caseload supervision
Consultant Care	Accessibility for women Role of midwife to advocate and support	Named consultant according to geographical area Named midwife to attend
Equipment	Current kit is sufficient for the role the midwives carry out in community. Additional labour and birth kit useful for increasing continuity.	AN/PN kit Labour and birth essentials for unplanned homebirths

Dress code	Decided as appropriate by teams and individuals	Uniform or Smart Plain Clothes Identification Badge

Louise reflected that each element of the framework was significant to designing and implementing a MCoCer model which was relevant to us, a view shared by the other members of the group. The framework honoured our divergent views by acknowledging the need for flexible design, whilst establishing structure through consensus. CI also aims to support transformation of those who participate, which is reported in the following section.

PART TWO: TRANSFORMATIONAL OUTCOMES

We learn from the part of the journey that we focus on. [Gadsby 2018]

This section presents the transformation outcomes identified through the evaluations and critical reflection of the inquiry. There were three threads of transformation identified in this inquiry: **Perspectives**, **Focus** and **Self-determination** (Figure 45).

Figure 45. The three threads of transformation
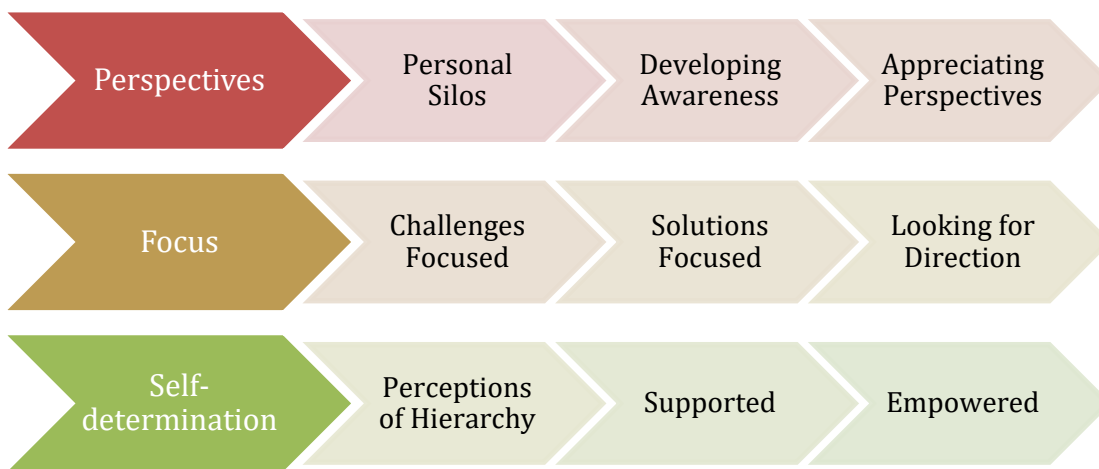
Each of these transformational threads occurred as a journey of discovery for the midwives, often in a non-linear fashion due to the complex nature of developing understandings and undergoing change. Each thread is discussed in turn.

5.4 Perspectives

I believe we could paint a better world, if we learnt how to see it from other people's perspectives, as many perspectives as possible. Because diversity is strength. [Gadsby 2018]

This transformational thread involved the process of moving from silos of our own personal views and understandings to appreciating diversity and wealth of shared perspectives in the group. This was identified through the evaluations and the change in discourse and communication between the

CI midwives. Our journey exhibited the development of critical reflexivity towards the subjectivity of our own opinion and the presence of differing views.

Personal Silos

A key feature of effective team working was identified as working with people who valued the same things, Louise outlined that she wanted to,

...to work with likeminded people who share the same philosophy of care. [Louise]

Louise believed that this facilitates effective and positive team working. Hayley seemed despondent at times that the views of the midwives did not support the same vision she had for woman-centred care. Her personal conflict with the view expressed by Lauren and Gayle that women did not want MCoCer is expressed in this quote;

I find it frustrating that it's not straightforward. I also see differing ideas about what 'Best start' will be and the concerns regarding whether it is sustainable. [Hayley]

These reflections highlight that while the inquiry supported the midwives to voice their needs, that they were not always fully compatible with each other, especially at the beginning of the inquiry process.

Developing Awareness

As the inquiry progressed the development of more reflective dialogue which acknowledged the subjectivity of personal opinion and the potential for others to have different and equally valid views. As commented by Gayle;

I appreciate that others may not feel the same. [Gayle-email correspondence]

Different perspectives began to be seen as a positive by the midwives as they appreciated the input from a diverse range of people both internal and external to the inquiry. Zoe commented;

It has been interesting for us all to hear each other's opinions and concerns. [Zoe]

My reflections on the engagement of the group noted the strengths of knowing others in the inquiry which developed a sense of camaraderie and mutual commitment. As commented by Bev;

It's very hard to be selfish to someone you know, someone you have had a drink with [Bev]

Hayley reflected on similar feelings about knowing and being known by the group,

Personally, I have felt encouraged and hopeful for the future of midwifery and have enjoyed meeting other midwives. Being new to Aberdeen, I felt included and

*found it a very positive space to express my own views and feelings while having
the space to also learn from others in a small environment. [Hayley- evaluation]*

Reducing the unknown both in terms of knowledge about MCoCer and knowing the other CI midwives were both associated with a sense of positivity and security which enabled the midwives to engage.

*I think this has changed our feelings of feeling vulnerable and alone in the fears
that this big plan can bring. [Zoe]*

The connection with others was a huge positive of the inquiry and supported the midwives to be critically reflective of their own preconceptions and open to the possible solutions that they could co-create.

Appreciating Diversity

The thread of appreciating diversity also included a desire for increased integration in future between midwives working in different areas and the wider maternity team. This was to encourage shared perspectives and understandings to improve wider midwifery culture and the working environment. Hayley suggested that changing the titles of 'hospital' and 'community' could begin to break down these personal silos. The suggestions of 'core' and 'caseloading' enabled this more integrated perspective for her. Discussions about the caseloading role highlighted that this was an opportunity to develop something new, which integrated both elements of acute working and community midwifery.

*I feel as a group we have come a long way in our understandings of others roles
and also saw much more of the wider picture that had not necessarily been
considered before. [Hayley-evaluation]*

However, diversity of opinion and ways of working were not always positive. Lauren who consistently attended the reflective meetings commented that she had initially felt that this was a group of people she could work with clinically in a team but through the inquiry process felt that the lack of consistency in engagement from the other CI midwives was concerning,

*…there are other aspects important to philosophy and group working practices as
well as being present colleagues have to work together and have a similar outlook
[Lauren- evaluation]*

This conversation led to the inclusion of the Framework element 'Choice of colleagues', to acknowledge the importance of working with people with a shared philosophy to enable a positive work environment. Alignment of ideologies between core and caseloading staff was a clear goal for

the CI midwives, to move away from the personal silos of disconnected practice, towards a joined up and person-centered model.

5.5 Focus

Challenges | Solutions | Looking for
Focus | Focused | Focused | Direction

Challenges Focused

Initially discussions with the midwives predominantly centred on the challenges of MCoCer and a lack of interest in working in this way. This exhibited itself through a focus on barriers to practice change and continuity working to presenting possible solutions to these.

> *I've had a few of those moments when I've thought, how is it going to work? [Gayle]*

Gayle and Lauren also expressed that they thought continuity of carer was not something that women wanted;

> *I don't think they (the women) want choice, I think they want to be told what to do. [Gayle]*

This focus on barriers to MCoCer was noted by myself and Hayley as certain midwives in the group trying to protect the status quo of current practice.

> *Though ultimately I feel we have come to a consensus about how we wish to work in the future, I felt certain situations were difficult when feeling that some midwives wished the system to stay the same and did not feel comfortable with a change in role…[Hayley- evaluation]*

Solutions Focused

The midwives appeared to engage more positively with the inquiry and the concept of practice change as the informational outcomes became more tangible. As commented by Lauren;

> *I feel like the framework produced provides a map or guide for how the model might work which is positive [Lauren-evaluation]*

This outcome was seen as a tangible result of the midwives' input in the inquiry, which was helpful in creating positivity and shared grass-roots vision. While there continued to be concerns for members of the group about the realities of working in this way, the focus on the framework provided a positive and solutions focused way of engaging with the proposed practice change.

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Louise commented that the framework provided structure to support them at an individual level in a MCoCer model of their own design. However, Lauren was concerned with the term 'flexible working',

> *I think most midwives are worried that 'flexible working' means for the service and not for them, they are concerned that they will be asked to work all hours and called in whenever. [Lauren]*

This led to a change in wording for the framework, to 'self-rostering' and 'action-based work' to ensure that it supported the midwives and their self-determined working practices.

Looking for Direction

During the final reflective meeting the midwives expressed continued apprehension for their future due to the uncertainties surrounding the practice change. While the CI midwives had worked together to develop solutions for a MCoCer model, Lauren highlighted that the proposed practice change was not a choice;

> *I started the inquiry feeling upset about moving from a job that I trained for and love to one that was never wanted including the on call [Lauren-evaluation]*

Practice change inevitably challenges the status quo which is difficult for all involved, especially when the change was not proposed by the midwives it will affect. The uncertainty of MCoCer working, in particular a lack of first-hand experience or information or updates from management meant that the midwives felt unable to know what to expect or plan for. As Hayley reflected in her evaluation of the inquiry (Figure 46).

Figure 46. Evaluation Phase Four [Hayley]

Most of the discussions appears to be of anxiety regarding how it will be shaped, whether it will be supported enough to be maintained and whether as midwives we will be genuinely autonomous or feel pressured and in fear of litigations that informed choice and evidence based practice will be hazed.

This fear of the 'unknown' and a lack of control about the practice change was directly linked with the concept of autonomy and empowerment, as discussed in the following transformational thread.

5.6 Autonomy

I think the key for me is being supported and empowered to support women
[Charlie- email correspondence]

Autonomy → Perceptions of Hierarchy → Supported → Empowered

Perceptions of Hierarchy

The interactions in the early stages of the inquiry indicated that the midwives lacked confidence to self- direct. This was noted in my initial reflections about organising the first meeting (Figure 47).

Figure 47. Reflective Diary excerpt pre-inquiry

Summary of week
Recruits are 'rule based professional group'-
Recruitment and participation process is reflective of the discourse in the literature.
Midwives who do not have autonomy find it difficult to make decisions and choices for themselves. The provision of choice for meetings was met with uncertainty by 2 who responded and half did not reply. No out of hours meeting times were accepted despite being paid working time and easier to accommodate. Shows that the midwives are not accustomed to flexible working and are not keen to work outwith typical working hours. All midwives at this stage of recruitment are community midwives and have chosen to work in this area perhaps because of the lack of out of hours commitment.

My own interpretation of this was that inflexible models lead to inflexible professionals, meaning that the midwives expect to be informed how to work and therefore struggle with autonomous decision making. Comments made by one of the midwives in the early stages of the inquiry outlined their own perceptions of the current organisational structure and their place in it. Gayle made this comment in relation to designing our own solutions to MCoCer several times;

> *But what are they going to make us do though? [Gayle]*

The discussions we had around professional autonomy and working practices indicated that the other midwives also felt disempowered and unable to self-direct in their current role, or the current organisational structure. This was reflected in the way the midwives deferred to me as the facilitator during Phase One and their initial expectations of me as the facilitator. It appeared that I was expected to provide answers regarding MCoCer and the plans for their future working. My reflection on the first meeting was that the midwives did not embrace the concept of the CI for them to co-create solutions from their perspectives (Figure 48).

Figure 48. Meeting notes Phase One

My overwhelming feeling is that the point of AR methodology was missed, the purpose of the action phases and the need for us to all have input to gain control over our working conditions.

The midwives identified that they did not feel autonomous in their working practices in the current organisational structure of NHS Grampian. The hierarchical nature of the current system was an established power dynamic which did not allow the midwives to practice autonomously. This caused me to reflect critically on my own role within the inquiry and my position of power as the facilitator. Figure 49 gives as example of this critical reflection and subsequent adaption of my facilitation style.

Figure 49. Reflective diary excerpt- reflection on Phase One

After listening to the audio dialogue it became clear that the aim and reason for creating group themes was not communicated clearly to the midwives by myself as the facilitator until after the process was complete. To prevent this happening in future it was discussed as a group with the decision made co-operatively to ask 'The 5 whys' of any of the participants in the inquiry at any time if the meaning or purpose were unclear until understanding is established.

The 5 whys and devil's advocate procedures (Project Connection 2018; Appendix E) were implemented to enable all members of the group to challenge each other and particularly myself on our ideas. This was to assist authentic collaboration and development of genuine transformation for the CI midwives. As the inquiry progressed the contextual knowledge of the midwives' and their position as employed midwives in the area we were researching

Supported

The development of confidence was supported from Phase Two through the power of storytelling and through the use of open questions. In this way the midwives were invited to speak as experts in their own field, to build confidence and ownership of the inquiry. The use of personal experiences in practice allowed the midwives to talk more freely about a topic they were confident in and passionate about. The development of confidence was not a simple progression, or uniform. While the CI midwives developed confidence to express themselves and felt more comfortable to do so, their perceptions of the caseloading role and their professional autonomy continued to be challenging for some.

Some of the CI midwives expressed strong boundaries on their practice which seemed to stem from fear. This fear involved a lack of experience and perhaps confidence in their skills or abilities, a fear of litigation and lack of support from more senior members of the team which they clearly sought. Several of the midwives expressed that care for women outside of pathways was outside their remit

as a midwife and they did not have the knowledge, nor seemingly the desire to care for women in these situations as evidenced in Figure 50.

Figure 50. Email correspondence [Louise]

> Additionally something which has come up in the last few days has made me think that we possibly need clearer guidance for women around in what circumstances we will/will not attend a home birth, e.g. non-cephalic lie, unsafe home environment (violent/mentally unstable women or partner), etc. Our safety, professionally and personally, has to be paramount and this is an area where we need to be completely supported by management. We should be supported to refuse a homebirth if we don't feel safe! I feel that this should go in our Framework so that we are all clear and there are no blurred lines between teams.

This theme precipitated several conversations over the course of the inquiry about perceptions of risk and relative to this, professional remit of a midwife, skill set and woman's choice. Despite the co-decisions made for the Team Charter which appeared to highlight informed choice for women supported by professionally autonomous midwives responsible for their care, the conversations about these aspects did not evolve through the inquiry. This indicated that while the midwives wished for shared philosophy to be the reality, that their own ideology or that of the institution did not support their autonomy. For the midwives who had not worked in MCoCer models they were not able to perceive the way continuity supports empowerment for women. I reflected that the midwives did not feel empowered and so could not enable women to feel empowered to make choices for themselves. Despite this it became evident in the inquiry that a sense of empowerment was emerging.

<u>Empowered</u>

The evaluations highlighted the inquiry strengths in building confidence through knowledge about MCoCer meanings and models through involvement in the inquiry.

> *Personally, I feel It has made me feel more optimistic and open to the Best Start plans due to the thought of it considering what we, as those who will actually be doing it, having it fit to what we would like and prefer [Zoe]*

This became most evident in Phase Three through the email discussions about the framework development and its presentation to management. Figure 51 gives an example of this empowerment, as Hayley identified the autonomous nature of our professional role as midwives.

Figure 51. Email correspondence [Hayley]

After reading the attachments and comments in the following emails, I have a few notes.

Firstly, I really think we should trained in NIPE, though we need to factor this into the time spent on first visits when they have not been done by a paed within the hospital.

In my previous job, midwives (both hospital an community) were trained in newborn examinations to promote continuity and the flow within the hospital.
The labour ward often has women who want an early discharge waiting hours over for a paed to get around to the ward.
Within a community setting, this would allow the community midwife to do the baby checks after home births, BBAs, early discharges that were not seen within the hospital. Since the midwife would be going out to visit on day one, this would be combined into the visit.

I reflected that this change in language and general sense of confidence of the CI midwives showed the progression of the group. As the CI midwives felt supported and empowered themselves, they wanted the same for women,

I do think women need to take more responsibility, it is their choice [Lauren]

This quote gives shows Lauren's personal progression within the inquiry from a position of believing women wanted to be told what to do, to feeling her role was to empower woman's choice.

Reflecting on the meeting with the managers in Phase Three, Louise commented that it had been a responsive process, that she felt listened to and heard. Lauren agreed and commented that the presence of people in senior positions in midwifery both within the NHS and at the university increased confidence that their views were being heard, understood and importantly supported. Both midwives noted that the buy in of the managers to their framework was integral to its implementation and success. Louise commented that the presence of midwifery managers and team leaders made the concept of them self-directing their own work structure 'believable'. This was also reflected by Hayley;

*I felt the managers were very supportive as a group, we came together well in the
end as the bigger picture emerged. [Hayley]*

While this continued to highlight the dependence and belief in a hierarchical model, the supportive presence of the managers did empower the CI midwives to feel their views were important and valued.

In the final reflective meeting an attempt was made to continue momentum for the transformations the midwives experienced by proposing the possibility of ongoing action. Zoe decided to pursue her personal dream to work in New Zealand, and Hayley made a plan to enable her to work

*…to pass my driving test within the year so that I might be considered if 'best start'
and NHSG consider rolling out a pilot. [Hayley]*

Both plans show the journey towards identifying and taking control of their own needs, both personal and professional. However, this was not the case for all the midwives, Lauren and Louise felt unsure how to proceed after the conclusion of the inquiry could not conceive a co-decided action.

> *I think it's difficult to visualise how to keep momentum going when we don't know what is happening with Best Start (in Grampian) or what the plan is for a pilot. [Louise]*

The response to the close of the inquiry from Louise and Lauren intimated that the structure of the CI had provided them both with guidance and support, and without continuation of this they did not feel able to realise their desire for self-directed working.

5.7 Summary of Outcomes

We began the inquiry by defining our views and understandings about continuity of care and carer and its implementation within our own practice. Through the phases of reflection and action we focused on the development of solutions to the challenges we perceived of working in a MCoCer model. These solutions manifested as a Team Charter identifying a philosophy of care and a Framework for a MCoCer model tailored to our needs as midwives working in Grampian. Through the process of developing these informational outcomes three threads of transformation were highlighted;

- Perspectives

- Focus

- Autonomy

These transformational threads were not linear in nature, or singularly progressive but do highlight the beginnings of personal and group change that we underwent through the inquiry process. The transformational developments were perhaps the most important outcome of the inquiry as they highlighted the potential for positive solutions to the challenges of practice change. Equally, confidence in self and empowerment to drive these necessary changes.

The next chapter discusses the inquiry outcomes in relation to what is known about the current Scottish NHS context and the systematic review findings presented in Chapter Two. The second question posed of the research project 'Does cooperative inquiry support midwives to create a vision of practice for a sustainable MCoCer model?' is also addressed.

CHAPTER SIX

DISCUSSION AND CONCLUSION

6.0 Introduction

Traditionally reporting of cooperative inquiries do not include a discussion of the findings due to the epistemological standing of the methodology (Bray et al. 2000). However, to satisfy the need for a critical analysis as part of a Master of Research thesis the themes of the inquiry identified through my personal reflections on the process and outcomes are discussed in relation to the findings of the qualitative systematic literature review reported in Chapter Two. The convergence and divergence of the key themes are identified, and their significance discussed in relation to the aim and objectives of the inquiry. A critical appraisal of the CI process, and assessment of its strengths and limitations as a methodology are then explored. This is followed by discussion on the implications for practice, research, education and policy and concludes by outlining areas for future research and the dissemination plans for this research.

6.1 Critical Appraisal of the Inquiry

While traditional thematic analysis was not undertaken as part of the CI, for the requirement of a Research Masters this section identifies and compares the findings of the CI and the Systematic Review to determine their commonalities and differences. As such this critical analysis has been undertaken by myself, reflecting on the outcomes of the CI and the findings of the Systematic Review. The themes discussed represent the key findings of the iterative process of the CI, our motivations and the outcomes we co-created. I now discuss these themes, their origin from the work we co-created and how they interrelate with each other and the findings from the qualitative systematic review.

The central theme of the inquiry identified through our discussions and the Phase One exercise 'Positives and Challenges' of MCoCer practice was **Balance. Balance** was identified as work-life balance for the CI midwives and the importance of addressing their needs alongside women. The development of systems to address and support life balance for the CI midwives and their needs alongside women were central to the inquiry aims and guided the development of our co-created outcomes. To achieve work-life balance the CI midwives identified that they would need structured

solutions to ensure regular designated time off and prevent gradual invasion of work into their expected personal time. This manifested in the form of the Team Charter and MCoCer Framework. These key documents are identified as **Structure to Support** which enable the central aim of **Balance** for the CI midwives.

Analysis of the key documents which represent **Structure to Support** in the CI along with the transformational themes identified four key themes: **Solutions for Practice, Personally Relevant, Self-Determined** and **Whole of Organisation Support** (Figure 52). These themes were derived from the ongoing critical reflection on each phase of the Inquiry and the transformational threads which ran through it.

Figure 52. Themes of the CI

Solutions for practice elements to ensure effective structure was an important aspect of the Framework, and Team Charter for a sustainable model.

This theme highlighted the importance of strategies that are contextually and personally relevant for midwives.

Solutions for Practice

Personally Relevant

Structure to Support

BALANCE:

A person-centred model incorporating women's and midwives' needs to support work-life balance

Whole of Organisation Support
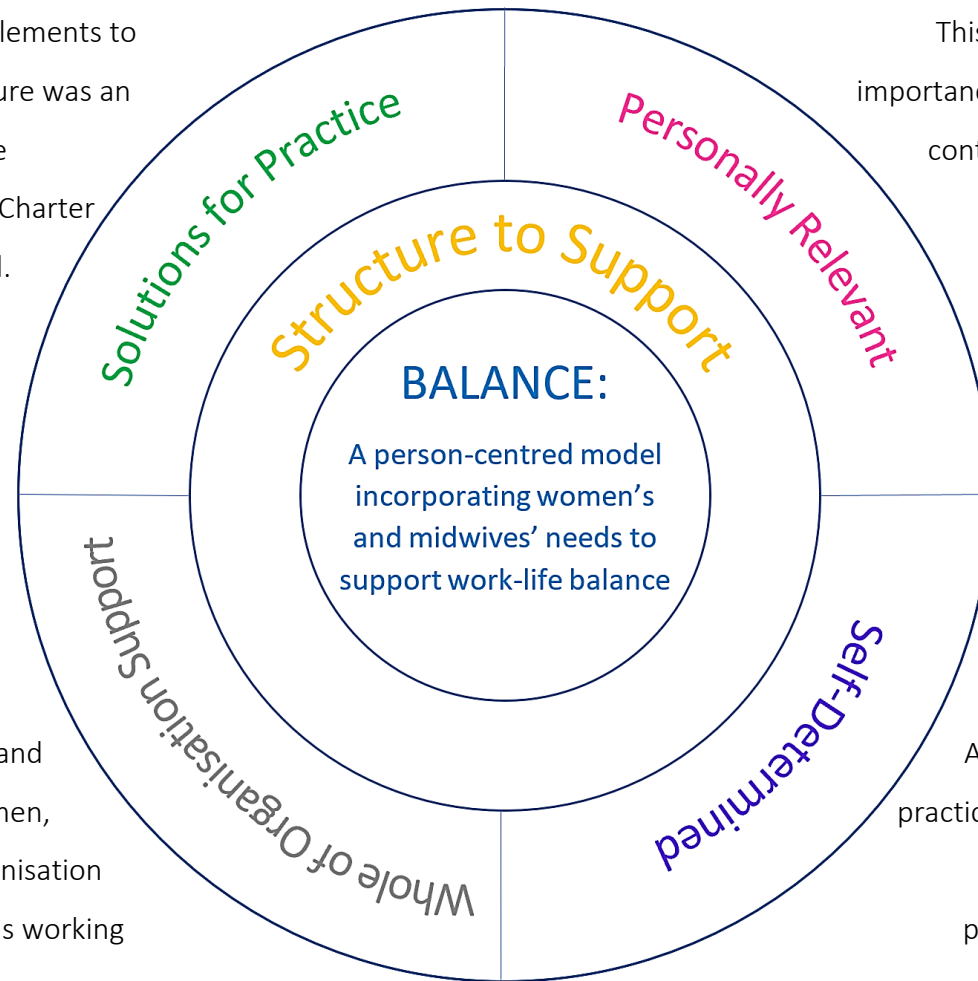
Self-Determined

Alignment of purpose and ideology between women, midwives and the organisation to support autonomous working and self-determine.

Autonomy over working practices was identified as an important factor for positivity and security in their midwifery role.

The meaning and significance of the CI themes and how they relate to the findings of the systematic review will now be discussed in turn. Table 23 presents the themes identified in the systematic review which will be referred to in the appraisal of the CI themes. Italics have been used for the systematic review theme names and themes from the CI are in bold to assist differentiation.

Central Theme: Balance

For the CI midwives the greatest concern with implementing MCoCer practice was balance between work and personal life and ensuring that there was a distinction between the two. The achievement of **Balance** was one of the key motivations identified by the midwives for engaging with the inquiry, and continued to be of central importance to the CI and the outcomes we co-developed. The 'Shared Philosophy of Care' exemplifies the central theme of **Balance** and acted as guiding principles for the design of structures to support balanced practice in reality for the CI midwives.

As part of our discussions about balance, concepts of woman-centredness and person-centredness arose. Woman centredness was identified as the core concept of midwifery care and MCoCer models, interestingly concurrent with the findings of McCourt and Stevens (2006) who stated continuity of carer is not simply an end in itself, but a facilitator of woman centred care as the core concept of midwifery. The CI midwives discussed extending the concept of woman-centredness to recognise the importance of the midwife's own needs within the care model design. The 'Shared Philosophy of Care' co-created in the CI related to a person-centred model which considers the contextual and personal needs of the midwife alongside that of the woman, described as 'happiness for all'.

Concerns about work-life balance in the CI follow national trends as identified in the WHELM study (Hunter et al. 2018) and Kings Fund Staffing Reports (Sandall et al. 2011), and in the Systematic Review theme *Counting the Personal Costs*. This indicates that midwife needs are often overlooked across models of care, leaving them feeling undervalued and limiting their ability to meet the needs of women in their care (International Confederation of Midwives et al. 2016). As stated by Shallow (2016), until midwives are valued, they will not be able to value childbearing women in their care.

Structure to Support

During the CI process we explored our ideas about the 'Positives and Challenges' of MCoCer which identified the most significant concern about work-life **Balance.** Objective 2 of the inquiry was to co-create effective support systems to negate these challenges or 'personal costs' whilst working on supporting strategies for improving the positives or 'joy of practice'. Fourteen of the seventeen studies from the qualitative systematic review recognised that there were both positive and

challenging aspects of practising in continuity models (Browne et al. 2014; Cox and Smythe 2011; Donald et al. 2012; Edmondson and Walker 2014; Engel 2003; Fereday and Oster 2010; Gray et al. 2015; Jepsen et al 2016; McCourt and Stevens 2006; Newton et al. 2016; Rawnson 2011; Sandall 1997). The convergence of findings between the CI and the systematic review for person centred models indicates that self-care is a considerable concern for midwives across all models of care. Fifteen of the studies from the qualitative systematic review (Browne et al. 2014; Cox and Smythe 2011; Donald et al. 2012; Edmondson and Walker 2014; Engel 2003; Fereday and Oster 2010; Gray et al. 2015; Jepsen et al 2016; McCourt and Stevens 2006; Newton et al. 2016; Rawnson 2011; Sandall 1997; Moore 2009) identified strategies which the midwives employed to maintain their work-life balance and address their own needs in order to maintain them in MCoCer. As expressed by Engel (2003):

> Keeping the balance between job satisfaction and setting boundaries around one's practice was seen as integral to the sustainability of practice by each of the participants...(p.14)

The strategies that midwives identified in these studies negated the challenges MCoCer posed, and supported the positive aspects of continuity for midwives and women. While these strategies were individually sensitive and therefore unique to each study, the commonalities involved for self-determination of working practices and supportive structures which combined to support work-life balance for the midwives. Further analysis of the informational outcomes of the CI led to the identification of four key elements within the **Structure to Support.** These were **Solutions for Practice, Personally Relevant, Self-Determined** and **Whole of Organisation Support** which are discussed in turn below.

Structure to Support: Solutions for Practice

This sub-theme identified the importance of supportive structures which addressed the practical elements of MCoCer working. Identifying solutions to the challenges that concerned the CI midwives was both positive for them in the short term, as reported in the transformational theme *Focus*, and long term, as they realised the potential that the Framework would have to support them. These were reflected in the practical solutions outlined in the Framework (Table 22 p.120) which included the practice elements:

- Caseload size, makeup and allocation
- Number of on calls
- Contact method

- Caseload role

- Managing commitments

- Unexpected Leave

- Professional Support

- Hours worked/Protected Time off

The theme *Strategies to Sustain* from the systematic review mirrored the importance of practical solutions to maintain successful MCoCer practice. The strategies identified in the systematic review were:

- The size and makeup of caseload

- On call: number and managing workload the day after

- Contact method

- Protected time off

- Safe working hours

- Shared expectations with colleagues

- Expectation setting with women

- Agreed plan for sickness, maternity leave and long-term staff recruitment and retention

The similarity of the practical elements between the CI and the systematic review identifies that all these midwives identified key considerations for sustainable MCoCer practice. These practical solutions all related to the theme of *Defining Professional Boundaries* from the systematic review and the practice element 'Setting expectations with women' from the CI. As identified by Lakshmin (2018) the very nature of healthcare is aimed at caring for others, which can be exploited either by the organisation or other people and often comes at the expense of personal needs. She goes on to say that we do not need self-care to promote resilience in the face of adversity, but boundaries to create sustainable ways of working. The development of professional boundaries is a proactive step to facilitate sustainable working environments and promote balance for midwives as identified by Donald (2012). This is significantly important for the success of MCoCer working and sustainability of the model.

The approach to defining professional boundaries was the area of greatest divergence between the systematic review and the CI. The CI midwives identified the organisation as the responsible party for the protection of their professional boundaries, whereas the strategies identified in the systematic review were developed and implemented by midwives to protect their own work-life

balance. The divergent approach between the two largely relates to the difference of perspective. For the CI midwives approaching MCoCer from an organisation which was hierarchical in nature, their working practices were determined by the institution and they could not perceive truly autonomous practice or self-determination. For the studies included in the review, the midwives were already working in woman centred MCoCer model of care and were therefore practising autonomously and able to self-determine to various degrees according to the specific organisation they worked in. To address this question of the 'unknown' for the CI midwives of working in a MCoCer model, the Framework was developed with the contingency to support flexible strategies to adapt the model to answer future realities of MCoCer. This was also addressed through the nature of the CI itself which supported the development of contextually and personally relevant solutions co-decided by the midwives.

Structure to Support: Personally Relevant

The process of developing a Team Charter and Framework for a MCoCer model highlighted the need for solutions which were contextually and personally applicable to the CI midwives. The importance of personally relevant solutions was reflected in the qualitative systematic review *Flexibility and Structure.* This convergent finding indicates that contextually and personally relevant solutions for practice are important both in the design and implementation and sustainability of MCoCer models. This is congruent with the ideological stance of MCoCer to promote the individualised care for women to support their needs, again supporting and highlighting that the model also needs to address the needs of midwives in an individual way (Crowther 2017). The central theme of Balance discusses the concept of person-centred models for MCoCer to satisfy the need for individualised care and working arrangements for sustainability.

 The State of Maternity services report (RCM 2018a; 2018b) identifies that dissatisfaction and attrition of midwives is an ongoing concern for the NHS. Morale is low and action is needed to change the conversation and reality of maternity services to align with a person-centred model of care. While there is a clear and distinct need to listen to midwives, these reports do not identify them as stakeholders who should be directly part of changing their circumstances:

> *The NHS, the Scottish Government, the RCM and others need to keep working together to identify these challenges and tackle them as best we can. [RCM 2018b p.4]*

Whilst the dialogue from RCM and other governing bodies continues to focus on a top down approach to practice change, it is unlikely that working practices will be personally relevant to the midwives working in them. The evidence from the systematic review and CI have shown that

solutions determined by midwives enables them to continue in practice. In order to do this midwives views must be considered and integrated within the MCoCer models to support their self-determination of professional practice. Support of self-determination is therefore a key recommendation for sustainable midwifery practice and implementation of MCoCer in the UK.

Structure to Support: Self-determined

The sub-theme **Self-determination** within **Structure to Support** was highlighted as an important feature of the Framework for the CI midwives as reported in the transformational thread **Autonomy** (p.130). The systematic review themes *Real Midwifery* and *Flexibility and Structure* identified the importance of professional autonomy over working practices in MCoCer for nine of the studies (Browne et al. 2014; Edmondson and Walker 2014; Engel 3002; Gray et al. 2013; McCourt and Stevens 2006; Newton et al. 2016; Rawnson 2011; Sandall 1997; Moore 2009). Crowther et al. (2016) also discussed the extent to which midwives have control over their immediate environment, directly relates to making their practice sustainable over time. For the New Zealand studies included in the qualitative systematic review (Cox and Smythe 2011; Donald et al. 2012; Engel 2003; Gilkison et al. 2015; Hunter et al. 2016; McAra-Couper et al. 2016) the midwives had capacity as self-employed professionals to organise and structure their working practices. However, the nature of their relationship with women meant that they had the potential to over-invest and not draw professional boundaries to sustain them. In the other studies included in the review, and indeed for the CI midwives, the midwives were paid employees and therefore their working conditions and boundaries on practice were set by the institution. These studies highlighted a distinct lack of self-determination over working practices which was reflected in the CI. The RCM (2008) has queried whether midwives are truly autonomous or whether our professional description purely rhetoric. Certainly, professionally autonomous practice is challenged by the current structure of maternity services in the UK and medicalisation of childbirth. Dixon-Woods et al. (2014) describes the NHS as a hierarchical and bureaucratic organisation, within which genuine transformation is difficult to achieve and rare in reality. While the CI assisted personal and group empowerment through emancipatory action it was limited by the organisational culture in which the inquiry took place. The systematic review theme *Working in a System* identified the difficulty of providing woman-centred care as an autonomous professional in an organisation not aligned with these goals.

Structure to Support: Whole of Organisation Support

Tracy (2010) refers to the notions of midwifery and birth as 'sustainable public good' which cannot be reconciled within a purely economic model of care. This concept relates to the organisation of maternity care and importance we place on women in society as a whole, and by association their

pregnancies, births, motherhood and those who assist these processes. When maternity organisations are not aligned with the ideological position of midwifery it creates conflict for midwives trying to provide care in a person-centred not institutionally focused way. The dissonance between what midwives want to provide, and what the organisation wants them to provide was identified as a source of conflict in the review theme *Working in a System*. This reflects findings by Shallow (2016) and Hunter (2004) that the conflicting responsibilities of midwives to answer to the organisation and to women who have different agendas is impossible to negotiate without experiencing dissonance. Both the CI and the systematic review identified that the reality of practice is typically organisation focused rather than person centred ones as reflected in the transformational thread of **Autonomy** (CI) and *Working in a System* (Systematic Review).

The transformation thread of **Autonomy** also outlined the midwives' views about the current hierarchical nature of the local maternity system. The idea of leadership 'buy-in' to the Framework for MCoCer was significantly important for the CI midwives, therefore the collaborative meeting with the managers was a highly valued element of the inquiry. The CI midwives recognised that their needs would not be met without the understanding and agreement of the organisation.

Figure 53 represents the current structure of maternity services in Grampian as outlined through reflective discussion in the CI.

Figure 53. Current structure of maternity services
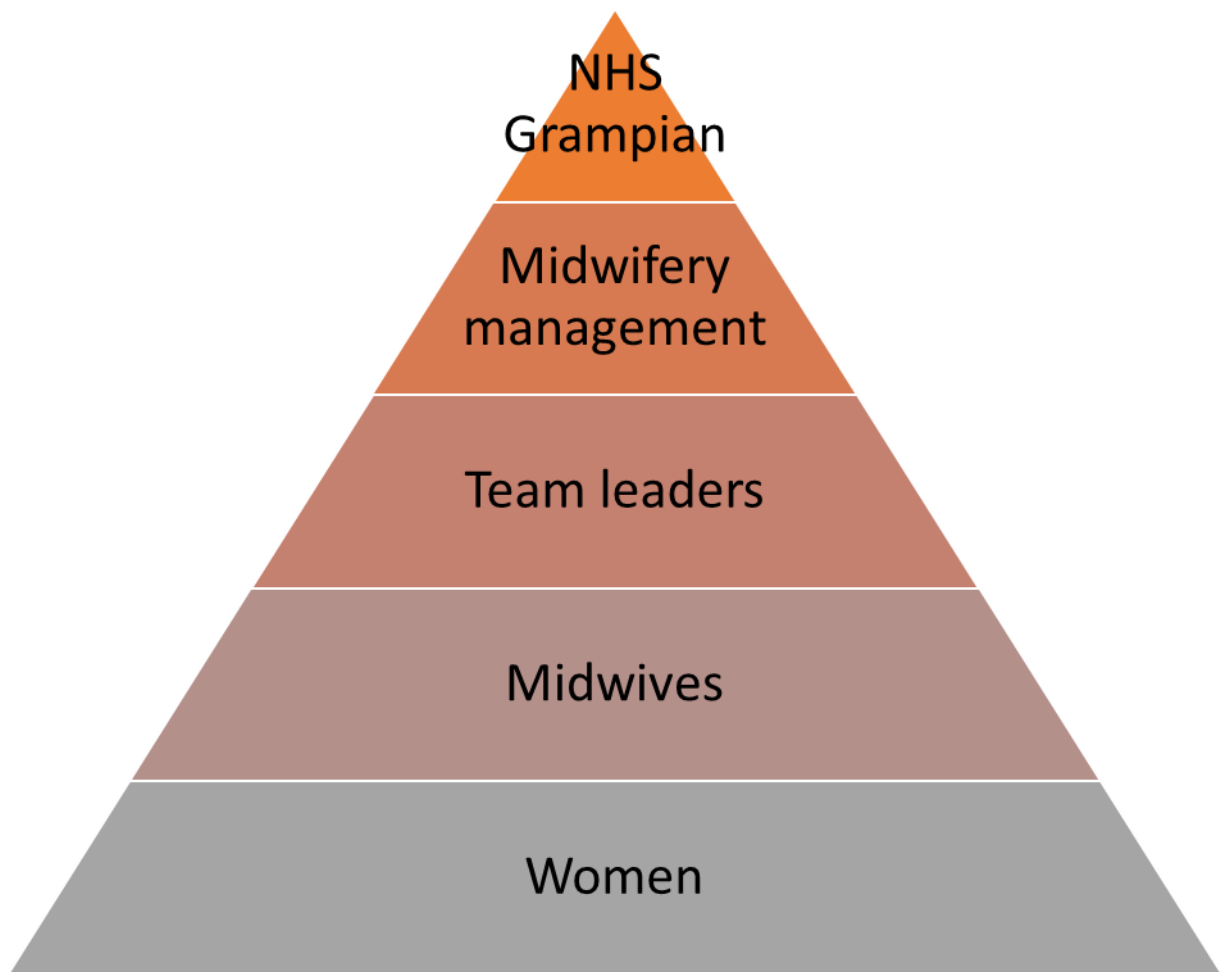
The transformational theme **Perspectives** identified that connection developed through 'knowing people' engendered understanding of other people's experiences, reducing personal silos and creating an environment conducive for collaborative working. The success of collaborative working in maternity services has also been highlighted by Shallow (2016).

The concept of 'coming together' to answer the needs of those who are central to the story; women as the focus and midwives as the facilitators, is key to success of midwifery models. A person-centred approach which recognises the needs of women and midwives as the key stakeholders in MCoCer models is necessary to change the current prevalent discourse of fragmented institutional focused maternity services. The studies included in the review which reported successful and sustainable MCoCer practice identified 'the whole of the organisation support' as a key factor. This included support of the midwives to work autonomously, both in their clinical decision making and self-determination of working practices, and alignment of ideologies between women, midwives and the organisation (Moore 2009).

Within the 'Shared Philosophy of Care' the person-centred practice approach focused on understanding and reciprocity between both midwife and woman and between colleagues. This was qualified through the Team Charter in the practice elements of 'Setting expectations with women' and 'Team working'. The importance of mutually reciprocal relationships between women and midwives was also identified in the systematic review theme *Knowing and being known.* This concept has been previously identified by Leap et al. (2010a) as, 'Relationships- the glue that holds it all together'. Reciprocal relationships with women and recognition and value of the investment of the midwife within a continuity relationship were identified as sustaining factors for MCoCer practice in the systematic review by all the studies except Donald et al. (2012) Fereday and Oster 2010, Gilkison et al. 2015 and Hunter et al. 2016. Likewise, the importance of reciprocal relationships and shared expectations with colleagues were identified as key for sustainable working through the theme *Community of Practice* (Browne et al. 2014; Cummins et al. 2015; Donald et al. 2012; Edmondson and Walker 2014; Engel 2003; Fereday and Oster 2010; Newton et al. 2016; Rawnson 2011; Sandall 1997; Moore 2009). Walsh (2006) described this concept as lasting and trusting collegial relationships and social capital necessary for effective team working and sustainable practice. Indeed, the significance of context and social capital, including reciprocal working relationships in caseloading rural midwifery has been emphasised as key to safe practice (Crowther et al. 2018). The importance of these reciprocal working relationships in MCoCer models has been identified as a 'generosity of spirit' (Hunter et al. 2016), and is considered as an important attribute for sustainable MCoCer practice arrangements. It can be construed by this theme that midwives working together in MCoCer practices need to be aware and be considerate of each other's needs and share similar values.

6.1.1 Summary

The key similarities between the CI and the qualitative systematic review were the identification of potential and actual challenges of MCoCer working and the need for strategies to mitigate these. Both the CI and the qualitative systematic review were most concerned with creating work-life balance. The convergence of considerations and potential solutions for MCoCer between the CI and the qualitative systematic review indicates that there are key practice elements which should be considered for midwives setting up, and sustaining MCoCer models. These key practice elements are identified in the informational outcomes of the CI in the Shared Philosophy of Care, the Team Charter and the Framework for a MCoCer model. While structure was clearly an important element of sustainable practice, the importance of personally relevant and self-determined solutions was key

to its success as shown through the qualitative systematic review findings and the evaluation of the CI.

Both themes were initiated from a sense of cumulative unreasonableness, however for the CI midwives it was the organisation who was responsible for increasing their workload, whereas for the systematic review it was a lack of self-implemented boundaries by midwives in MCoCer which prevented effective work-life balance.

6.2 Thesis of the thesis

Figure 54 is a pictorial representation of the thesis conclusions. It indicates the importance of the midwife-woman relationship which is key to the maternity journey and the need for connection and ideological alignment between all of the parties involved.

Figure 54. Model for person-centred midwifery
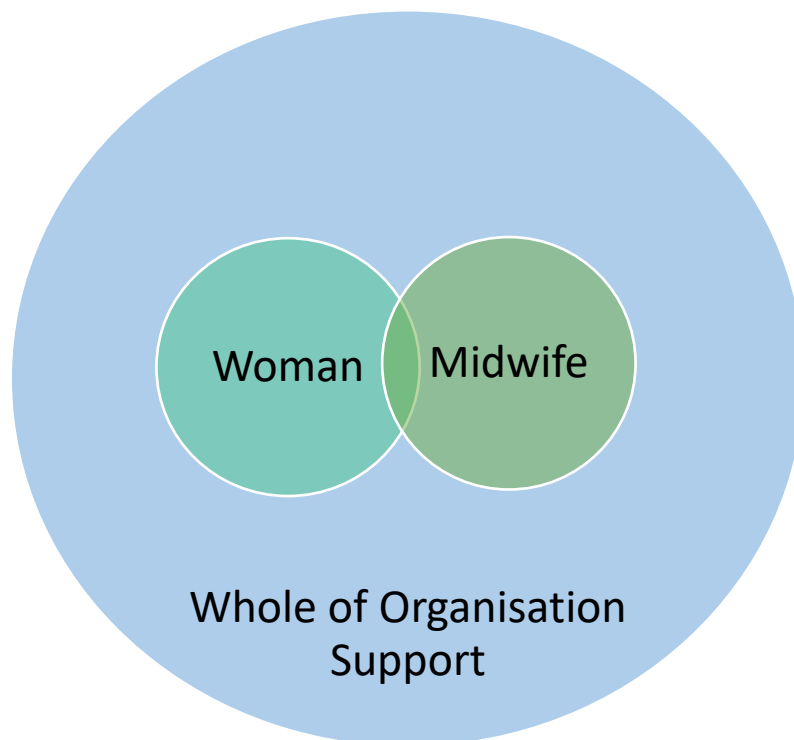
Development of mutually reciprocal and meaningful relationships with women and colleagues have been identified as the key to sustaining MCoCer for midwives. A seeming paradox is that meaningful relationships with women can make it difficult for midwives to negotiate professional boundaries on their practice in order to address their own needs. The systematic review and CI both highlight how professional boundaries are crucial for sustainable MCoCer practice, to enable the positive aspects of continuity which sustain and mitigate challenges which cause stress. In order to do this, midwives must be enabled to self-direct and create their own contextually and personally relevant solutions. A shared vision and ideology of the whole of maternity services organisation for person centred practice will help ensure that the needs of women and midwives are met and MCoCer models are sustainable.

6.3 Validity of the Inquiry

The success of a CI is judged by its catalytic validity, or ability to change a situation in a positive way as perceived by the inquiry participants (Lather 1991). The aim of the inquiry was to engage midwives to co-create a vision for a MCoCer model relevant to them. The objectives of the inquiry were:

1. To explore the midwives' views about continuity of care and carer and its implementation within their own practice.

2. To co-create solutions based on these views which support the CI midwives.

3. To evaluate the inquiry and its ability to support midwives in the current practice change.

Objectives 1 and 2 were addressed through the collaborative development of the Team Charter (Table 21) and Framework for a MCoCer model (Table 22). These outcomes evidence the successful engagement of the midwives in developing co-designed solutions which were relevant to them. Objective 3 was addressed through evaluations of the inquiry by the midwives at Phases Two, Three and Four which informed the write up of the transformational outcomes. The CI midwives underwent considerable transformation in a short period of time and evaluated the ability of the CI to address their needs as positive. There were factors which affected the extent of transformation and the outcomes we were able to achieve together during the inquiry.

This section discusses the validity procedures outlined in the Methodology Chapter which were undertaken to promote trustworthiness and validity (Heron 1996).

1) Balance: reflection-action
2) Balance: order-chaos
3) Research cycling
4) Critical subjectivity
5) Equitable collaboration and Authentic participation
6) Member checking
7) Audit trail
8) Authentic representation
9) Evaluation: the process and outcomes.

<u>1) Balance: Reflection/Action</u>

The reflective meetings were well attended by the CI midwives until the final meeting as outlined in Chapter Four. This provided an ideal space and time to reflect effectively on the topic and the actions we had undertaken. While the midwives engaged enthusiastically with the reflective element of each phase, the action part of each phase was not always approached with the same interest or investment. The use of open questions and story-telling were effective at engaging the midwives in their own rhetoric and developing new understandings, however there was a lack of self-direction in suggesting actions and was often referred to a 'homework'. For the CI midwives who did not choose to engage with the group action it reduced the development of new understandings and transformative power of the inquiry for them personally.

<u>2) Balance: Order/Chaos</u>

As the facilitator and instigating researcher, I designed and invited the midwives to participate. The first phase was also quite directed by myself to initiate the flow of ideas and set a direction for the inquiry which we all agreed on. The structured (Apollonian) elements of the inquiry meant that our ideas were generated quickly and allowed for quick progression of outcomes which was positive in a time pressured study. Once the aim of the group was established, I was able to create space and time for unstructured dialogue between the group to challenge and reconfirm our perspectives and understandings. In retrospect a preliminary session to create direction before the inquiry began could have been a more successful approach and may have allowed for increased freedom with how we approached the topic as a group. The Dionysian (more unstructured) storytelling component of dialogue was the most authentic element during the early stages and may have supported more authentic participation of the midwives throughout if the inquiry had been less structured.

<u>3) Research Cycling</u>

 Decision making was an ongoing process of reflection and action. The iterative process of reflection cycles allowed us to revisit and reaffirm our views and solutions for a MCoCer model several times. This reconfirmation process in each phase following the generation of new knowledge, meant that the outcomes of the inquiry were products of layers of reflection and therefore truly representative of our views as a group. Revisiting the same themes allowed us to establish strong connection to each practice element within the final framework and justify its inclusion.

Research cycling also allowed for the development of our critical reflection skills, as we developed deeper knowledge and awareness of MCoCer practice and of each other's views, the midwives began to question their own pre-conceived ideas.

4) Critical subjectivity

The awareness of the midwives' own contextually and personally relevant ideas developed through the inquiry as discussed in the transformative outcome *Perspectives* in Chapter Five (p. 125). The use of the 5 Whys and the Devil's Advocate procedure to challenge our own personal silos was useful for initiating the process of critical reflection and reflexivity (see Appendix E). The reflective language which began to be used as the midwives became more aware of self and others evidenced the beginning of their journey to appreciating their own and others perspectives. The meeting with the managers also provided a platform for further self-reflection, both in the meeting itself and following when we reflected as a group.

5) Equitable collaboration and Authentic participation

These two elements are reported together due to their mutual connectivity. Authentic Participation was the chief concern for the success of the inquiry as CI is research '*with not on people*' (Heron 1996). This included the considerations of the engagement of the midwives with the inquiry, whether the process was truly collaborative including my own ability to facilitate authentic collaboration. The engagement of the midwives fluctuated throughout the inquiry, I reflected that this was due to two core reasons;

1. Due to the nature of their professional everyday responsibilities as clinical midwives.
2. Whether the midwife felt that the inquiry provided personal gains for their contribution.

These two factors led to significant attrition in the final meeting of the inquiry. Reason one was an inevitable and unavoidable factor for engagement issues because clinical need was always a priority over the needs of the inquiry. Reason two appeared to be related directly to the personal beliefs of each midwife and whether these were addressed by the direction and outcomes co-decided as a group. Moreover, this inquiry was about changes in local practices and any practice change inevitably challenges the status quo which is often difficult for all involved, especially when the change was not proposed by the midwives it will affect. For several of the CI midwives', protection of the status quo was not facilitated by the inquiry, hence it could be construed that this contributed to their increasing lack of engagement. Another potential reason for lack of engagement related to personal gain was a lack of belief that the CI would genuinely affect change for them in NHS Grampian. This was raised in the inquiry as '*what will they make us do?*' [Gayle] which highlighted the oppressive nature of disempowering leadership.

Due to the initial Apollonian (formal organisational and structured) design of the inquiry, the perceptions of the midwives and my role as the instigating researcher and facilitator my position was unintentionally one of power. This was something I reflected on throughout the inquiry and adopted facilitation techniques to address the power dynamic and enable authentic collaboration (Loewensen 2014). One of the ways we successfully achieved this was through a Dionysian (less structured and informal enabling more creative) approach to the start of each reflective meeting, asking open questions and using storytelling to empower and develop the direction of the inquiry collaboratively. However, for two of the CI midwives the perception of my role as an informer rather than a co-inquirer remained, along with their expectation that I would provide answers to their concerns directly rather than support them to collaboratively create them. This seemed to be related directly to the midwives' perceptions of hierarchy within midwifery as well as the inquiry itself, which affected the extent to which they were able to engage or undergo individual transformations.

6) Member checking

While procedures for member checking were employed at the beginning of each reflective meeting to ensure that the collaborated findings from each phase were reflective of the group's views, the midwives did not always fully engage with this. To negotiate this challenge, the devil's advocate procedure was applied when I felt appropriate, and the data and themes generated were re-visited at the end of each reflective session again, to provide further opportunity to discuss them. This seemed effective as once the midwives had 'settled in' to each meeting they became more comfortable within the group and able to present ideas more openly.

7) Audit Trail

The following records were kept and maintained to accurately document and report the process of the CI:

- Reflective research diary
- All data generated with the CI midwives during the reflective sessions
- Audio recordings of the reflective meetings
- Email communications with the CI midwives during Action Phases for collaborative purposes
- Notes and progress logs from supervision sessions
- Curriculum vitae of all training undertaken

These records were kept faithfully and all primary data and photographs of our co-created findings have been stored according to data protection and management protocols (Health Research

Authority 2017; European Parliament and Council 2016; The Stationary Office 2018). Data will be kept for 10 years and is available to the midwives on request. These procedures ensure transparency of the research process.

8) Authentic Representation

The process of writing up the inquiry process and outcomes was managed contemporaneously with each cycle of the inquiry, allowing the meaning making we co-created to be recorded in a truly representative way. The contemporaneous recording also provided an excellent platform for my own reflections and collaborations of the data generated as a group. This was an important step in assuring the validity of the data generated and outcomes we co-produced. The strength of this study is its contextual particularity and orientation to naturalistic generalisations arising from the practice realities of the CI midwives. The practice arrangements required in each midwifery context are variable and bound by local circumstances and therefore empirical generalisations are not claimed in this study. However, while the outcomes of the inquiry are directly applicable only to the CI midwives in one NHS region in the UK, the process and Framework can be used to guide similar groups to co-create their own individually sensitive solutions for MCoCer.

9) Evaluation: the process and the outcomes

Due to the convergent nature of the inquiry the outcomes which we co-developed and revisited at each reflective meeting were genuinely representative of the midwives' views and ideas. The process of member checking further assured that the outcomes were co-created. Evaluations of the inquiry were taken at phases two, three and four to assess the midwives' views of the inquiry, how they felt about the process and to encourage critical reflection of them and myself. The evaluations evidenced the transformational outcomes identified in Chapter Five.

While care was taken to ensure that the CI was undertaken with the upmost standard and ensure quality of the outcomes, as with all research there are strengths and limitations within its process. The strengths and limitations of the CI have been identified in the discussion of its validity and are outlined and summarised in the following section.

6.4 Strengths and Limitations of the Inquiry

Discussion of the validity procedures identified the key strengths and limitations of the inquiry which are detailed in Table 23 and summarized below.

Table 23: Strengths and Limitations of the Inquiry

Element of the CI	Strengths	Limitations
Engagement	• Enthusiastic engagement with the reflective meetings when organised in working time	• Nature of midwifery practice made consistent engagement at all the reflective sessions difficult • Lack of engagement in the action phases as they were seen as additional work and the midwives felt unsure at the level of personal gain for participation
Structure	• Structured (Apollonian) elements of the inquiry enabled quick progression in the time frame	• More unstructured time in the inquiry may have allowed for more authentic participation • The duration of the inquiry was time limited due to requirements of the research Masters
Authentic Participation	• Evaluations of the inquiry throughout provided feedback and enabled effective critical reflection on facilitation, the CI process and outcomes • The inquiry provided a 'safe-space' for midwives to voice their concerns and enable their agency within the process of change	• Current structure of the organisation was not a conducive environment for emancipatory transformation • The design of the inquiry from the perspective of an outside researcher potentially promoted a continued perception of hierarchy for the midwives
Representative Outcomes	• Research cycling ensured the outcomes were truly representative of the group's views • Member checking enabled clear definition of our ideas and challenged our preconceptions	• The outcomes and write up of the inquiry were agreed as group consensus and were therefore not necessarily representative of each individual
Documentation	• A clear audit trail was kept which evidences the whole process of the inquiry	

While there were considerable transformational developments which occurred through the process of the inquiry, due to the time constraints of the project and the starting perspectives of the CI midwives the anticipated full transformational journey was not achieved. Time taken for the study was classed as working time as agreed with management, however the perception of the CI midwives remained that any work outside of their agreed hours would not be honoured. To negate this issue the reflective meetings were held in working hours which did affect attendance in phases 3 and 4 due to the pressures of the midwives' clinical role. A perceived lack of personal gain from the research may also have been a factor in declining engagement, as the midwives could not see the framework they co-created being accepted by the organisation. These challenges to engagement may have been mitigated through a longer inquiry which would have allowed us to deepen the exploration into our preconceptions and challenge our personal beliefs relating to the topic of continuity. Through the process of CI the midwives also identified regular updates and collaborative input with management as factors which would increase midwife engagement with the practice change at a local level in the future.

Group involvement within the action phases of the inquiry were persistently poor, with several midwives referring to each co-decided task as 'homework'. The perception of the actions as 'homework', which were additional to the time taken for the study and the midwives existing workload, was a challenge. As such I took on the role of collaborating and the majority of our outcomes were co-created in the reflective sessions.

While the informational and transformational outcomes of the inquiry clearly show the validity of the CI, the time scale of the research and the current structure of maternity services in NHS Grampian dictated the extent of change we could achieve. The time scale dictated the design of the CI prior to the engagement of the midwives, identifying the project as externally rather than internally conceived. This may have affected the balance of power and authentic contribution at the start of the inquiry, and precipitated the expectation of the midwives for direction in the CI initially.

The ability for midwives to be change agents had a positive effect on their autonomy to design a MCoCer model applicable to them. The inquiry assisted the development of new knowledge about continuity of carer, potential models and a deeper understanding of self and others which were significantly important for collaborative working necessary for positive and sustainable practice. The inquiry was also successful at encouraging multidisciplinary working and open conversations about midwife work practices with management. The increased understandings between midwives and

managers in different roles reduced the barriers of personal silos and engendered mutually respectful working relationships.

However, the hierarchical and medicalized nature of the current organisation identified by the CI midwives was difficult to see past and work round, as it dictated their contextual reality. This affected the extent to which the midwives were willing to engage with the CI and dictated the emancipatory potential of the inquiry. As identified by the CI midwives and in the qualitative systematic review, midwives must be supported to be self-directed and the whole of the organisation must be aligned with the same aim for care in order to establish and support meaningful change.

Both the midwives and management identified elements of practice such as staffing levels in the NHS and salary which were out with the control of local maternity systems and controlled at a country-wide level. The reality of this caused concern for the midwives and controlled the extent to which they felt autonomous about their role and were able to engage with the concept of transformation and emancipation as an outcome of the inquiry.

Member checking procedures and research cycling assisted the co-creation of outcomes representative of our ideas. As the outcomes and write-up were co-decided as a group and agreed through consensus. This meant that while each individual's views were discussed, the final outcome was a mutually agreed solution.

6.5 Personal Reflections

My own perceptions were outlined in the Introduction Chapter to foreground the meaning making process of the inquiry. I now revisit and reflect on my own perceptions and transformation through the inquiry process.

I have felt an overwhelming sense of burden as I complete the write-up to do justice to the findings we co-created as a group, and to communicate the real and pressing need that this Masters research has identified for organisations to listen and respond to the needs of their midwives. The subject and methodology choice were very personal to me, from the perspective of a caseloading midwife and believer in individual significance and social emancipation. My personal belief that midwifery is a person-centred profession and does not naturally fit in to a hierarchical and organisationally focused model was challenged by the setting and the participants in the inquiry who were immersed in such a system. The position of facilitator and co-inquirer was a personal challenge at times as I was hoping for a sense of equality from my co-inquirers, but was initially expected to direct and advise the group. Balancing the role of facilitator and simultaneously encourage the ideas and transformation of the group was therefore a focus of mine throughout.

I began the CI hopeful that it would support emancipation and transformation for the midwives taking part. I personally felt disappointed at the lack of genuine engagement from some members during the CI and related to this the extent of their personal transformations. On reflection of this I was perceiving the transformation from my own perspective, not that of my co-inquirers. The place that they ended was very different from the place that they started and shows that their transformation from their perspective was real and substantial. The CI was only able to empower the midwives to a certain extent due to the hierarchical nature of the system in which the midwives currently work in and which I also experienced as a student and working as a bank community midwife throughout the inquiry. The NHS does not currently support professional autonomy or self-directed working practises, meaning that the transformative power of the methodology was limited to an extent.

My own experiences of the current fragmented model and organisation of maternity services in Grampian reflected the concerns raised by the CI midwives regarding a lack of cohesion and mutual respect or ability to practice autonomously. I missed knowing the people I worked with, both colleagues and women I cared for. I longed for a sense of connection in midwifery and did feel that the relationships developed with the CI midwives provided this to some extent. The ideas of knowing and connection were also important to the group and reminded me of a caesarean birth I had attended while I was a student midwife in Grampian. The woman was a member of staff and therefore known in the theatre. The respect and reverence for the process and at the moment of birth was protected in that space more than any other I had seen. The reason for this, I reflected was knowing. Knowing creates these environments. Knowing creates the connection and the reverence, the special, the individual. It is born of knowing and fuels us in our practice. Knowing is sustenance to our souls.

As the inquiry concluded I was also aware of events occurring locally which involved directed practice change arrangements. It saddened me that this was happening as we were trying to promote the opposite path, and the way it affected the midwives involved. It became clear to me that while the CI had been successful at answering the aim and objectives of the research a culture shift is required in maternity services to support autonomous and self-directed working practice in the future.

6.6 Implications

This inquiry successfully engaged midwives to explore their views on MCoCer and develop individually sensitive solutions for practice which support them. The implications on Practice, Research, Education and Policy are discussed below.

6.6.1 Practice

The findings from both the qualitative systematic review and the CI clearly show that midwives must be valued and have their needs met to ensure their ability to meet the needs of women. The concept of 'value' discussed in both the systematic review and by the CI midwives had both emotional, physical and financial aspects. Both the CI midwives and midwives in the included studies discussed the importance of financial recognition for their continuity role and support of their emotional and physical needs to sustain them in MCoCer. As identified by Filby et al. 2016 there has been a lack of investment in midwifery due to underlying gender inequality. To address this short fall and enable midwives to provide care which address short- and long-term improvements to public health, investment which recognises the increasing responsibility and expanding role of the midwife must be made.

Surveys show that many midwives work part-time and require flexible working to accommodate family arrangements. Both increased financial value and free or subsidised childcare arrangements would enable midwives to maintain practice while facilitating their personal needs. For caseloading practice job share arrangements and reduced caseloads would support midwives to have greater flexibility. Phased return and shadowing opportunities for midwives following maternity leave or extended absence would increase confidence in returning to work in a supported environment.Ability to self-determine working practices and alignment and support of the organisation are also necessary to support midwives needs. From these findings it is clear that MCoCer models must be developed with midwives for contextually relevant and sustainable solutions. The principles of collaborative working which were honoured through this cooperative inquiry have empowered the participants in this research to co-create solutions for practice. The CI midwives identified open communication with senior NHS maternity leads through ongoing development and implementation of MCoCer as a central requirement of support for them. The midwives reported that continued collaboration would help to reduce uncertainty about practice change and improve engagement and commitment across the maternity services in NHS Grampian. Two key actions identified to help facilitate this engagement were:

- Regular updates and accessible information sessions for midwives and student midwives in the local area

- Involvement of midwives and student midwives in the planning stages

Practice arrangements must continue to be applicable and safe for the midwives' working in them. MCoCer models must take into account the Working Time Directive (The Stationary Office 2003) and safe staffing levels to account for on call, sickness and annual leave. The RCM (2018) document 'The nuts and bolts' outlines many of the concerns regarding payment for the commitment to continuity and supportive features to support work-life balance which could be used as a template for those approaching implementation to structure MCoCer discussions with midwives.

6.6.2 Research

The use of cooperative methodologies for successful practice change has been shown in other areas (Friedman 2011). Objective three of this study was concerned with how this methodology would be useful to midwifery practice change. This inquiry has highlighted its strength in reducing fear and uncertainty of practice change through the use of CI methodology. The transformational outcome of *Autonomy* described the CI midwives' journey to gain empowerment through the use of collaborative methods was enlightening and demonstrates the worth of using this form of action research to effect change from the ground up. The importance of this is significant as maternity services in the UK prepare to provide MCoCer national wide requiring the ability to practice autonomously with confidence. The importance of hearing the voices of midwives who will be affected by significant practice changes is imperative if acceptable and sustainable new models of care are to be established. The strengths of this methodology as a collaborative and inclusive development tool for sustainable change can be utilised throughout the practice change to implement, develop and sustain MCoCer practice arrangements.

6.6.3 Education

The findings of the systematic review and inquiry highlighted the importance of autonomous working for the success of MCoCer models. The importance of developing both meaningful relationships and personal and professional boundaries to safeguard the longevity of this model must be addressed at an educational level in undergraduate and postgraduate midwifery education. As such education of student midwives must develop future generations to be confident and competent in autonomous working roles, such as MCoCer practice. This should include caseload holding to prepare student midwives for the realities of MCoCer working and establish the importance of relational care as shown by (Rawnson et al. 2011). The use of action research as demonstrated by Fraser (2000)

through the multi-site research project and in this study to establish meaningful practice change could be replicated in Scotland on a national scale.

Equally, continuous professional development and provision of training which addresses the needs of each midwife so that they are confident and competent in MCoCer roles should be of high importance. Despite assurances of such training, a top down approach to organisation of maternity services causes concern for midwives approaching practice change that their professional needs are not fully supported.

The NMC has recently revised the Standards for pre-registration midwifery education (2018) and have launched consultation on the future of midwifery in February 2019 to respond to the need to ensure there are clear goals for the midwifery profession as we transition into an autonomous and woman-centred relational continuity model. These goals must be focused and aligned with person-centred models to ensure the sustainability of MCoCer for the future.

6.6.4 Policy

Midwife job satisfaction and work-life balance are integral to the success of MCoCer models. The systematic review revealed that self-directed and autonomous working are features of successful and sustainable MCoCer models. The inquiry exhibited that collaborative working between midwives and leadership is necessary to support autonomous and self-directed working as outlined in NMC (2009) and Midwifery 2020 (DoH 2010). In addition to current recommendations for MCoCer from the perspectives of women and service provision, policy must recognise the needs of midwives providing care and their right to self-determine their working practices to facilitate them. The work by Hunter et al. (2018) highlights the importance of listening to midwives to promote high quality maternity care. To successfully achieve this, the role of leadership and management should be outlined and how they can support midwives to achieve this (West et al. 2015). The inclusion of the Framework co-created with the midwives within policy recommendations could be considered to support the development of person centred and sustainable MCoCer practice.

To promote alignment of organisation and midwifery ideologies the context of maternity care must be understood (Shallow 2016). Recognition of midwifery as a distinct profession which is aligned with a social, not medical model of care and the formation of a Midwifery Council to support this separate from the NMC would support this.

6.6.5 Future Research

The next stage of the research would be to replicate the inquiry through collaborative workshops for groups of midwives who are implementing the practice change. The aim would be to evaluate the

use of cooperative methodologies and the use of the Framework to co-create models for MCoCer which are contextually relevant and individually significant for other groups of midwives. Another potential research project could be application of a Delphi study to elicit and establish national criteria from experts in this area. The systematic review and CI outcomes from this thesis could provide the initial domains of exploration.

An identical CI involving women and midwives would address both key stakeholders within the midwife-woman relationship and facilitate the development of mutually reciprocal relationships and true person-centred models. This would assist co-design of services that are relevant to specific populations such as women in remote rural community settings and women with complex physical and/or psychosocial needs. Equally, a cooperative inquiry involving midwives and management would enable collaborative development of MCoCer models with mutually agreed structure. Collaborative working will enable and engagement of midwives and buy-in to models which authentically represent how midwives wish to work and self-determine their working practice. New and transformative research approaches can address the underlying socio-political and economic mechanisms which enhance or constrain the well-being of women, families and broader society.

6.7 Dissemination

The plans for the dissemination of this work intend to support continued transformative action with midwives as they approach the proposed practice change in Grampian, Scotland and the UK. The findings of the systematic literature review and inquiry outcomes are to be disseminated via production of papers in high impact journals such as *Midwifery, Birth* or *Women and Birth* and a synopsis in a magazine such as *The Practising Midwife.* The cooperative midwives will be given the opportunity to be acknowledged as co-inquirers in these publications (Löfman, Pelkonen and Pietilä 2004). Findings of the study and the co-created vision for a midwifery continuity of carer model developed by the midwives are planned to be shared through presentation at a local level within NHS Grampian and with the undergraduate students at Robert Gordon University as well as nationally across Scotland at the MAMA conference and the UK at the RCM conference.

The Team Charter and Framework developed are intended to be used in facilitated workshops with groups of midwives implementing the Best Start (Scottish Government 2017) and Better Births (NHS England 2016) recommendations for MCoCer. The Framework will act as a guide to support midwives to develop individually relevant working practices which address their contextual needs. The materials will eventually be made open source and available to all via the internet in order to assist the development and implementation of MCoCer models with the midwives practising in them.

6.8 Conclusion

This study has addressed the three objectives it set out to achieve. The systematic review and CI highlighted the potential challenges of working in MCoCer and how we can approach practice change in a collaborative way to develop contextually and personally relevant solutions. The co-created Framework and Team Charter provide structure to support the central concept of **Balance** that emerged from the study as a whole. The most significant transformative outcome was the development of awareness of both by the CI midwives and NHS Grampian management, foregrounding the potential for positive future change. The limitations outlined affected the overall emancipatory action of the CI, however its worth as a methodology for engaging midwives in the process of practice change has been demonstrated.

There is mounting evidence for MCoCer models from the perspectives of women and significant support from government policy to implement these in the next few years. Midwives are dissatisfied with the current model and MCoCer enable the development of meaningful relationships with women which is associated with significant job satisfaction. However, awareness of the potential challenges to work-life balance through MCoCer practice must be addressed by enabling autonomous and self-determine working practices for midwives as evidenced in this thesis. The development of person-centred models of care and alignment of ideology across the organisation to support effective individual informed choice and facilitate work-life balance for midwives is needed for successful and sustainable MCoCer practice. While the organisational structure in NHS Grampian is currently not conducive to facilitate professional and personal autonomy, the CI has outlined the potential for collaborative working to enable this in the future.

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Appendices

Appendix A: Personal reflection of caseloading practice

Personal reflection of caseloading practice

It is 11pm, I'm on my way to the airport to pick up my partner which is a 45 minute drive away. I'm tired and emotional having been on call 24/7 all week. I have been up since 2am with a woman in labour and haven't managed to eat as I have been rushing to finish all my visits which had to be rearranged after the beautiful, but time-consuming birth this morning. I am still on call, and on call for my buddy who is having some time off. I'm anxious as I drive away from the city hoping no one will need me tonight.

My phone rings and I pull over to call back an unknown number. A concern and request for advice and I am communicating with the hospital asking them to review her following multiple episodes of reduced movements. I continue and arrive without incident to the airport where I collapse on my poor partner and sleep while he drives home.

Saturday morning, 7am I am woken by the harsh ring of the phone. A woman from my buddy's caseload who is struggling to breastfeed. My buddy will be back on call at 12 but I do not want to leave this mother and baby to wait. I throw on some clothes and grab something to eat promising my partner I will see them as soon as possible. 2 hours later and mum is happier, baby is still not feeding well at the breast but we have made a plan together and I have enlisted the help of a breastfeeding support worker. Knowing continuity is key I have promised a teary mother that I will visit her later this afternoon although I am meant to be off. As I drive away to go home my phone rings again, one of the midwives, asking for Entonox supplies and for me to second her birth….

The relationships I develop with the women I care for and my colleagues, the professional autonomy my role brings and the difference I am able to make for women and their families all bring me great joy in practice.

The challenges with the hours worked, the continuous on call and the lack of work/life balance feel fairly constant and are starkly highlighted when I am not able to live a life of my own with the people I love. This model of practice has so many positives but must exist in a way that midwives also can experience joy in their own personal lives.

Appendix B: JBI Critical Appraisal Checklist for Qualitative Research

THE JOANNA BRIGGS INSTITUTE

JBI Critical Appraisal Checklist for Qualitative Research

Reviewer_____Date_____

Author _____Year_____Record Number_____.

		Yes	No	Unclear	Not applicable
1.	Is there congruity between the stated philosophical perspective and the research methodology?	☐	☐	☐	☐
2.	Is there congruity between the research methodology and the research question or objectives?	☐	☐	☐	☐
3.	Is there congruity between the research methodology and the methods used to collect data?	☐	☐	☐	☐
4.	Is there congruity between the research methodology and the representation and analysis of data?	☐	☐	☐	☐
5.	Is there congruity between the research methodology and the interpretation of results?	☐	☐	☐	☐
6.	Is there a statement locating the researcher culturally or theoretically?	☐	☐	☐	☐
7.	Is the influence of the researcher on the research, and vice- versa, addressed?	☐	☐	☐	☐
8.	Are participants, and their voices, adequately represented?	☐	☐	☐	☐
9.	Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	☐	☐	☐	☐
10.	Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	☐	☐	☐	☐

Overall appraisal: Include ☐   Exclude ☐   Seek further info ☐

Comments (Including reason for exclusion)

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_____

Critical Appraisal Checklist for Qualitative Research | 3

Appendix C: Completed JBI Data Extraction Form for Interpretive and Critical Research (Sandall 1997)

JBI QARI Data Extraction Form for Interpretive & Critical Research

Reviewer: C. Pace   **Date:** 22.5.18

Author: SANDALL   **Year:** 1997

Journal: BJOM   **Record Number:** 17

Study Description

Methodology: Qualitative

Methods: Semi-structured interviews, audio recorded with consent.

Phenomena of Interest: Exploration of personal, organisational and professional factors which contribute to the success and failure of providing continuity of carer.

Setting: 3 sites providing continuity of carer by a single or small group of professionals. Site 1 MGP,

Geographical: London, UK

Cultural: Fragmented model of care standard maternity practice, movement towards continuity models following Changing Childbirth

Participants: 48 midwives interviewed, 7/7 from MGP, 19/23 from traditional community practice, 22/28 for team continuity

Data Analysis: Tapes transcribed and analysed using a computerised qualitative data analysis package.

Authors Conclusions: The type of caseload can enhance or reduce opportunities to 'know' women. Control over work and continuity of care are important to midwives to enable balance of work and home life. Personal caseload models of care which incorporate these factors may be more sustainable and create greater professional accomplishment with reduced burn out compared with team caseloads. Midwives with children can be integrated into caseload models if they have autonomy over their working schedule, remuneration for on call and support from colleagues and home.

Comments Quotes do not always clearly define who stated what and from which team therefore cannot be used confidently.

Key: TM- Team midwife, MGP-Midwife group practice, CMW- community midwife

Findings

Theme	Description	*Evidence*
Occupational Autonomy	All midwives across the sites said that the stress they felt was related to the degree of control they had over how they worked rather than to the actual workload. The more control they had the more they could reduce the uncertainties and the impact which this had on them and their personal lives.	*'The only thing you need to worry about is births. Everything else you can fit in, absolutely to your own life. So i could do all my visits, all the antenatal, all the postnatal at a time that suited me as well as the woman and her family, which was generally daytime, but occasionally evening.' MGP* *'Never knowing what you're facing into. and i don't mean that in a bad way, i don't mean that...sort of traumas or medical, but i mean actual workload. Never being able to plan anything.' TM*
Social Support	Supportive professional and personal relationships reported as one of the greatest stress reducers.	*'It's all very pally, all very nice. i feel less drained after a day here than i do after a day with my children. i feel very light of step when i get home, always have done' CMW* *'The other main problem i saw was very poor communication between the team. You didn't meet up...i found there was no team spirit as such'. TM*
Developing Meaningful Relationships with women	Providing continuity of care was a major source of satisfaction to all midwives. the inability to develop meaningful relationships. MGP and CMWs were able to develop meaningful relationships	*'That's one thing I do miss...the birth, the whole continuous thing, and for me that's one of the best things of the job.' TM* *'Continuity, knowing everybody; the social side; sometimes I don't feel like I'm going to work, more like i'm going to visit a friend who is having a baby. The fact that it is generally a happy job, i like women, i like talking to women, being with women, whether it is women colleagues or women clients, i like it.' CMW*
On Call MGP 7/7 (with 3 month holiday) CMW 2-3/7 TM 2-3/7	Frequency and length of on call biggest difficulty for all. Stressful due to uncertainty, although MGP midwives had significantly less due to knowing their women and because they could set boundaries for practice.	*' the interesting thing about being on call 24 hours a day is that people don't call you...You've set up a system which means that its not necessary; you've done enough...'MGP* *'it can be anything, absolutely anything. you'd be amazed what people ring about…. The unpredictability sometimes, that can add to the stress' TM*
Burn out	Disillusionment that results from the inability to provide CoCer in a system that is designed for team care.	*To my mind, they were nearly over dedicated to their job. You know the job came before anything else, even those with family, social life, the job seemed to come before everything else. They would drop their days off to come and work all hours, which in one way you might say well that's wonderful, but I think as a result they were totally exhausted from it'. TM*

Appendix D: Key findings and Author Themes from included studies in the Systematic Qualitative Review

STUDY	KEY FINDINGS REPORTED BY AUTHORS	AUTHOR THEMES
BROWNE ET AL.	Continuity of career experiences comes at significant cost to individual students but is beneficial to their comprehensive learning. It is also beneficial for women, midwives and maternity organisations, and promotes and maintains a strong woman centred midwifery care focus.	Woman centred care Mutual Benefit Counting the cost Into the future
COX AND SMYTHE	The descriptions given by the midwives shows they found this way of working unsustainable. The paradox that the joy and intensity of relational care can also be detrimental to the midwife as it overburdens them with responsibility.	Passion and commitment Making the decision to leave Emotional impacts of practice
CUMMINS ET AL.	The new graduate midwives in this study felt prepared through their education and supported in practice to work autonomously in continuity of carer models. The authors identified that further research was required in why a certain number of years' experience for midwives wishing to work in continuity models is required and what transition program is required.	'the relationship with the woman' 'the relationship with the group'
DONALD ET AL.	To succeed in creating innovative ways to practise, the participants agreed that they needed to change their assumptions about how they provided care. This required adopting an empowering approach to care focussed on the woman's ability to cope rather than allowing the development of a dependent relationship between the woman and the midwife. All midwives, from the clinical practitioners themselves to the leaders and educators, need to act as change agents, to promote skills for work-life balance awareness so that everyone enjoy sustainable, safe midwifery practice while still honouring the principles of partnership and continuity of care.	Tension between work and home commitments Changing assumptions about commitments Sustaining practice change

EDMONDSON AND WALKER	Autonomy of practice, ability to use full range of midwifery skills and development of meaningful relationships were all associated with job satisfaction for midwives. Good work-life balance and sustainability of the role were made possible through flexible working practices around family commitments, setting boundaries with women and having a supportive family. Effective working relationships with colleagues who shared a philosophy of care and respected decision making both supported autonomy and created a positive working environment for the midwives. Guidelines for practice were both seen as protective for the midwives and restricting for individualised care planning.	Autonomy of practice Good work-life balance Guidelines for practice Effective working relationships Continuity of care
ENGEL	The structure of maternity care funding models influenced the size of caseloads and ability of individuals to tailor the way they wish to work in a demanding vocation. The personal and midwifery philosophy of individuals in this study appeared to be more influential in the organisational aspects of each midwifery practice. Personal autonomy and a sense of accomplishment from practising as a continuity of carer were the major source of their job satisfaction. Good back up in the form of supportive colleagues and a pre-determined plan was highlighted as important for women and midwives for sustaining the model.	The balance depended on the funding model Keeping the balance Job satisfaction Setting boundaries on practice
FEREDAY AND OSTER	It is important for midwives working in MGP to actively manage the flexibility of their role with time and on call. Organisational, team and individual structure influenced how flexibility of hours was managed; however, a period of adjustment was required to achieve this balance. The study findings offer a description of effective, sustainable strategies to manage flexible hours and on-call work that may assist other midwives working in a similar role or considering this type of work setting.	Flexibility and structure at an organisational level Flexibility and structure within a team Flexibility and structure for the individuals Period of adjustment
GILKISON ET AL.	This paper identifies the fundamental practice arrangements our participants found were needed to sustain self-employed caseload	Having regular time off

| | midwifery practice within the New Zealand model of maternity care. Each practice of midwives finds and defines its own unique arrangements for working together. This study identifies aspects of sustainable practice which are very specific to the New Zealand model of midwifery which are also congruent with the international research. The findings of this research provides guidance for midwives both in New Zealand and globally who seek guidance about how caseload midwifery can be organised sustainably. | Having a manageable caseload size

The way midwives work together as a practice

Financial arrangements

Sharing of arrangements with women |
|---|---|---|
| GRAY ET AL. | The follow-through experience is an innovative midwifery education strategy and facilitates learning for midwifery students. Challenges need to be addressed at a systematic level and new strategies developed to support the learning opportunities from these experiences. Ensuring that the requirements are realistic, taking into account the balance that students must make between clinical and university needs and ensuring appropriate supports are all essential. Until the inherent value of midwifery continuity of care is recognised and these models of care are made more widely available to women, the integration of the follow-through experiences in Australia midwifery education will continue to be seen as a burden. | You really get to know what makes her tick

This woman's care is in your hands

It was gruelling…it really was

It is something more meaningful, something different |
| HUNTER ET AL. | This paper draws attention to the significance of generosity of spirit in LMC practice and how this acts synergistically with personal and professional boundaries. Reciprocity and partnership work well when generosity of spirt is enabled to flourish, and this, in turn, supports joy of practice. This paper provides further insight into how LMC practice is sustained over time and provides direction for midwives in LMC practice, and those planning to enter LMC practice, in New Zealand and elsewhere. | Generosity of spirit

Negotiating boundaries |

JEPSEN ET AL.	Caseload midwifery requires commitment which brings encourages the midwife's desire to go beyond for women. In return midwives need appreciation, recognition and meaningfulness of the role to make this worthwhile and gain job satisfaction. It is a balance between the meaningful job and impact which it has on personal life. For this group of midwives the benefits outweighed the disadvantages. Authors indicate that preparation for disruption is key to sustain this type of practice as well as caseload numbers.	Having a high degree of job satisfaction Being a personalised professional Creating my own space Creating cohesiveness through knowing Working in an obligating but rewarding job
MCARA-COUPER ET AL.	In this study the primary factor found to sustain midwives providing continuity of carer is the joy of practice and the reciprocal relationship with a shared philosophy of care. The joy of midwifery practice is reflected in a passion for 'being with' women and families, supporting and empowering them through their childbirth experiences and to have the birth they aspire to. Joy alone is not enough to sustain practice, the data shows a paradoxical conflict; relationship sustain but can also cause burnout, and that negotiation of boundaries to ensure professional and personal lives are balanced is imperative for sustainability.	Joy and passion for midwifery Working in partnership Negotiating and keeping boundaries
MCCOURT AND STEVENS	Continuity of carer was inherent in the way these midwives worked and underpinned the qualities of the role the midwives valued. This did not mean that one midwife should provide all care, or always be present. The authors suggest that if the goal of practice is women- and midwife- centred care, then the aim of the model is not the achievement of continuity of carer itself, but rather the development of conditions of practice that enable the core themes we have highlighted to be present. Continuity of care without continuity of carer is difficult to achieve in a fragmented model of care. Conversely, it may be that in different practice environments that can support autonomy and personal care more effectively, such as small, midwife-	Relationship Being there Reciprocity Autonomy Development Confidence

	led birth centres, continuity of carer is less important. The satisfaction midwives experienced centred around the relationships they were able to develop with women, and autonomy which allowed them to practice in this way. Autonomy was both an outcome of practising in caseloading practise and necessary to make it an acceptable way for midwives to continue working. Midwives needed choice and flexibility in their working practice in order to provide continuity of carer and provide choice to women.	
MOORE	The midwives' passion for midwifery and their philosophy reflected the nature of MGP making it a sustainable form of working for them. The themes of Mutual Respect, The Midwives Journey, Professional Fulfilment and Women and Midwives Together all linked and connected as a whole 'range of vision' which form the components of this MGP. The essential elements identified by this group of midwives which sustain their working practice were work/life balance, shared group philosophy, group antenatal care, peer support/case management and organisational support.	Mutual Respect The midwife journey Professional fulfilment Women and midwives together
NEWTON ET AL.	Caseload midwifery was identified as being 'different' to mainstream midwifery work, in both the organisation and the meaning of the work for those working in the model. For those outside the model, features of caseload work may be poorly understood, which could result in a reluctance to work in this way. Caseload work is a 'package', which requires a different way of working but also provides an opportunity to practice midwifery in a way that, for many midwives, is closely aligned with their perceptions of 'real' midwifery. Increased understanding of the differences between caseload work and mainstream maternity models, demystifying negative perceptions, and introducing opportunities to be exposed to caseload work may contribute to sustainability of caseload models.	A 'different' way of working Perception of 'real' midwifery
RAWNSON	Students found caseloading highly beneficial for facilitating application of theory to practice and acquisition of new skills to promote confidence and competence. Relationships developed with women were key to their enjoyment of the work but created feelings of letting them down if they could not meet the women's expectations. This, and the logistics of caseloading holding were emotionally stressful for many students. Effective preparation of students for the realities of	Making it good Developing and managing caseload Learning partnerships

	caseloading, the development of realistic caseloads that take account of the student's individual situation, and the provision of supportive frameworks are essential.	Feeling like a midwife Afterwards
SANDALL	Control and continuity are as important to midwives in how well they balance their work and home life as they are to women experiencing childbirth. Factors associated with reduced burnout are having control over the organization of work, social support at work and home, and being able to develop meaningful relationships with women. Personal caseload models of care which incorporate these factors may be more sustainable and create greater professional accomplishment with reduced burn out compared with team caseloads. Midwives with children can be integrated into caseload models if they have autonomy over their working schedule, remuneration for on call and support from colleagues and home.	Occupational autonomy Social support Developing meaningful relationships with women On call Burn out

Appendix E: Facilitation Toolkit

2. Facilitator Toolkit

Following attendance and completion of Facilitation Training and a *Leadership for Change* Workshop with Aberdeen City Council this toolkit has been developed using resources from *Learning for sustainability- Facilitation tools and techniques* (Allen 2018), *Leadership and Management* (Community Toolbox 2017), and *Coaching Area: Facilitating a group problem-solving issue* (Project Connections 2018).

Facilitation Styles

Heron (1999) describes an effective facilitator as flexible and responsive to the needs of the group, individuals and inquiry purpose. Awareness of the groups needs and ability to react to this by altering facilitation style are key to an effective inquiry. The table below outlines the six stages of learning within the inquiry and the three facilitation approaches which can be adopted.

Figure 3. Dimensions and modes of Facilitation adapted from Heron (1999).

	Hierarchical	Co-operative	Autonomous
Planning	Plan and decide the agenda for the group what they will learn	Planning agenda with the group through negotiation and integration of ideas	Planning is delegated to the group
Meaning	You draw meaning for the group	Collaboration of the group to generate understanding	Interpretation reflection and review of meaning delegated to the group
Confronting	Highlight rigid behaviours and direct people to address them	Work with the group to raise consciousness of avoided issues and defensive behaviour in a collaborative way	Create a safe space to enable members to practice self and peer confrontation
Feeling	Management of the group members feelings and emotions	Discussion and collaborative management of feelings and emotions	Management of feelings and emotions delegated to group
Structuring	Structured learning exercises directly supervised	Learning processes devised cooperatively with group	Self and peer directed control over learning process
Valuing	Facilitator invests in and takes responsibility to care for the group	Development of an inclusive, collaborative environment of mutual respect	Space provided for the group to develop and celebrate their own self-worth

Evaluation of the reflective sessions will provide feedback of facilitation skills and style and develop insight to enable growth and progression for an effective inquiry (Heron 1999).

Toolkit

Meeting Ground rules
Development of ground rules in the first phase of the inquiry with all members of the group. Agreed ground rules written up and placed somewhere visible with group asked to take responsibility for maintaining them for a sense of ownership

Group decision over meeting setting and time
Meeting space must be appropriate, relaxed and safe for all cooperative midwives to ensure authentic participation. Considerations include privacy, associations and power dynamics.

Group Agenda

Development of an agenda will take place at the end of the first phase using the themes identified and group consensus. This will ensure that the inquiry flows well and keeps within the time allocated to support the cooperative midwives.

Group Roles

Outlining and discussion of the roles of the facilitator and cooperative midwives within the inquiry. Styles of facilitation and aim of progression towards the group self-facilitating. Roles will be cycled through the group to allow for equal participation and fairness.

- Facilitator- taken on by the researcher, facilitation styles and role discussed with group. Progression towards group self-facilitating and self-determining to improve autonomy
- Co-facilitator- development of self-determination of individual group members, gradual transition to a self-sustaining inquiry meeting
- Recorder/ Note taker – scribing the discussions and themes identified by the group
- Timekeeper- makes sure each agenda item gets enough time for discussion, and that the meeting finishes at the agreed time

Data collection methods
- Flip charts
- Post it notes
- Mind maps
- Creative expression through collage, drawing, paint, poetry
- voice recorder

Facilitation methods
- Confirming direction of inquiry
- Go-rounds to ensure equitable collaboration
- Prioritising themes/ideas with the group
- Re-framing to show active listening and ensure clarification
- Pair ups, Group work
- Icebreakers
- Breaks
- Open Questions
- Use of 5 Whys and Devil's Advocate procedures to challenge views and preconceptions (Project Connections 2018)

Open Questions

Use of open questions will initiate creative idea generation and establish concepts of self-determination and autonomous thinking (Cook 2012).

- What do you enjoy about being a midwife?
- What challenges do you find in current practice?
- What are your understandings about continuity of care/carer?
- What evidence is there for continuity of care/carer?
- Is it important to you/us/NHS Grampian?
- How do you feel about the implementation of a continuity of carer model in your own practice?
- What do you see as a good model of continuity of carer? (Look at different models and their evaluation)
- What would you need to implement a model of continuity of carer? (training, rotas, hours, support, suitable premises)

Problem Solving suggestions:
- SWOT (Strengths, Weaknesses, Opportunities, Threats) Analysis
- Force Field Analysis
- 6 Thinking Hats
- Mind mapping
- 'Park' wall, for issues or conflicts which are proving difficult to solve. Challenge can be revisited later in session. Validates and ensures flow of meeting.

Mindfulness Exercises
- Making a cup of tea/coffee- 5 minutes
- Mindful Listening through music- 5 minutes
- Self-hand massage with aromatherapy or moisturiser- 5 minutes
- Mindful appreciation- 5 everyday things and how they support your life (kettle, transport, dog etc.) 5 minutes

Appendix F: Approval Letter SERP committee RGU

ROBERT GORDON
UNIVERSITY ABERDEEN

Charlotte Pace
MRes Student
RGU

6th March 2018

SERP reference number: 18-07

Dear Charlotte

The co-creation of guiding principles and a practical framework for a Midwifery Continuity of Carer model: A Cooperative Inquiry with midwives

The School of Nursing and Midwifery Ethics Review panel has now reviewed the above research proposal. Please find details of the outcome and recommended actions below.

Your proposal has been approved. You may go ahead with your research, providing approval from any relevant external committee/s has been obtained.*

Your proposal has been approved subject to amendments. Please consider review and amend all relevant documentation in respect of the comments given before forwarding to the Convenor for final approval.

* Where the project involves NHS patients, approval through the NRES system must be obtained.
Where the project involves NHS staff, approval through the NHS R&D Office must be obtained.
Members of the School Panel can advise on this process if necessary.

Yours sincerely

Panel member 1   Heather Bain
Position held: Academic Strategic Lead

Panel member 2
Position held:

If you require further information please contact the Acting Panel Convenor,
Fiona Baguley, on 01224 262652.

Fiona Baguley
School of Nursing and Midwifery
Robert Gordon University
Garthdee Road
Aberdeen
AB10 7QG

Email: NM-Serp@rgu.ac.uk

Appendix G: Approval Letter Research and Development NHS Grampian

Research and Development Foresterhill House Annexe
Foresterhill
ABERDEEN
AB25 2ZB

NHS
Grampian

Professor Susan Crowther   Date   13/04/2018
Robert Gordon University   Project No   2018OG001
Garthdee Campus
Garthdee Road   Enquiries to   Louise
Aberdeen   Extension   53846
                                  Direct Line   01224 553846
                                  Email   grampian.randdpermissions@nhs.net

Dear Professor Crowther

Management Permission for Non-Commercial Research

STUDY TITLE: The co-creation of guiding principles and a practical framework for a
Midwifery Continuity of Carer model: A Cooperative Inquiry with midwives.

PROTOCOL NO: v2
REC REF: n/a
NRS REF: n/a

Thank you very much for sending all relevant documentation. I am pleased to confirm that the project is now registered with the NHS Grampian Research & Development Office. The project now has R & D Management Permission to proceed locally. This is based on the documents received from yourself and the relevant Approvals being in place.

All research with an NHS element is subject to the Research Governance Framework for Health and Community Care (2006, 2nd edition), and as Chief or Principal Investigator you should be fully committed to your responsibilities associated with this.

R&D Permission is granted on condition that:

1) The R&D Office will be notified and any relevant documents forwarded to us if any of the following occur:
   - Any Serious Breaches in Grampian (Please forward to **pharmaco@abdn.ac.uk**).
   - A change of Principal Investigator in Grampian or Chief Investigator.
   - Any change to funding or any additional funding

2) The R&D Office will be notified when the study ends.

3) The Sponsor will notify all amendments to the relevant National Co-ordinating centre. For single centre studies, amendments should be notified to the R&D office directly.

NHSG-RD-DOC-019 – V4.0 – R&D Management Permission Letter (Non CTIMP)

We hope the project goes well, and if you need any help or advice relating to your R&D Management Permission, please do not hesitate to contact the office.

Yours sincerely

Susan Ridge
Non-Commercial Manager

cc: CI/Sponsor
        Research Monitor

Sponsor: RGU

Appendix H: Participant Information Sheet

NHS Grampian

RGU ROBERT GORDON UNIVERSITY ABERDEEN

Participant Information Sheet

Date Information Sheet Produced: 05.03.2018
Version 2.

Project Title: The co-creation of guiding principles and a practical framework for a Midwifery Continuity of Carer model: A Cooperative Inquiry with midwives.

An Invitation: This is an invitation for you to participate in a research study. This information sheet outlines why the research is being done and what it will involve. The study will be qualitative, using Participatory Action Research (PAR) to focus on and value your views on continuity of care and carer within your individual context as a midwife in Aberdeen. Cooperative Inquiry is a branch of PAR which has been selected for this study to emphasise the importance of your involvement and input for effective and sustainable practice change. Your participation would be voluntary and you may withdraw at any time without any adverse consequences. Please take time to read and consider the following information, contact details are listed below for myself and the research team if you have any further questions.

Purpose of the study:
Background: Current NHS policy recommends transformation of maternity services to provide midwifery continuity of carer. While this model has been shown to improve maternity experiences and outcomes for women and their families, it is associated with both positives and challenges for midwives. Midwives must be listened to and heard, be involved in any practice change and for their ideas to be honoured and valued to create positive and sustainable developments.
Aim: The aim of this study is to provide an opportunity for you to develop a vision (framework of practice) for a midwife continuity of carer model which would work for you.
Outcome: The study will use cooperative inquiry to gain insight from your perspectives in practice. The mutual understanding and knowledge you create together will inform a co-created vision of a continuity of carer model consisting of guiding principles and a practical framework relevant to this group of midwives.

How was I chosen for this invitation?
You have been sent this invitation as a midwife working in the Aberdeen City Community Midwife teams/ Midwife Led Unit (MLU). There is no minimum post-registration experience required to participate and staff can be full or part time employees. We are looking for midwives with experience and knowledge of working in Grampian (either as a student midwife or as a qualified midwife), who currently enjoy or wish to provide care across the scope of practice (antenatal, intrapartum and postnatal) and want to explore how this could work for you in Aberdeen.

What will happen in this research?
Cooperative inquiry involves phases of reflection and action, to highlight mutual understandings and support individual and organisation transformation. The inquiry will involve four phases, lasting around 4 weeks for each phase. The phases are planned for April, May, June and July, when the inquiry will conclude following the final meeting.

6-12 midwives will be selected to participate, each midwife will be a co-inquirer within the group with equal standing and opportunity to contribute.

The study will begin with a reflexive meeting to explore your understandings and views of continuity and identify key issues. This reflexive meeting will be followed by an action phase. As participants you will co-decide what you wish to explore to develop practical solutions before the next meeting. The three subsequent phases will begin with a meeting to reflect on the action taken in the previous phase, each followed by an action phase.

Data will be collected during each meeting with consent in the form of written and audio recordings. All findings will be co-operatively created and mutually agreed by group consensus and will contribute to an overall vision of what a continuity of carer model would 'look' like for you and how it would 'operate' sustainably in NHSG.

What are the possible discomforts and risks of taking part?

There will be 4 meetings, one at the start of each phase. Each meeting will be 2 hours long, this time will be classed as working time as agreed with NHSG management as recognition of the investment of your time. The process of cooperative inquiry is aimed at personal and group transformation and can be emotionally and physically demanding for participants. Establishing ground rules and joint decisions about timing and setting of the meetings will help the creation of a 'safe space' which will be supported by myself as the facilitator. Midwives can approach their clinical supervisors, colleagues and members of the research team at any time for support.

What are the possible benefits of taking part?

The inquiry will provide a unique opportunity for you to explore and develop a vision for a continuity of carer model in NHSG which is meaningful and sustainable in the context of your own practice. All work undertaken as part of the study can be submitted as CPD and is suitable for revalidation evidence.

Will information obtained be kept confidential?

Each participant in the focus groups will be asked to sign a consent form agreeing to keep information discussed in the meetings confidential and to protect the anonymity of the participating midwives. All data produced will be kept in a secured cabinet and uploaded to a protected electronic database. There will be full consultation with participants at each phase of the study and pseudonyms will be used to protect anonymity in any published work.

What will happen to the results of the research study?

Your permission will be requested prior to publishing the results of the study, as a co-inquirer you will also have the opportunity to be named as a co-researcher. The findings are planned to be shared at a local and national level and published in various journals. Conference and workshop sessions are planned to disseminate the results of this inquiry. You will be given opportunity at the end of the inquiry to ask for data to be removed or changed.

Who is organising and funding the research?

Funding for a full-time masters in research was granted by Robert Gordon University, School of Nursing and Midwifery. Contact details for the research team are included at the bottom of this information sheet.

Who has reviewed the study?

This study has been reviewed by the Robert Gordon University Ethics board, approved by NHS management and approved through NHS R and D.

How do I agree to participate in this research?

If you wish to participate you will be asked to complete and the included consent form to the research team. The first 6-12 midwives who respond with a completed consent form will be recruited. Following recruitment, the midwives will then be contacted to decide the date and place for the first meeting.

Contact for Further Information
Charlotte Pace, Research Masters Student, School of Health and Social Care, Robert Gordon University, AB10 7QG, email: 1309591@rgu.ac.uk, Phone: 012242617124
Dr. Susan Crowther, Professor of Midwifery, School of Health and Social Care, Robert Gordon University, AB10 7QG, email: s.a.crowther@rgu.ac.uk, Phone: 01224 263291
Dr. Annie Lau, Lecturer in Midwifery, School of Health and Social Care, Robert Gordon University, AB10 7QG, email: a.lau2@rgu.ac.uk, Phone: 01224262637

Appendix I: Consent Form

NHS Grampian

RGU ROBERT GORDON UNIVERSITY ABERDEEN

Consent form

Research Study Title: The co-creation of guiding principles and a practical framework for a Midwifery Continuity of Carer model: A Cooperative Inquiry with midwives.

Centre Number (if applicable):	**Study Number (if applicable):**
Participant ID Number:	**R and D reference:**
Name of CI: Charlotte Ashely Pace	

Please initial

1. I confirm that I have read and understand the information sheet Version No: .... Date: .... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. Data collected up until the point of withdrawal may still be used and reported.

3. I understand that data collected during the study may be looked at by individuals from Robert Gordon University, from regulatory authorities if appropriate, or from the NHS Board/Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

4. I agree to participate in the reflective sessions and co-decided actions between each reflective session

5. I agree to the group sessions being audio recorded. I understand that anonymised quotations from these sessions may be used for presentations and publications.

6. I agree to maintain confidentiality of the reflective sessions to external parties and to protect the identity of the other cooperative midwives.

7. I agree to the storage and use of written data collected in each reflective session to be reported anonymously at the conclusion of the study

8. I agree for my information to be stored on servers at Robert Gordon University

10. I agree to take part in the above study.

Name of participant	**Date**	**Signature**

Name of researcher	**Date**	**Signature**

One copy for participant, one copy for researcher   Version: 01 Date: 05.03.2018

Appendix J: Action Worksheet informed by RCM Can Continuity work for you? Toolkit (2017a).

Making sense of the practical details

Knowing that midwives in midwifery continuity of carer teams/groups or buddy systems working a variety of ways, it is important to find out more about how you might be asked to work or how implementation might take place in your area.

Organising my working day

How and where will you provide care for women?

How long does each appointment take?

How do I manage all the appointments, for example postnatal visits, if I have been called out the night before?

Figuring out how to schedule work

Do you have caseload only or caseload days and unit days/ antenatal/postnatal/labour/admin days?

Do you self-roster or does a manager roster you/your buddy/the team?

Is my pay fixed with an enhancement or variable from month to month?

How do the on-calls work with caseload and weekends?

What can I do if I need to swap my on-call at short notice or leave partway through for personal reasons?

How do you schedule annual leave?

Making sense of the practical details

The women in my caseload

How many women do you think you would care for at one time?

Is it a set caseload number or does it change according to the needs of the women? How do you decide this?

How will women be allocated to the MCoCer team/group or buddy system?

What is the geographical area we need to cover?

What happens if the caseloads are getting too large or too small?

Starting out in a team/group or buddy system

What is the starting caseload for a midwife joining the team/group or buddy system?

What is the induction programme in place and how long will it be for? What if I need extra support in certain areas to gain more confidence?

Getting to know my team/group or buddy midwives

How often will we meet and where? How does handover work?

How do I access the notes/information for women in our team/group or buddysystem?

Is there a named obstetrician for my team/group or buddy system and what is their role?

If there is more than one MCoCer team/group or buddy system, how will we be working together?

Appendix I: Completed Action Worksheet informed by RCM Can Continuity work for you?

Toolkit (2017a)

Making sense of the practical details

Knowing that midwives in midwifery continuity of carer teams/groups or buddy systems working a variety of ways, it is important to find out more about how you might be asked to work or how implementation might take place in your area.

Organising my working day

How and where will you provide care for women?

- Antenatal + Postnatal visits at home
- Booking appt 2hrs-average> A/N 40minutes P/N 40mins

How long does each appointment take?

- Mw mobile app to arrange visits and communicate with women + team.
  → automatic alerts to appt + mw if on call to arrange
  → resnaduley pass on to team leader to take over care for * period of time.

How do I manage all the appointments, for example postnatal visits, if I have been called out the night before?

- women contact mw direct to arrange named appts.

Figuring out how to schedule work

Do you have caseload only or caseload days and unit days/ antenatal/postnatal/labour/admin days?

- 1 admin day per week (4-6hrs) to update notes/alerts/prioritise and liaise/handover with mw team. 1 hospital day every week at least.

Do you self-roster or does a manager roster you/your buddy/the team? Is my pay fixed with an enhancement or variable from month to month?

- All self rostering (flexible) signed off by manager to ensure right working hours.
- Basic Salary + unsocial hours + time back/ paid overtime

How do the on-calls work with caseload and weekends?

- On call for own women/shared on call with team for 2nd mw. Depending on area.

What can I do if I need to swap my on-call at short notice or leave part way through for personal reasons?

- Flexible – discuss with team leader as usual. prioritise + reschedule, pass on to team mw.

How do you schedule annual leave?

- Scheduled as usual with preferences and work out with team.

Making sense of the practical details

The women in my caseload

How many women do you think you would care for at one time?

Is it a set caseload number or does it change according to the needs of the women? How do you decide this?

→ 40 women average + if low risk case load
   – if high risk

→ Team allocations → team leader - weekly
   30 minute morning   - allocations

How will women be allocated to the MCoC team/group or buddy system?

What is the geographical area we need to cover?

→ Community area either at GP's catchment/ home
   working system

What happens if the caseloads are getting too large or too small?

→ too large → no more allocations → too small → extra in low
   → assist in low
   → extra allocat

Starting out in a team/group or buddy system

What is the starting caseload for a midwife joining the team/group or buddy system?

→ Part time 25-30   to 75 women per day average
   Starting caseload 25 women
   Introduction for 2 weeks.
   Shadow for 2 weeks. Assist for 2 weeks.

What is the induction programme in place and how long will it be for? What if I need extra support in certain areas to gain more confidence?

→ Team

Getting to know my team/group or buddy midwives

How often will we meet and where? How does handover work?

→ Weekly meetings at either office   team leaders home BASE
   NHS GP/ conference room

How do I access the notes/information for women in our team/group or buddysystem?

→ work laptops   caseload team folder

Is there a named obstetrician for my team/group or buddy system and what is their role?

→ normal ob care → meet if high risk/concerns

If there is more than one MCoC team/group or buddy system, how will we be working together?

→ 2-3 teams in area
   team 1 will be on call for 72   via nurse