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ORIGINAL RESEARCH

'There is no other option': Exploring health care providers' experiences implementing regional multisite midwifery model of care in South Australia

Lois McKellar PHD[1,2] | **Julie-Anne Fleet PhD**[1] | **Pamela Adelson MPH**[3]

[1]Clinical & Health Sciences, University of South Australia, Adelaide, South Australia, Australia

[2]School of Health and Social Care, Edinburgh Napier University, Edinburgh, UK

[3]Rosemary Bryant AO Research Centre, University of South Australia, Adelaide, South Australia, Australia

Correspondence
Lois McKellar, School of Health and Social Care, Edinburgh Napier University, Sighthill Campus, Sighthill EH11 4EP, Edinburgh, UK.
Email: l.mckellar@napier.ac.uk

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Abstract

Introduction: In the past 30 years, 60% of South Australia's rural maternity units have closed. Evidence demonstrates midwifery models of care offer regional Australia sustainable birthing services. Five birthing sites within the York and Northern Region of South Australia, designed in collaboration with key stakeholders, offered a new all-risk midwifery continuity of care model (MMoC). All pregnant women in the region were allocated to a known midwife once pregnancy was confirmed. In July 2019, the pilot program was implemented and an evaluation undertaken.

Objective: The study aimed to evaluate the effectiveness, acceptability, and sustainability of the new midwifery model of care from the perspective of health care providers.

Design: The evaluation utilised a mixed methods design using focus groups and surveys to explore experiences of health care providers impacted by the implementation of the MMoC. This paper reports on midwives, doctors and nurses experiences at different time points, to gain insight into the model of care from the care providers impacted by the change to services.

Findings: The first round of focus groups included 14 midwives, 6 hospital nurses/midwives and 5 doctors with the overarching theme that the 'MMoC was working well.' The second round of focus groups were undertaken across the five sites with 10 midwives, 9 hospital nurses/midwives and 5 doctors. The overarching theme captured all participants commitment to the MMoC, with agreement that 'there is no other option - it has to work'.

Discussion: All participants reported positive outcomes and a strong commitment to navigate the changes required to implement the new model of care. Collaboration and communication was expressed as key elements for success. Specific challenges and complexities were evident including a need to clarify expectations and the workload for midwives, and for nurses who were accustomed to having midwives 24 hours a day in hospitals.

Conclusion: This innovative model responds to challenges in providing rural maternity care and offers a sustainable model for maternity services and

workforce. There is an overwhelming commitment and consensus that there is 'no other option–it has to work'.

KEYWORDS

continuity of care, maternity services, midwifery, regional/rural midwifery caseload, service redesign

1 | INTRODUCTION AND BACKGROUND

Sustaining maternity services in rural and remote regions remain a global challenge. In Australia, 60% of rural maternity units have closed since 1992 and in South Australia (SA) about a quarter of all country women birth away from their usual region of residence.[1] Current workforce shortages in rural maternity services threaten the sustainability of birthing in rural hospitals. The Strategic Directions for Australian Maternity Services[2] aim to maintain and expand existing rural maternity services.[3] One of the key implementation strategies in the 2021–26 SA Rural Health Workforce Plan is the development of new and sustainable workforce models for rural health care.[4] Increasing access to midwifery continuity of care may contribute to this goal. Evidence demonstrates the benefits and significance of midwifery continuity of care in terms of maternal satisfaction, efficacy and reduced cost to health services.[5–8] This paper presents findings from focus groups that explored the perspective of registered health care providers from five regional birthing sites who were impacted by the introduction of a midwifery caseload model of care.

What is already known on this subject

- Many of Australia's rural maternity units have closed with 25% of women birthing away from their usual region of residence.
- Current workforce shortages in rural maternity services threaten the sustainability of birthing in rural/regional hospitals.
- Closing rural maternity units and removing the option to give birth locally have significant consequences for women and health care providers.
- Midwifery models of care are an option for increasing the sustainability of birthing services in regional Australia.

What this paper adds

- Midwifery continuity of care models represents an innovative response to providing an effective, acceptable and sustainable model for rural maternity care.
- All participants agree that the model worked well and that it was an important strategy for sustainable rural maternity services.

1.1 | The midwifery caseload model of care pilot in the Yorke and Northern Region

In 2017, a small project team of the Country Health South Australia Local Health Network (CHSALHN) Maternity Services Committee was tasked to develop a sustainable midwifery workforce model in country SA with the aim of keeping birthing as close to home where safely possible. With strategic vision and leadership, the project executive lead along with the project manager, project team, and expert working group developed the framework and working plan for a pilot study.[9] In 2019, following an 18-month period of extensive community engagement and consultation with doctors (general practitioners and obstetricians), midwives and nurses from the York and Northern Local Health Network (YNLHN) region of South Australia, an all-risk midwifery continuity of care model (MMoC) was piloted.[9] This region was chosen as there were critical maternity workforce shortages in some locations along with areas of successful midwifery group practice programmes. Midwifery group practice is a caseload model of care provided by midwives working in a team, providing backup for one another to provide antenatal, intrapartum and postnatal care to a group of women.[7,10]

The YNLHN provides health care access to approximately 77 000 people within the Yorke Peninsula, Southern Flinders and the Lower and Mid North areas of SA.[11] This region is 38 500 square kilometres with a combination of arid and coastal geography and is situated approximately 3 h by road from Adelaide. It has a diverse population that face psychosocial challenges unique to living outside of

a major city.[1] The MMoC brought together five regional/rural birthing sites (Clare, Jamestown, Crystal Brook, Wallaroo and Port Pirie) with a combined average of 420 births per year. The model replaced the existing maternity service where midwives were rostered to the hospitals for each shift. These hospital-based midwives were given the opportunity to transition to a caseload model, while the few midwives who chose not to, continued to work at their local hospital primarily in general wards to provide acute nursing care. The midwives who transitioned to the MMoC were no longer rostered to hospital shifts, instead, they managed a caseload of women predominately attending antenatal and postnatal appointments in the woman's home and were 'on call' to attend the hospital for labour, birth and initial postnatal care. As midwives were no longer rostered to the maternity ward, nurses had new responsibilities to provide care for women and newborns. Obstetricians and general practitioners (GP's) in the region who had traditionally provided all antenatal care now engaged in a new shared care collaborative arrangement with the MMoC midwives. GP's providing obstetric shared care in SA have maternity care training and experience and meet the accreditation requirements of the GP Obstetric Shared Care Program (GP OSC SA).[12]

In this model, all pregnant women in the region are referred to a known midwife once pregnancy is confirmed. Each midwife is allocated a caseload of 38 women and provide antenatal care at a health care site, designated clinic or in the women's home with the frequency of visits in accordance with the women's needs. The obstetric doctors work in partnership as negotiated and dependant on women's needs and their workload. Midwives consult and refer to doctors and other caregivers according to practice care guidelines and clinical need. Women may birth outside their local region due to personal choice or level of acuity. However, these women can still access a midwife through this model for antenatal and postnatal care.[13] This collaborative approach enables clinicians to share resources and provide professional support to one another to deliver safe and effective care to women and their families[9] (Figure 1). Importantly, graduate midwives work in the MMoC and are supported through the SA Health graduate programme. This program is a designated 12-month transition to practice programme which includes allocated education days and clinical supervision with a reduced caseload.

The MMoC model was implemented as a 2-year pilot programme and an independent evaluation was undertaken by the authors to report on clinical outcomes and explore service users and care provider experiences.[14] The aim of this paper is to report the experiences of registered health care providers engaged in the MMoC. The experiences of the women and key maternity and neonatal outcomes are reported in a separate paper.[15]

2 | METHODS

Drawing on a mixed-method design, the evaluation followed principals outlined in the UK National Institute for Health Research guide to conducting evaluations in health care[16] and assessed key aspects of care outlined in the Quality Maternal and Newborn Care (QMNC) Framework.[17,18] The overall evaluation objectives were to report satisfaction, effectiveness and sustainability from the perspective of all participants. To ensure contextual relevance and evaluation of all key elements of the pilot programme, an evaluation advisory committee was formed and met approximately every 4–6 weeks over the course of the evaluation.[9] Membership was appropriate for their expertise and included: The Executive Officer, Maternity Services Committee/Maternity Lead, Rural Support Service (RSS), the Executive Director, Nursing and Midwifery, YNLHN Maternity Unit Manager, a consumer representative, the UniSA evaluation team and a part-time research assistant (RA) contracted for the project. This paper reports the experiences of registered health care providers collected over 18 months, through focus groups. Ethics was approved by the Women's and Children's Human Research Ethics Committee, HREC/19/WCHN/68 and by the University of South Australia (UniSA) Human Research Ethics Committee (HREC) Application ID: 202393.

2.1 | Registered health care providers' focus groups

In 2019, there were 102 registered health care providers who were directly impacted by the implementation of the MMoC; midwives ($n=12$) and doctors ($n=10$), and midwives and nurses providing direct maternity care at the five local hospitals ($n=80$). All health care providers were emailed a participant information sheet and consent form and invited to participate in recorded focus groups held at two time points by the evaluation team. In addition, brochures were strategically distributed throughout the hospital by the RA; the midwifery and nursing managers were informed and encouraged to promote the focus groups; and doctors were made aware at their monthly meeting of the upcoming focus group. Reminder emails were sent by the evaluation team to all groups the week prior to the scheduled focus groups. The first focus group was 9 months after commencement in April–May 2019; the second focus group was in November and December 2020. The focus groups were conducted separately for: (i) MMoC midwives, (ii) doctors who provided maternity services in the region and (iii) nurses and midwives who worked at the hospitals. For health care providers unable

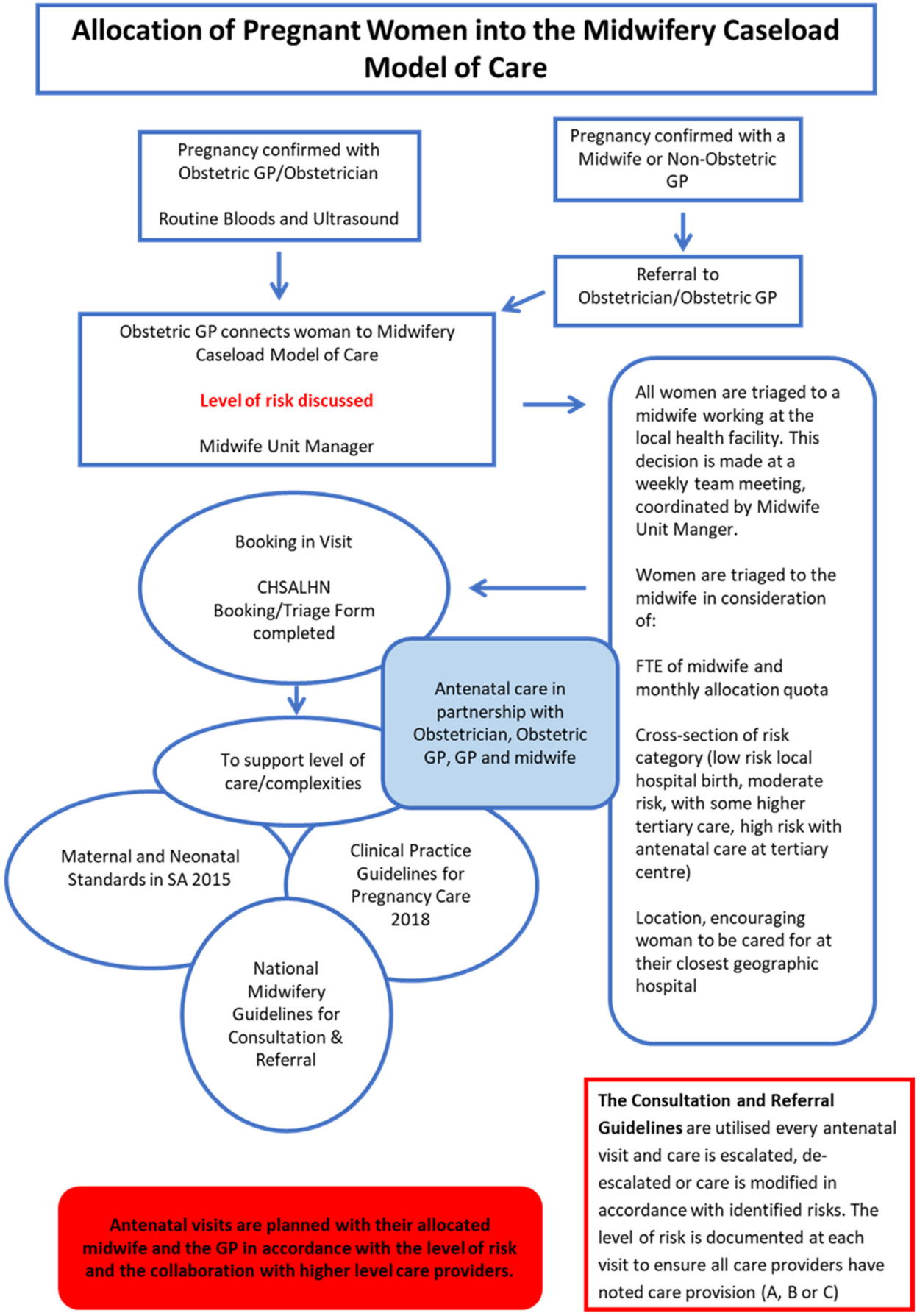

FIGURE 1 Allocation to MM0C.[9]

to attend focus groups and/or those wishing to elaborate further, an anonymous online survey of the same general topics was made available after the focus groups, for all care provider groups.

The aim of the first round of focus groups was to gain insight into the early transition to the MMoC and to provide an opportunity for health care providers to identify what was working well and what concerns needed to be addressed. The second round of focus groups was to seek in depth feedback on the impact to their role, whether early concerns had been addressed, what worked well and/or may need further attention. Due to the COVID-19 pandemic, originally scheduled in-person focus groups were changed to Zoom sessions and recorded with permission from participants. To facilitate open and candid dialogue, the focus groups were facilitated by members of the independent research evaluation team who were experienced in facilitation. Members of the evaluation advisory team were not included in the focus groups to ensure that all care providers were provided an opportunity to speak honestly. A semi-structured format was used and included prompt questions, focused on key aspects as aligned to the QMNC Framework.

2.2 | Data analysis

Data from the focus groups were transcribed verbatim using a transcription service. Thematic analysis of all findings, including additional data from the surveys, was undertaken to identify overarching themes regarding health care provider's experience and impact of the new MMoC. The phases of thematic analysis included: data familiarisation, initial coding, searching for themes, reviewing themes and coding, defining and naming themes and summarising findings.[19] Analysis was undertaken independently by two researchers and themes reviewed independently by a third. Findings from the first focus group guided the discussions in the second round to understand the barriers and facilitators to success, and opportunities for improvement. This paper reports the first focus group in a summary form to enable a more substantial description of the analysis of the second focus group.

3 | FINDINGS

3.1 | Focus group round one

The overarching theme from the analysis of the three separate focus groups—MMoC midwives ($n=14$), hospital nurses/midwives (HN/M) $n=6$ and doctors ($n=5$)—was the 'MMoC was working well', with many positive outcomes identified. Within this, six subthemes identified challenges or areas for improvement that related to collaboration; communication; scope of practice; regional distance; workload; awareness and access. A summary of the first focus group is provided.

3.2 | The MMoC is working well

Feedback focused on both positive aspects as well as challenges faced by the clinicians. However, overall, there was agreement that it was working, they reported women loved the model, and it was working well for the women. Midwives were seen to be able to work to full scope of practice and there were increased professional development opportunities; women had a team and stronger rapport with midwives; there was less disruption on the ward; a supportive environment for students; early discharge and good postnatal follow-up; women discharged from care in Adelaide could be supported.

Some respondents reported teething problems with implementation and transition to the MMoC; for some sites, this appeared more evident than others. Factors related to the need for change included changes to teams, new staff, positions not filled immediately, change in role for some midwives not engaging in the MMoC. Some nursing staff at the hospital found the change quite challenging at first, but this resolved with time. Feedback included recommendations that should the model be implemented in other regions the key to success is sufficient lead in time, with community engagement and multiprofessional consultation.

COVID-19 disrupted some communication and resulted in practice development education being cancelled. However, participants noted that COVID-19 provided an environment that enabled midwives to do more home visits, provide virtual antenatal education, virtual follow-up clinics and the doctors engaged in telehealth.

3.3 | Focus group round two

Findings from round one informed the second round at the end of the evaluation period. Four separate focus groups were undertaken across the five sites; MMoC midwives ($n=10$), doctors ($n=5$) and two for HN/M ($n=9$). Additionally, participants unable to attend (or wanted to provide more detail) completed an online survey based on the focus group questions (respondents included HN/M ($n=7$), MMoC midwives ($n=5$) and a doctor). From the second focus group analysis, the overarching theme captured the absolute commitment to the MMoC and general belief that, *'there is no other option - it has to work'*.

3.4 | There is no other option—it has to work

All health care providers reported a strong sense that the MMoC was required to keep birthing services available to the community.

> Absolutely this is the way ahead – it is how we are going to keep birthing units in rural areas.
> (MMoC)

Alongside this, the findings demonstrated three key themes, (i) the benefit to 'community care and care providers', (ii) a genuine 'commitment to change' from all stakeholders, while (iii) acknowledging the 'challenges and complexities'. Within these key themes, a number of subthemes were evident (Figure 2).

3.4.1 | Community care and care providers

The model benefitted both the community and health care providers as identified by participants in this study. It was clear from all the participants' perspectives that the MMoC was working well for the women, providing an improved and accessible service that supported the local community. The MMoC midwives valued working with women and each other, and many times they expressed that they 'loved' working in the model.

Best for women and keeps care local and accessible

There was consensus that the model of care was beneficial to the women, acknowledging that receiving care, often at home, from a known midwife was very valuable and responded to psychosocial needs and breastfeeding.

> I think some women are getting better care cause its one on one, more intensive and have relationship with them prior to birth the trust is there.
> (HN/M)

> I think it's great it is an amazing change – it's fantastic for community and women.
> (MMoC)

> Women seem to like the model as they have their own midwife.
> (GP)

Midwives value working with women and with each other

The midwives spoke passionately about the model of care, they described the professional fulfilment that reflected their philosophy of practice and a context to engage in woman-centred care.

> I absolutely love it and can't see any other way to go (agreement from other midwives).
> (MMoC)

The midwives commented on the satisfaction of working to the full scope of practice and thought that this model would provide an incentive for other midwives to work in the region. The graduate midwives expressed very positive experiences about the support they received. While at times it had been a steep learning curve, this contributed to their knowledge and clinical skills.

> I feel so much more confident in my skills ... I feel really well supported.
> (Graduate MMoC)

Improvement in service provision

The impact on service provision was discussed, mostly from a positive perspective recognising that without the change their maternity services were threatened.

> I am aware that without the model of care, our site would have birthing closed. The

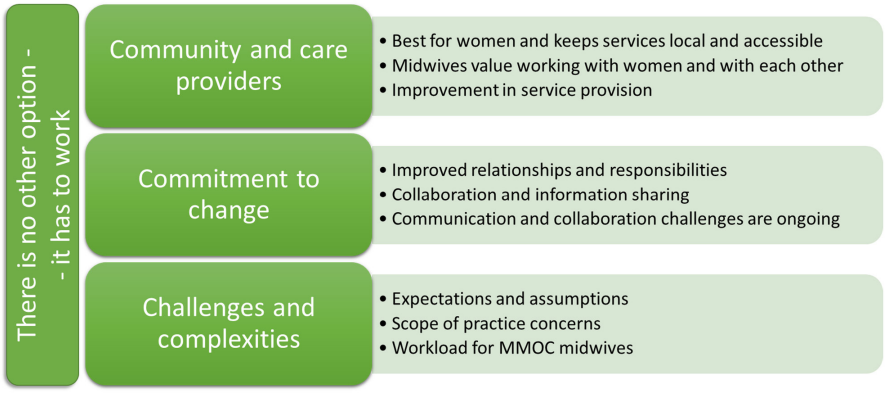

FIGURE 2 Three key themes and subthemes from second focus group analysis.

> women of our large service area deserve a local birthing site and this provides a continuation to the service.
>
> (MMoC)

Nursing staff identified the model contributed to better care for all as they explained in the past dual qualified Registered Nurse/midwife (RN/RM) could be taken from other wards to attend to a labouring woman leaving them short.

> [Better] that a staff member is not taken off the ward while a mid is labouring/ being induced as designated midwives are allocated.
>
> (HN/M)

Participants reported that women had reduced stay on the postnatal floor and less outpatient presentations, 24 h on call cover was available for regional hospitals with each woman allocated a midwife. While challenges were raised throughout the focus group discussion, there was strong support for the model to continue from all represented stakeholder groups. In particular one GP stated, 'I think it is working brilliantly for the midwives' *(GP)*.

3.4.2 | Commitment to change

The participants were asked to reflect on the themes from the initial focus group, particularly regarding early challenges with communication and collaboration. All participants reported a commitment to navigate change, and many had actively contributed to strategies to build relationships and improve information sharing.

Improved relationships and responsibilities

It was recognised that there had been a period of transition and adjustment as each group had come to understand each other and how to work together better.

> At [regional site] we have GP Obs they were resistant at first – we are going through a transition phase to a better place and we communicate a lot better – we are getting there.
>
> (MMoC)

> Communication has been good, there is always going to be situations where there are differences of opinion where you just respect each other.
>
> (GP)

> I think we have done a fair bit of work to improve the cohesion between the ward staff and mid team – through communication – our ward midwives have really stepped up.
>
> (HN/M)

Collaboration and information sharing

Strategies to improve collaboration and communication had been proposed and tried—some with very good effect, while recognising that this would be an ongoing 'trial and error' process. Noticeably, there was a clear solution focussed approach taken.

> Collaboration has improved over the last 6 months since we have started regular face to face meetings for clinical discussions and CPD [continuous professional development].
>
> (GP)

Strategies to improve information sharing included bedside handovers, colour-coded teams, documentation proformas, case reviews and ongoing education.

Communication and collaboration challenges are ongoing

While it was clear there had been a concerted effort to improve communication and collaboration, participants recognised ongoing challenges that needed continuing attention and creative solutions. As one participant noted '*communication between all parties is probably the single biggest issue*' (HN/M). Other comments included:

> From our point of view I guess I miss some communication from the midwives cause they used to consult down by our rooms so their used to be more corridor discussion.
>
> (GP)

> There is definitely room for improvement. Starting with a good handover from the midwives and the nursing interventions they want RN's to do.
>
> (HN/M)

3.4.3 | Challenges and complexities

A number of distinct challenges and complexities were also raised, and some discussed intensely. These related directly to the change in roles, alongside the difficulties of

working in a rural region. A need to clarify expectations and assumptions of non-midwifery staff working alongside the model and their scope of practice, and workload for MMoC midwives was important.

Expectations and assumptions

There was still some confusion about the roles of each health professional, particularly for nurses and midwives, with expectations and assumptions that had not been explicitly clarified. There were several comments which indicated tension for some between the expected role of the midwife and the GP, but this was improving.

> Sometimes in handovers the midwife makes an assumption that the nurse understands the terminology, practice – when they have no idea.
>
> (HN/M)

> After I've seen the patient, you know I think there's possibly differences in how we use language, how we come to patient's decision making and that sort of things.
>
> (GP)

> I think the medical team understand the model more now whereas at the beginning they did not, perhaps lacking knowledge of how the program worked.
>
> (MMoC)

The midwives recognised the value of working well with their medical colleagues,

> They (GP) are an amazing source of information and all highly skilled in their own right which shouldn't be overlooked.
>
> (MMoC)

Scope of practice concerns

Discussion around the scope of practice and education for nursing staff working in hospital with postnatal women and neonates was raised. Not having midwives on the ward once the immediate postnatal care has been provided meant that nurses needed to attend to the woman and baby, or call the MMoC back to provide midwifery care.

> About out of hours when group midwives go home – we ran for a long time with a midwife on every shift and overnight – now the midwife will do their 4 h post-delivery if the patient stays in they get left with the ward staff and get ignored....
>
> (GP)

Scope of practice for nurses was acknowledged by the MMoC midwives as well,

> Transition for hospital staff for not having midwives – they are managing well but for some they have no experience – they have done a really good job grasping that there won't be a midwife 24/7 they have taken this responsibility well.
>
> (MMoC)

Midwives though willing to stay longer, indicated that this was challenging due to workload.

Concern for midwives who had elected not to work in the MMoC model was raised with discussion around the loss of identity and skills. Interestingly, the doctors were quite vocal about this change. Participants recognised that, for sustainability, it was important to provide solutions to be more inclusive of midwives not engaged in the MMoC.

> I sort of feel sometimes that they [ward midwives] are excluded as they are not part of the [MMoC] team but they are a good resources good support to ward nurses and others – need to make them feel included.
>
> (HN/M)

> The model is different, there is some residual hurt feelings from some of the midwives who aren't part of the team (agreement) they think that they are the poor cousins to the maternity service, they are called on when no one is available to pick up the hours that are needed when no one is available – not sure of the answer.
>
> (GP)

Workload for MMoC midwives

Workload of the MMoC midwives was discussed by all stakeholders, perhaps because of the flow on effect for other clinicians The MMoC midwives provided rationales for the increased workload; this included unpredictability of the work, the on-call, administration load, distances travelled and the psychosocial support provided that might otherwise be managed by allied health professionals.

> We only see a small section of what they [MMoC midwives] do- they have a lot of

> hours – home visit, birth, clinic, community – its full on.
>
> (HN/M)

> Care is working very well – the big problem is the midwives are getting overloaded particularly with the workload they are getting with the patients coming back from Adelaide which is over half the workload.
>
> (GP)

> Country MGP [midwifery group practice (MMoC)] is a different breed to city- we get the women early we are looking after them from the moment they ring us and say they are pregnant - when you look at our workload when we don't have administrative support, we are doing the administrative for social work – putting in referral, helping fill out paper work for women to get housing – DASA.
>
> (MMoC)

One aspect that was discussed at length was Country Home Link, a follow-up service for all women who birthed out of the region. This was often in addition to the midwifes caseload and contributed to increased and at time, unpredictable workload.

> Previously they had more care in Adelaide they would stay 2 or 3 days to get things established now they go home straight away and midwives here are expected to give all their postnatal care.
>
> (GP)

Caseload was not well understood by all parties, how it was calculated or how it equated to standard hours. Additionally, midwives suggested that a case load of 38 women was too large in a rural environment.

> I agree that increase in FTE [full time equivalent] has increased our workload exponentially not just because its caring for women but because in this model we now have so much more education opportunities – we have more meetings, more administration jobs – I think there has to be a reduction in FTE to make the workload sustainable to provide the quality care that we want to provide so.
>
> (MMoC)

While most MMoC midwives felt they were managing, several midwives identified a risk of burnout.

The participants recognised that some of the challenges had been due to deficits in positions being filled and the need to back fill for maternity and other leave. This had impact on nursing staff being able to provide the care needed to women who remained admitted to hospital, many times the nurses were reluctant to call the midwife back if she had attended a birth earlier.

> Yes we know they are there but we know they are exhausted, doing delivery after delivery- try not to call them but I call if I have to but sometimes the mid [patient] has to wait an hour or hour and half cause the midwife is far away.
>
> (HN/M)

4 | DISCUSSION

Bringing together five different rural sites under the governance of a midwifery caseload model is unique and impacted all health care providers working within the region. Despite the significant change to roles, all care providers supported the continuation of the MMoC and agreed that the benefits for all stakeholders far outweighed the challenges. Challenges were identified with a solution-based focus and evidence of a commitment from all to succeed. Caseloads that consider local need, defining roles and responsibility and strong visionary leadership are key to continuing success.

4.1 | Challenges implementing a rural MMoC

Challenges working in rural areas include distance to travel, isolation and lack of resources.[1,20–22] In this study, midwives identified the allocated caseload of 38 women, in addition to providing postnatal home care to women returning after birthing in metropolitan services to be a significant challenge. Concern around regional/rural caseload is not new, with studies asserting that the caseload contract system has been designed for urban-based midwives and that it does not work as well for rural maternity services.[23,24] In a study which explored midwives working in a caseload model in rural Victoria,[22] the on-call element of caseload interrupted midwives' personal lives and was one of the most difficult factors. Similar to this study, being called in for a birth would necessitate reorganisation of other appointments, impacting not only the women but other care providers as well.[22] The MMoC midwives all felt that they were well supported and prepared; however,

the need for adequate resources, protected time-off and a competent workforce were identified. Simple measures, such as available service cars, shared resources between sites and ongoing professional development specific to context, were recognised as important to ensure sustainability. Similarly, in an exploration of rural midwifery practice in New Zealand and Scotland, Gilkison et al.[25] concluded that appropriate and available education strategies were necessary to ensure ongoing competence and retention of midwives.

Participants also discussed the increased psychosocial needs of women living in the region as an unrecognised workload, yet as reported in similar studies, recognised that midwifery-led care is ideal to provide care that meets diverse psychosocial needs.[26,27] Continuity within midwifery care is a key feature in developing a strong therapeutic relationship and enables the midwife to identify and organise care around the needs of the woman, while simultaneously strengthening the woman's own capabilities.[17] To ensure sustainability, there is a need to ensure that the caseload is appropriate to the local need, complexities and organisational structure.

4.2 | Roles and responsibilities

The QMNC Framework advocates the provision of good quality care through appropriate division and integration of roles and responsibilities of all health care providers.[18] In the MMoC, nearly all women had a known midwife, which both women and midwives reported as highly satisfying. Additionally, most women also regularly saw a doctor through their pregnancy. In some cases, care was coordinated by the midwife and in others by the GP's/obstetricians depending on the woman's needs, the woman's choice and local arrangements. This was largely due to existing maternity care service organisation and to meet expectations of medical maternity care providers in the region. Notably, doctors reported their roles did not change rather the midwifery model facilitated reduced out of hours call and improved communication between the health services and women. Collaboration between midwives and doctors is one of the central tenets of the MmoC. Studies exploring midwifery continuity of care have described barriers to effectively implementing this model of care, including underutilisation of midwives or 'contested care,' whereby power struggles exist between midwives and doctors.[17,28,29] In this study, the focus group data indicated that the relationship between the doctors and midwives was functioning well, but some discussion suggested that a further transition and acceptance of midwives, particularly as lead care providers, may need to evolve. A Canadian study which explored the barriers and facilitators of interprofessional collaboration with midwives identified that disciplinary difference and service arrangements were a genuine factor to negotiate.[28] This was sometimes exacerbated in remote areas due to lack of clearly defined roles, scope of practice and organisational structures.

Midwifery continuity of care models is not always well understood by other health professionals and role boundaries are potential areas for conflict.[22] For instance, Kashani et al.[22] described an 'us' and 'them' relationship between continuity midwives and hospital midwives. They noted that doctors sometime considered caseload midwives less positively, or as reported by Crowther and Smythe,[23] midwives did not always value the perspectives of doctors. Interestingly, a study that investigated collaborative practice between maternity care providers found that doctors and midwives had different core beliefs about models of care and that this was the main source of conflict threatening collaborative practice.[30] In their exploration of maternity care in rural New Zealand, Crowther and Smythe[23] concluded that collegiality, where teams worked together well, appreciated one another's difference was vital. They called for each profession to work co-operatively rather than competitively and concluded that intentionally nurturing respectful and trusting professional relationships were required. Activities such as collaborative learning and interprofessional case reviews and debriefs were suggested.[25] Other recommendations included planned team building activities focussed on strengthening collegial relationships[22] as well as interdisciplinary professional development.[28] Tennett et al.[21] noted that despite the sometimes difficult working conditions, rural services present an opportunity to forge secure community relationships and collegial teams. Notably, all care providers in this study were committed to improving collaboration and communication through a variety of strategies.

4.3 | Enablers for the success of the MMoC

A significant key to the success of the model of care in the YNLHN was strong visionary leadership and well-developed overarching management. Early and extensive stakeholder engagement and willingness to change at the group level[31] had fostered a shared commitment to transform the existing five services into an integrated, multi-disciplinary model of care. The impact of the leadership and in-depth collaboration was evident in the participants shared agreement that the MMoC had been a success. The need for effective leadership and collaboration is reported repeatedly in studies on implementing

midwifery models of care.[32–36] In particular, McInnes et al.[33] evaluated a midwifery model of care in the United Kingdom and concluded that leadership was essential in building trust across all stakeholders. Larsson et al.[32] reported the need for strong, supportive midwifery and obstetric leadership, as well, as interprofessional collaboration. Likewise, when upscaling a midwifery continuity of care model in coastal Queensland, Styles et al.[36] concluded that managerial support, co-operative interdisciplinary relationships and positive organisational culture were crucial. These studies advocated that interdependency, underpinned by mutual respect and shared ownership of the service goals should support expansion of midwifery continuity models.[33,36] Positive outcomes were also credited to the midwives who provided the services, as was evident in this study.[37] Leadership that enables midwives to flourish particularly within midwifery models of care is essential.[30,36] There is a need to 'protect, lead, manage and juggle the internal and external demands', which required leaders with both management skills, and a transformative, relationship-based leadership approach.[32(p. 175)] Specifically, there is a need to ensure that MMoC leadership is supported and sustained within a shared vision for the YNLHN, recognising that multi-professional commitment is imperative for sustainability.

Midwives described high satisfaction when working in continuity models particularly around establishing effective relationships with women based on trust and respect, autonomous practice and flexibility.[22,33,38] To support longevity and sustainability of the MMoC, there will be a need to continue to attract midwives. In this evaluation, midwifery graduates and early career midwives were employed to work in the model. While feedback from graduates was limited, overall they indicated they were well supported and noted supervision and assistance was always close by. There is strong evidence that graduate midwives supported to practice in continuity of care models are able to successfully consolidate their knowledge and skills across the full scope of midwifery practice.[17,33,39–41]

While there remain some challenges, all care providers reported a strong commitment to navigate the changes. There were benefits across all stakeholders and recognition that this model represented a means to provide high quality and safe maternity service in rural SA for all women living in the region.[15] This might mean that some women with high risk factors will be referred to metropolitan services through referral arrangements but return for midwifery postnatal care. Hospital midwives and nurses were required to make significant adjustments but agreed that benefits outweighed disadvantages. Following the end of the MMoC pilot programme, the model was endorsed as the ongoing model of care for the YNLHN region.

4.4 | Limitations

Restrictions due to the pandemic meant that both sets of focus groups originally planned to be held on site had been rescheduled at short notice to online (Zoom). This may have affected attendance and candid conversations from clinicians, although attempts were made to overcome this by way of optional, anonymous, follow-up surveys for those who wished to say more in a private forum. Additionally, the authors recognise that the findings are based on a particular model as implemented in one region of South Australia and may not be generalisable to other regions. However, the findings contribute to the growing body of knowledge on implementing successful midwifery models of care.

5 | CONCLUSION AND RECOMMENDATIONS

There is evidence to support that the MMoC is effective, acceptable and sustainable from all stakeholders. There is strong support for the MMoC from all health care providers, recognising benefits for maternal outcomes and satisfaction. There was an evident commitment to ensure that this model would be sustainable within these communities, with all participants seeking to improve collaboration and communication. The MMoC midwives were extremely positive about working in the model but raised concerns over caseload. Alongside this, there was some concern for the non-midwifery staff who provided care when women remained in hospital, if midwives were not available, as well as some disappointment from hospital midwives regarding their loss of diversity in practice.

The most evident recommendation from this evaluation is the MMoC should continue in this region as standard maternity care. Additionally, this model may be replicated and expanded upon for other regional networks with consideration of local need and organisational structure. It represents an innovative approach and offers a sustainable model into the future.

AUTHOR CONTRIBUTIONS

Lois McKellar: Conceptualization; investigation; writing – original draft; methodology; writing – review and editing; formal analysis. **Julie-Anne Fleet:** Conceptualization; investigation; writing – original draft; methodology; writing – review and editing; formal analysis. **Pamela Adelson:** Conceptualization;

writing – original draft; investigation; methodology; writing – review and editing; formal analysis; project administration.

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CONFLICT OF INTEREST STATEMENT

The author of this paper declares that the work included has been complied in originality and there are no conflicts of interest in this paper.

ETHICS STATEMENT

Ethics was approved by the Women's and Children's Human Research Ethics Committee, HREC/19/WCHN/68 on 06/06/2019 and by the University of South Australia (UniSA) Human Research Ethics Committee (HREC) Application ID: 202393 on 14 August 2019.

ORCID

Lois McKellar https://orcid.org/0000-0001-7490-2478
Julie-Anne Fleet https://orcid.org/0000-0001-6228-5636

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