

Manuscript Details

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Title	Enabling new graduate midwives to work in Midwifery Continuity of Care Models: a conceptual model for implementation
Article type	Discussion

Abstract

Background: High-level evidence demonstrates midwifery continuity of care is beneficial for women and babies. Women have limited access to midwifery continuity of care models in Australia. One of the factors limiting women's access is recruiting enough midwives to work in continuity (Dawson et al. 2016; Hartz et al. 2012). Our research found that newly graduated midwives felt well prepared to work in midwifery led continuity of care models, were well supported to work in the models and the main driver to employing them was a need to staff the models (Cummins, Denney-Wilson & Homer 2015, 2016). However limited opportunities exist for new graduate midwives to work in midwifery continuity of care. Aim: The aim of this paper therefore is to describe a conceptual model developed to enable new graduate midwives to work in midwifery continuity of care models. Method: The development of a conceptual model that enables new graduate midwives to work in midwifery continuity of care. Findings: The model contains the essential elements to enable new graduate midwives to work in midwifery continuity of care models. Discussion: Each of the essential elements are discussed to assist midwifery, managers, educators and new graduates to facilitate the organisational changes required to accommodate new graduates. Conclusion: The conceptual model is useful to show maternity services how to enable new graduate midwives to work in midwifery continuity of care models.

Keywords	New graduate midwives Midwifery led continuity of care Facilitate organisational change
Taxonomy	Midwifery-Led Care in Health Technology, Midwifery
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5 **Enabling new graduate midwives to work in midwifery**
6 **continuity of care models: A conceptual model for**
7 **implementation**
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13 **Statement of significance**
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15 **Problem or Issue** ☒
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17 Women have limited access to midwifery continuity of care models, in Australia. As
18 models are expanded across the country managers may experience difficulties in
19 recruiting midwives to work in the models. New graduate midwives rarely have the
20 opportunity to work in midwifery continuity of care.
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23 **What is Already Known** ☒
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25 New graduate midwives are well prepared to work in continuity of care models.
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27 When they do have the opportunity to work in these models they are well supported
28 with a good orientation, a reduced workload initially and mentoring. Midwifery
29 continuity of care is beneficial to women and government recommendations are to
30 expand the models in Australia.
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33 **What this Paper Adds**
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35 This paper provides a conceptual model that will show managers, educators and
36 other key stakeholders how to enable new graduate midwives to work in continuity
37 of care models.
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41 **Introduction**
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43 Midwifery continuity of care is important to women, midwives and maternity
44 services. High level evidence now shows that women, who experience midwifery led
45 continuity of care, are more likely to experience a normal birth with reduced
46 obstetric interventions, while babies are less likely to be born prematurely or
47 admitted to the neonatal intensive care unit (Sandall et al. 2016). Women report
48 higher levels of satisfaction with their birth experience when they know their
49 midwife (Common 2015; Fereday et al. 2009) and midwives enjoy working this way
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63 (Collins et al. 2010; Newton et al. 2014b). Research has also shown benefits to the
64 health service including cost effectiveness (Tracy et al. 2013).
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68 While the benefits are now evident, midwifery continuity of care has not been
69 widely implemented in many countries including Australia. A recent study estimated
70 that less than 10% of women have access to midwifery continuity of care in Australia
71 (Dawson et al. 2016). Similar low rates are seen in the United Kingdom, with rates
72 around 15%, an improvement but continuity across the continuum is still not
73 universal (National Maternity Review 2016). New Zealand has the highest rates of
74 midwife led continuity of care with around 85% of women having access to this
75 model (Gray et al. 2016).
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84 One of the reasons preventing the expansion of midwifery continuity of care models
85 is a shortage of midwives who want to work in this way (Dawson et al. 2016). Given
86 new graduate midwives often want to work in midwifery continuity of care models,
87 facilitating their transition directly from student to midwife in a continuity of care
88 model could help to address staffing issues. Previous research in Australia has
89 suggested that new graduate midwives could be employed in midwifery continuity
90 of care models to increase their confidence rather than working in a transition to
91 profession practice program (Clements, Fenwick & Davis 2012; Davis et al. 2011).
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99 Most current transition programs for new graduate midwives provide a structured
100 rotational clinical program with preceptorship and study days (Nursing and
101 Midwifery Office 2015). The programs often last 12 months and are based on the
102 new graduate rotating into different areas of the hospital for a specified time frame.
103 A study of new graduate midwives' experiences of the transition program showed
104 that this may not be the best way for a new graduate midwife to transition,
105 particularly when they desire to work in a midwifery continuity of care model
106 (Clements, Fenwick & Davis 2012) and have been educated for this model (Gray,
107 Taylor & Newton 2016). In New Zealand, about half the new graduate midwives will
108 transition directly to midwifery continuity of care models and are supported through
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123 the Midwifery First Year of Practice Program (New Zealand College of Midwives
124 2014). This could be an opportunity for other countries, such as Australia.
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128 In Australia, only a small number of new graduate midwives have been employed to
129 work in midwifery continuity of care models. Our previous research has shown that
130 these models facilitate the consolidation of skills and knowledge better as the new
131 graduates develop a relationship of trust with the woman and their colleagues
132 (Cummins, Denney-Wilson & Homer 2015). New graduate midwives have high job
133 satisfaction when they 'know the woman' assisting with ongoing retention of staff in
134 the workplace. In addition, the new graduates struggled with creating professional
135 boundaries however they were supported by the relationship with the small team of
136 midwives they worked alongside. Support included mentoring and regular team
137 meetings (Cummins, Denney-Wilson & Homer 2016b). Further research with
138 managers and other key midwifery leaders found that the main driver for employing
139 new graduate midwives into midwifery continuity of care models was to staff the
140 models (Cummins, Denney-Wilson & Homer 2016a). Visionary leaders talked about
141 how they sought out well-prepared graduates to work in the models and provided
142 support such as a reduced workload and mentoring (Cummins, Denney-Wilson &
143 Homer 2016a).
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157 Our research made us interested in how best new graduate midwives could be
158 supported to provide midwifery continuity of care early in their transition. In
159 response to this interest, we synthesized the findings from our studies into a
160 conceptual model that provides advice and guidance in relation to enabling new
161 graduate midwives to work in these models (Cummins, Denney-Wilson & Homer
162 2015, 2016a, 2016b). The conceptual model is designed to assist midwifery,
163 managers, educators and new graduates to facilitate the organisational changes
164 required to accommodate new graduates. The aim of this paper therefore is to
165 describe the conceptual model and show how it may be used in maternity services.
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172 **Informing the development of a conceptual model**

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183 We drew on our previous studies that were undertaken to understand the
184 experiences of new graduate midwives working in midwifery continuity of care
185 models and the challenges to employing them. Initially, newly graduated midwives
186 were interviewed and the findings showed that they felt well prepared to provide
187 continuity of care in a small group practice. When working in continuity of care
188 models, they were able to quickly consolidate their skills and their confidence grew
189 as they developed relationships of trust with the women and the small group they
190 worked alongside. Essential to their successful transition was the support provided
191 by the group of midwives in the continuity of care models (Cummins, Denney-Wilson
192 & Homer 2015). This support often took the form of mentoring (Cummins, Denney-
193 Wilson & Homer 2016b).

204 The second study examined the views of managers, clinical educators and clinical
205 support midwives. Their main driver to employing new graduate midwives was a
206 need to staff the continuity of care models (Cummins, Denney-Wilson & Homer
207 2016a). They recognised that a longer orientation period, initially a reduced
208 workload, and other forms of support such as mentoring were required for success
209 (Cummins, Denney-Wilson & Homer 2016a). Managers also had to overcome
210 barriers in employing new graduates in this way, such as managing the myths that
211 new graduates need to complete a standard transition program or have several
212 years of experience before working in the models. Those managers who were able to
213 employ new graduate midwives in this way were seen as 'visionary leaders'
214 (Cummins, Denney-Wilson & Homer 2016a).

224 The findings from the two studies were synthesized with the literature (Tables 1 and
225 2) and the conceptual model was developed.

229 Insert Table 1 and 2

232 The essential components to enable new graduates to work in midwifery continuity
233 of care models are represented in the centre of the model (Figure 1).

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243 Insert figure 1
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245 The individual components are discussed below.
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248 **The conceptual model: Enabling new graduate midwives to work in** 249 **midwifery continuity of care models.** 250

251 252 253 **Essential component 1: Building relationships of trust through a high level of** 254 **continuity of care** 255

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257 *Midwifery continuity of care models should be organised in small teams of 2-4 to*
258 *provide women and midwives with high levels of satisfaction, and to promote*
259 *confidence in new graduate midwives.*
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263 Relational or interpersonal continuity of care (Saultz 2003) is provided through small
264 group practices or small teams. As part of a small group, the midwife provides
265 continuity of care to around one to four women a month and develops a relationship
266 of trust with that woman, as she gets to know her and her family throughout the
267 pregnancy (Page 2003). Women are most satisfied when they know their midwife
268 and when their primary midwife provides most of the woman's antenatal and
269 intrapartum care (Williams et al. 2010). Women build trusting relationships and feel
270 in control of their birth experience when they know their midwife (McLachlan et al.
271 2016; Williams et al. 2010). The relationship with the woman improves job
272 satisfaction for midwives and collegiality is enhanced when the midwife works in
273 small groups of around four midwives (Collins et al. 2010; Edmondson & Walker
274 2014; Newton et al. 2014b).
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285 The relationship with the woman enables the new graduate midwives to consolidate
286 skills and grow in confidence (Cummins, Denney-Wilson & Homer 2015). Confidence
287 to practice will be enhanced with the nurturing and support that is found in a small
288 team or group of two to four midwives working in a continuity of care model
289 (Clements, Davis & Fenwick 2013; Cummins, Denney-Wilson & Homer 2015; Hartz et
290 al. 2012; Page 2003).
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303 New graduate midwives who have worked in both a transition program and a
304 continuity of care model reported being highly satisfied when working in the latter
305 option (Cummins, Denney-Wilson & Homer 2015). Caseload midwives providing
306 continuity of care have been shown to have lower levels of professional exhaustion
307 known as burnout compared with midwives working standard shifts suggesting that
308 continuity may be an important strategy to reduce staff attrition (Fereday & Oster
309 2010; Newton et al. 2014a). Similar satisfaction levels have been found in groups of
310 community midwives in England (Common 2015).
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318 Job satisfaction is key to attracting and retaining staff. The main driver for the
319 employment of new graduate midwives into midwifery continuity of care models is
320 mainly due to workforce needs (Cummins, Denney-Wilson & Homer 2016a) often
321 filling positions because of maternity leave (Cummins, Denney-Wilson & Homer
322 2016a; Hartz et al. 2012). A study in New Zealand, where the majority of midwives
323 work in midwifery continuity of care models, found that the reciprocal nature of the
324 trusting relationship with the woman sustained midwives' enthusiasm for their job
325 (McAra-Couper et al. 2014). Enabling new graduate midwives to work in midwifery
326 continuity of care models, where there is a high level of continuity may also address
327 staffing issues and assist with staff retention.
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338 **Essential component 2: Providing support and mentoring from within the small** 339 **group of midwives**

340 *A facilitator to enabling new graduate midwives to work in Midwifery continuity of*
341 *care models is to provide a longer orientation period, a reduced caseload and*
342 *mentoring.*
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348 New graduate midwives have expressed that they feel supported through the
349 relationship with the small team and some level of mentoring from either within or
350 outside the team (Cummins, Denney-Wilson & Homer 2015, 2016b). Mentoring can
351 occur in different ways. It can be ad hoc where the new graduate finds a midwife
352 from within or outside the small team, or occur within a formalised program where
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363 the manager allocates a buddy to support the new graduate (Cummins, Denney-
364 Wilson & Homer 2016b; Kensington 2006; Lennox 2011; Lennox, Skinner & Foureur
365 2008). New graduate midwives find both types of support valuable.
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370 In some settings, formal mentoring programs have been established for new
371 graduates, especially in continuity of care models. For example, in New Zealand, the
372 'First Year Midwifery Experience Program' is a structured program consisting of a
373 named mentor, the ability to be released from work to attend ongoing education
374 and professional activities (Dixon et al. 2015). This program enables the new
375 graduate midwife to transition directly into midwifery continuity of care models, and
376 is similar to the Australian 'transition to practice' program. There seem to be few, if
377 any, formal first year support systems for new graduates working in continuity of
378 care models in Australia.
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387 There are some examples of mentoring or support for new graduate midwives but
388 not all have been successful. In some instances, new graduates have been allocated
389 preceptors but these may not be rostered on the same days as the new graduate
390 which means the development of a mentoring relationship is limited. The level of
391 activity on the ward also prevents new graduates from attending some of their
392 planned supportive study days (Clements, Fenwick & Davis 2012). The new
393 graduates have also complained they are not consolidating skills across all areas of
394 midwifery as they remain in one area for three or four months which was not
395 enough (Clements, Fenwick & Davis 2012). Ongoing funding of mentorship programs
396 like the one described in New Zealand is a challenge (Lennox, Skinner & Foureur
397 2008; McKenna 2003). Health services and organisations may argue there is not
398 enough funding to support a formalised mentoring program and hence an ad hoc
399 program is utilised. Support for mentoring and support is needed to support new
400 graduate midwives to work in midwifery continuity of care models and this may
401 mean diverting funds from traditional transitional models.
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423 **Essential component 3: Prepare graduates to work in midwifery continuity of care**
424 **models**
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426 *Managers and midwives working in the continuity of care models need to actively*
427 *seek out students and new graduates who they think will be suited to work in this*
428 *way.*
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433 By embedding valuable continuity of care experiences into the midwifery curriculum,
434 new graduate midwives in Australia complete their degrees prepared to work in
435 these models (Carter et al. 2015; Dawson et al. 2015; Gray, Taylor & Newton 2016).
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437 The findings from our study (Cummins, Denney-Wilson & Homer 2015) add to the
438 growing evidence that new graduate midwives are well prepared to work in
439 midwifery continuity of care models due to their experience as midwifery students.
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445 Managers may only actively seek out students and new graduates to work in the
446 models during times of staff shortages (Cummins, Denney-Wilson & Homer 2016a).
447 However, attracting enough midwives to work in these models can be a major
448 barrier to their implementation or expansion (Dawson et al. 2016). Employing new
449 graduate midwives into these models may be one answer to meeting staffing
450 demands (Hartz et al. 2012), and also seeking out students who are interested and
451 those who have had clinical experience in a continuity of care model can be helpful.
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459 Fears have been raised that new graduate midwives lack confidence or experience to
460 work in midwifery continuity of care models without completing the transition to
461 practice program or without several years of experience (Cummins, Denney-Wilson
462 & Homer 2016a). Managers and other key stakeholders who do employ and support
463 new graduate midwives can see that new graduates are able to move directly into
464 the models as they have met the registration standards and licensing requirements
465 to be registered as a midwife and they will always work as part of an integrated team
466 – usually on the usual hospital birth unit (Cummins, Denney-Wilson & Homer 2016a;
467 Nursing and Midwifery board of Australia 2017). Support and mentoring again is
468 required to help build the confidence of new graduate midwives so that they can
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483 effectively and quickly transition into working in midwifery continuity of care
484 models.
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487 488 **Essential component 4: Provide and access collaborative and reflective team** 489 **meetings** 490

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492 *Collaborative and reflective team meetings need to regularly occur in order to*
493 *provide education and emotional support for new graduate midwives who work in*
494 *continuity of care models. These need to involve all staff in the model, as well as a*
495 *supportive obstetrician. Care planning for women and concerns of the new graduate*
496 *midwives should be addressed in these meetings.*
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503 New graduate midwives who attend regular group meetings seem to have the
504 confidence to reflect on their own performance and interactions with others through
505 collaborative, reflective team meetings (Lennox, Jutel & Foureur 2012). Attending
506 regular team meetings offer an opportunity for new graduates to discuss any
507 concerns, reflect on their practice and collaborate with their peers. These meetings
508 consist of all the midwives in the group, the manager, a clinical support midwife, an
509 educator and sometimes an obstetrician.
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517 New graduate midwives often find it easier to discuss a woman's care with an
518 obstetrician who regularly supports the continuity of care model and the midwifery
519 team. Collaboration is enhanced through this relationship (Beasley et al. 2012;
520 Cummins, Denney-Wilson & Homer 2015; Edmondson & Walker 2014; Hartz et al.
521 2012). It is imperative for new graduate midwives and managers/other key
522 stakeholders, who support them, to seek out obstetricians who are collaborative and
523 supportive of continuity of midwifery care. The majority of new graduate midwives
524 are employed in a public hospital but not all models have access to a named
525 obstetrician and the level of medical support that can occur in the continuity of care
526 models varies. Having a named obstetrician in one organisation was useful (Beasley
527 et al. 2012; Hartz et al. 2012) and could be replicated to enable new graduate
528 midwives to work in continuity of midwifery care.
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543 **Essential component 5: Having an approachable/available manager, educator or**
544 **clinical support midwife**
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546 *Managers, educators and clinical support midwives should be approachable and*
547 *available for the new graduate midwives to facilitate collaboration, communication*
548 *and address any concerns.*
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553 Managers of maternity units have demanding and stressful roles and often the
554 needs of new graduates may not always be a priority (Clements, Fenwick & Davis
555 2012). Having a good understanding of midwifery continuity of care models can also
556 be very important for managers as it helps support the models more generally (Kay
557 2010 ; Menke et al. 2014).
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563 Historically in Australia, the leaders in midwifery have had a nursing background and
564 may not always have experience in expanding midwifery services (Cummins,
565 Denney-Wilson & Homer 2016a). In our study, managers who understand the
566 flexible way midwives work in midwifery continuity of care models, and were
567 approachable and available, were seen as visionary leaders and this was
568 fundamental to enabling new graduate midwives to work in midwifery continuity of
569 care models.
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576 Visionary leaders practice a transformational leadership style (Taylor, Corneilus &
577 Colvin 2013). Transformational leadership is characterised by facilitating change in
578 an organisation (Taylor, Corneilus & Colvin 2013). Their vision for improvement and
579 change, is often shared with the midwives who work in the models (Rainey 2013).
580 Visionary leadership is needed to enable new graduate midwives to work in
581 midwifery continuity of care models.
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588 In Australia, visionary leaders in midwifery over the last two decades have engaged
589 in research and worked with consumers to raise the profile and visibility of
590 midwifery (Bogossian 1998; Brodie 2002; Brodie & Barclay 2001; Teakle 2013).
591 Visionary leaders have tried and tested a range of strategies to implement continuity
592 of care into practice and many of these have also been applied to new graduates.
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603 For example, rotating new graduate midwives into midwifery continuity of care
604 models, as part of the transition to practice program, has been adopted to introduce
605 the employment of new graduate midwives into midwifery continuity of care
606 models. The majority of these new graduates remained working in the midwifery
607 continuity of care models after the rotation was complete addressing the staff
608 shortages (Cummins, Denney-Wilson & Homer 2016a). The midwives were highly
609 satisfied and decided to stay working in the models rather than continue with the
610 transition to practice program.
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618 Visionary leaders will attract and retain midwifery staff, including new graduate
619 midwives, to work in the expanding continuity of care models based on a shared
620 philosophy and vision. Both the new graduate midwives and the more experienced
621 midwives who work in the midwifery continuity of care models are usually protective
622 of the woman centred philosophy and are committed to working in this way
623 (Cummins, Denney-Wilson & Homer 2015). Midwives are more likely to leave the
624 profession if they cannot develop meaningful relationship with women as is
625 facilitated more easily through midwifery continuity of care (Curtis, Ball & Kirkham
626 2006; Stevens & McCourt 2002; Sullivan, Lock & Homer 2011). Having the
627 opportunity to work in a relationship-based model may attract new graduate
628 midwives to apply for these positions, address staffing shortages and provide high
629 levels of job satisfaction for the midwives (Cummins, Denney-Wilson & Homer 2015,
630 2016a).
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642 Other barriers to employing new graduate midwives to work in midwifery continuity
643 of care models are the persistent cultural myths that surround graduates from the
644 different midwifery education programs - Bachelor of Midwifery (BMid); Graduate
645 Diploma or Masters; and, Double Degree (Nursing and Midwifery). All graduates are
646 able to work competently as a midwife once they have graduated and registered as a
647 midwife with the Nursing and Midwifery Board of Australia (Australian Nursing and
648 Midwifery Accreditation Council 2014; Nursing and Midwifery board of Australia
649 2017). All new graduates have low levels of confidence when they begin practise
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663 with increasing levels over the first months especially with mentoring and support
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665 (Davis et al. 2011).
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668 Another cultural myth is the need for new graduates to have a number of years'
669 experience to be able to provide midwifery continuity of care. There is evidence that
670 the new graduate midwives are well prepared to work in the models, they
671 consolidate skills and knowledge better when they know the woman and they are
672 well supported by the small team of midwives they work alongside (Cummins,
673 Denney-Wilson & Homer 2015). Visionary leaders will demystify the belief that new
674 graduate midwives are unable to provide midwifery continuity of care without years
675 of experience and they do not distinguish between graduates from different
676 programs recognising all new graduates need nurturing and support.
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684 **Conclusion**

685 Enabling new graduate midwives to work in midwifery continuity of care models is
686 achievable and offers a solution that may assist maternity services to introduce or
687 expand midwifery continuity of care models for women to access. Five essential
688 components are described as well as suggestions for funding to assist the transition
689 of well-prepared new graduate midwives into midwifery continuity of care models
690 without having to complete a transition program. Visionary leadership that
691 promotes a woman centred midwifery philosophy throughout the maternity service
692 underpins the model to enable new graduate midwives to work in midwifery
693 continuity of care models.
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Figure 1

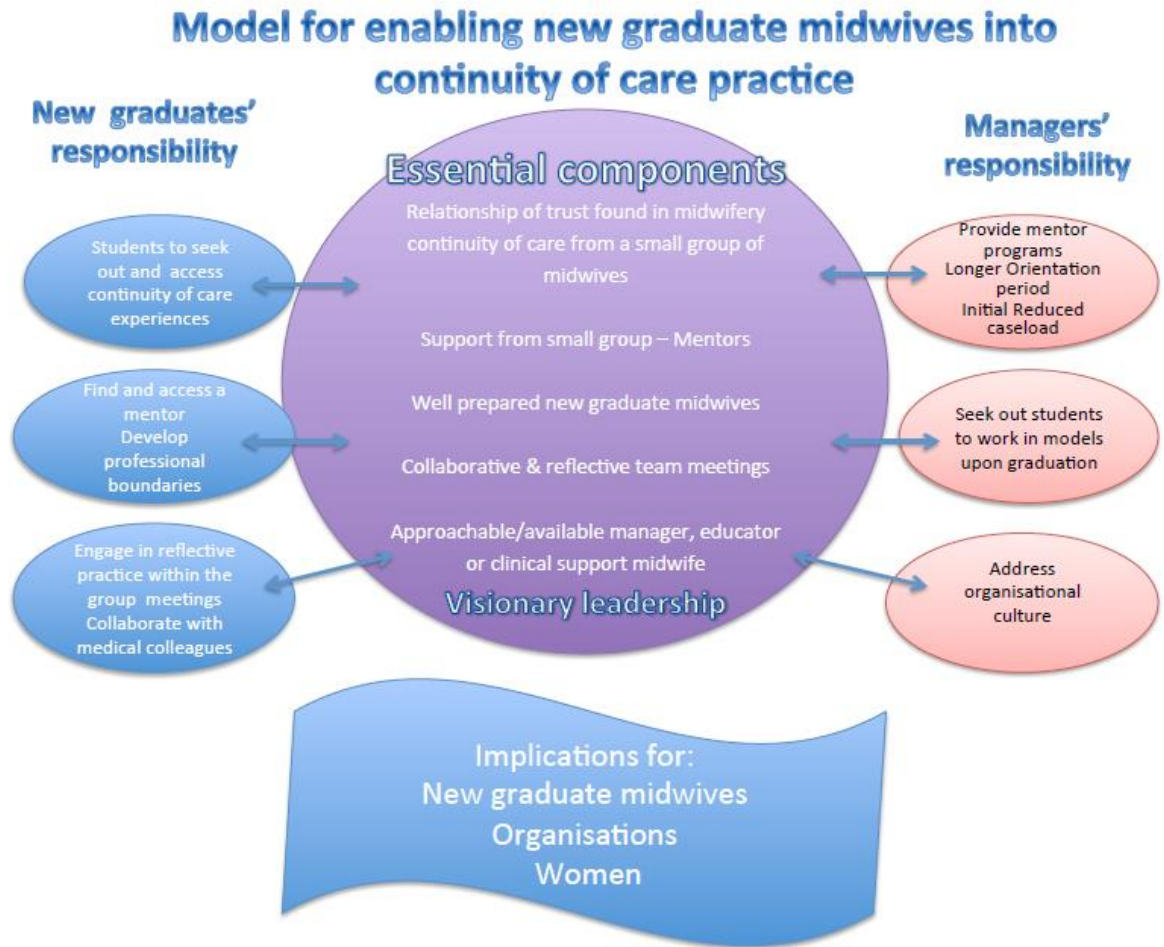


Table 1

INTERPERSONAL CONTINUITY OF CARE THEORY			
My Findings		Conceptual model	
Phase one	Findings synthesised with existing literature	Essential elements	Responsibilities
<p>The importance of the relationship with the woman</p> <ul style="list-style-type: none"> • Having trusting relationships • Consolidating skills through continuity • Finding satisfaction through continuity • Defining professional boundaries through continuity 	<p>The evidence states there are better outcomes for mothers and babies with midwifery continuity of care. The higher the level of midwifery continuity the higher levels of satisfaction</p> <p>My study found new graduates confidence grows when they know the woman. The midwives experience increased satisfaction.</p> <p>Professional boundaries are an integral part of continuity of care . New graduates working in this way are challenged.</p>	<p>Provide new graduates with opportunities to work in midwifery continuity of care models</p>	<p>Students to seek out and be offered clinical experience in continuity of care models to obtain the continuity of care experiences</p>
<p>The importance of the relationship with the small group of midwives</p> <ul style="list-style-type: none"> • Feeling supported from the group • Sustaining continuity model • Prepared to work in continuity 	<p>The evidence state: Students experience continuity of care as part of their degree. New graduate midwives need support. Mentoring from either inside the group or outside the group of midwives is positively evaluated</p> <p>My study found new graduate midwives were dependant on collaborative and reflective meeting and developed professional relationships with the midwives and medical colleagues</p>	<p>Provide support from the small group including mentors</p> <p>Leads to well prepared graduate midwives</p> <p>Ensure collaborative & reflective team meetings</p>	<p>New graduate midwives need to develop professional boundaries</p> <p>New graduate midwives need to find and access a mentor</p> <p>New graduate midwives need to engage in reflective team meetings and collaborate with medical colleagues</p>

Table 2

DIFFUSION OF INNOVATION THEORY			
My Findings		Conceptual model	
Phase Two	Findings synthesised with existing literature	Essential elements	Responsibilities
<p>Innovation is the employment of new graduate midwives working in midwifery continuity of care models.</p> <ul style="list-style-type: none"> • Drivers - Recruiting for the future • Enablers- Finding new graduates, looking at students to transition to the models. • Facilitators - orientation, reduced workload • Barriers -Managing the myths, changing organisational culture 	<p>The evidence states: Exposing students to midwifery continuity of care models prepares them to work in the models. New graduates need support such as a longer orientation period.</p> <p>My study found managers need new graduate midwives to staff the continuity of care models. They provided a longer orientation period and a reduced caseload initially to support their transition</p> <p>These findings indicate visionary leadership is required to instigate change-related behaviour. The vision is shared between the leader and the constituents of the organisation so all engage in adopting the innovation. Some adopters are slower than others.</p>	<p>Prepare new graduate midwives through providing continuity of care experiences to students</p> <p>Having an approachable/available manager</p> <p>Aim for visionary leadership</p>	<p>Managers should seek out students to work in models upon graduation</p> <p>Managers will schedule and attend the meetings, and provide learning plans to support new graduates as they transition into the models.</p> <p>Mangers will provide a longer orientation period and initially a reduced caseload</p> <p>Managers need to address organisational culture</p>

TITLE: Enabling new graduate midwives to work in midwifery continuity of care models: A conceptual model for implementation

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