Manuscript Details

Manuscript number	WOMBI_2017_130
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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Enabling new graduate midwives to work in midwifery continuity of care models: A conceptual model for implementation

Statement of significance

Problem or Issue⌧

Women have limited access to midwifery continuity of care models, in Australia. As models are expanded across the country managers may experience difficulties in recruiting midwives to work in the models. New graduate midwives rarely have the opportunity to work in midwifery continuity of care.

What is Already Known⌧

New graduate midwives are well prepared to work in continuity of care models. When they do have the opportunity to work in these models they are well supported with a good orientation, a reduced workload initially and mentoring. Midwifery continuity of care is beneficial to women and government recommendations are to expand the models in Australia.

What this Paper Adds

This paper provides a conceptual model that will show managers, educators and other key stakeholders how to enable new graduate midwives to work in continuity of care models.

Introduction

Midwifery continuity of care is important to women, midwives and maternity services. High level evidence now shows that women, who experience midwifery led continuity of care, are more likely to experience a normal birth with reduced obstetric interventions, while babies are less likely to be born prematurely or admitted to the neonatal intensive care unit (Sandall et al. 2016). Women report higher levels of satisfaction with their birth experience when they know their midwife (Common 2015; Fereday et al. 2009) and midwives enjoy working this way

(Collins et al. 2010; Newton et al. 2014b). Research has also shown benefits to the health service including cost effectiveness (Tracy et al. 2013).

While the benefits are now evident, midwifery continuity of care has not been widely implemented in many countries including Australia. A recent study estimated that less than 10% of women have access to midwifery continuity of care in Australia (Dawson et al. 2016). Similar low rates are seen in the United Kingdom, with rates around 15%, an improvement but continuity across the continuum is still not universal (National Maternity Review 2016). New Zealand has the highest rates of midwife led continuity of care with around 85% of women having access to this model (Gray et al. 2016).

One of the reasons preventing the expansion of midwifery continuity of care models is a shortage of midwives who want to work in this way (Dawson et al. 2016). Given new graduate midwives often want to work in midwifery continuity of care models, facilitating their transition directly from student to midwife in a continuity of care model could help to address staffing issues. Previous research in Australia has suggested that new graduate midwives could be employed in midwifery continuity of care models to increase their confidence rather than working in a transition to profession practice program (Clements, Fenwick & Davis 2012; Davis et al. 2011).

Most current transition programs for new graduate midwives provide a structured rotational clinical program with preceptorship and study days (Nursing and Midwifery Office 2015). The programs often last 12 months and are based on the new graduate rotating into different areas of the hospital for a specified time frame. A study of new graduate midwives' experiences of the transition program showed that this may not be the best way for a new graduate midwife to transition, particularly when they desire to work in a midwifery continuity of care model (Clements, Fenwick & Davis 2012) and have been educated for this model (Gray, Taylor & Newton 2016). In New Zealand, about half the new graduate midwives will transition directly to midwifery continuity of care models and are supported through

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124 the Midwifery First Year of Practice Program (New Zealand College of Midwives
125 2014). This could be an opportunity for other countries, such as Australia.
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129 In Australia, only a small number of new graduate midwives have been employed to
130 work in midwifery continuity of care models. Our previous research has shown that
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132 these models facilitate the consolidation of skills and knowledge better as the new
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134 graduates develop a relationship of trust with the woman and their colleagues
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136 (Cummins, Denney-Wilson & Homer 2015). New graduate midwives have high job
137 satisfaction when they 'know the woman' assisting with ongoing retention of staff in
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139 the workplace. In addition, the new graduates struggled with creating professional
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141 boundaries however they were supported by the relationship with the small team of
142 midwives they worked alongside. Support included mentoring and regular team
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144 meetings (Cummins, Denney-Wilson & Homer 2016b). Further research with
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146 managers and other key midwifery leaders found that the main driver for employing
147 new graduate midwives into midwifery continuity of care models was to staff the
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149 models (Cummins, Denney-Wilson & Homer 2016a). Visionary leaders talked about
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151 how they sought out well-prepared graduates to work in the models and provided
152 support such as a reduced workload and mentoring (Cummins, Denney-Wilson &
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154 Homer 2016a).
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157 Our research made us interested in how best new graduate midwives could be
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159 supported to provide midwifery continuity of care early in their transition. In
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161 response to this interest, we synthesized the findings from our studies into a
162 conceptual model that provides advice and guidance in relation to enabling new
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164 graduate midwives to work in these models (Cummins, Denney-Wilson & Homer
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166 2015, 2016a, 2016b). The conceptual model is designed to assist midwifery,
167 managers, educators and new graduates to facilitate the organisational changes
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169 required to accommodate new graduates. The aim of this paper therefore is to
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171 describe the conceptual model and show how it may be used in maternity services.
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173 ## Informing the development of a conceptual model
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We drew on our previous studies that were undertaken to understand the experiences of new graduate midwives working in midwifery continuity of care models and the challenges to employing them. Initially, newly graduated midwives were interviewed and the findings showed that they felt well prepared to provide continuity of care in a small group practice. When working in continuity of care models, they were able to quickly consolidate their skills and their confidence grew as they developed relationships of trust with the women and the small group they worked alongside. Essential to their successful transition was the support provided by the group of midwives in the continuity of care models (Cummins, Denney-Wilson & Homer 2015). This support often took the form of mentoring (Cummins, Denney-Wilson & Homer 2016b).

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

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

Insert Table 1 and 2

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

Insert figure 1

The individual components are discussed below.

The conceptual model: Enabling new graduate midwives to work in midwifery continuity of care models.

Essential component 1: Building relationships of trust through a high level of continuity of care

Midwifery continuity of care models should be organised in small teams of 2-4 to provide women and midwives with high levels of satisfaction, and to promote confidence in new graduate midwives.

Relational or interpersonal continuity of care (Saultz 2003) is provided through small group practices or small teams. As part of a small group, the midwife provides continuity of care to around one to four women a month and develops a relationship of trust with that woman, as she gets to know her and her family throughout the pregnancy (Page 2003). Women are most satisfied when they know their midwife and when their primary midwife provides most of the woman's antenatal and intrapartum care (Williams et al. 2010). Women build trusting relationships and feel in control of their birth experience when they know their midwife (McLachlan et al. 2016; Williams et al. 2010). The relationship with the woman improves job satisfaction for midwives and collegiality is enhanced when the midwife works in small groups of around four midwives (Collins et al. 2010; Edmondson & Walker 2014; Newton et al. 2014b).

The relationship with the woman enables the new graduate midwives to consolidate skills and grow in confidence (Cummins, Denney-Wilson & Homer 2015). Confidence to practice will be enhanced with the nurturing and support that is found in a small team or group of two to four midwives working in a continuity of care model (Clements, Davis & Fenwick 2013; Cummins, Denney-Wilson & Homer 2015; Hartz et al. 2012; Page 2003).

New graduate midwives who have worked in both a transition program and a continuity of care model reported being highly satisfied when working in the latter option (Cummins, Denney-Wilson & Homer 2015). Caseload midwives providing continuity of care have been shown to have lower levels of professional exhaustion known as burnout compared with midwives working standard shifts suggesting that continuity may be an important strategy to reduce staff attrition (Fereday & Oster 2010; Newton et al. 2014a). Similar satisfaction levels have been found in groups of community midwives in England (Common 2015).

Job satisfaction is key to attracting and retaining staff. The main driver for the employment of new graduate midwives into midwifery continuity of care models is mainly due to workforce needs (Cummins, Denney-Wilson & Homer 2016a) often filling positions because of maternity leave (Cummins, Denney-Wilson & Homer 2016a; Hartz et al. 2012). A study in New Zealand, where the majority of midwives work in midwifery continuity of care models, found that the reciprocal nature of the trusting relationship with the woman sustained midwives' enthusiasm for their job (McAra-Couper et al. 2014). Enabling new graduate midwives to work in midwifery continuity of care models, where there is a high level of continuity may also address staffing issues and assist with staff retention.

Essential component 2: Providing support and mentoring from within the small group of midwives

A facilitator to enabling new graduate midwives to work in Midwifery continuity of care models is to provide a longer orientation period, a reduced caseload and mentoring.

New graduate midwives have expressed that they feel supported through the relationship with the small team and some level of mentoring from either within or outside the team (Cummins, Denney-Wilson & Homer 2015, 2016b). Mentoring can occur in different ways. It can be ad hoc where the new graduate finds a midwife from within or outside the small team, or occur within a formalised program where

the manager allocates a buddy to support the new graduate (Cummins, Denney-Wilson & Homer 2016b; Kensington 2006; Lennox 2011; Lennox, Skinner & Foureur 2008). New graduate midwives find both types of support valuable.

In some settings, formal mentoring programs have been established for new graduates, especially in continuity of care models. For example, in New Zealand, the 'First Year Midwifery Experience Program' is a structured program consisting of a named mentor, the ability to be released from work to attend ongoing education and professional activities (Dixon et al. 2015). This program enables the new graduate midwife to transition directly into midwifery continuity of care models, and is similar to the Australian 'transition to practice' program. There seem to be few, if any, formal first year support systems for new graduates working in continuity of care models in Australia.

There are some examples of mentoring or support for new graduate midwives but not all have been successful. In some instances, new graduates have been allocated preceptors but these may not be rostered on the same days as the new graduate which means the development of a mentoring relationship is limited. The level of activity on the ward also prevents new graduates from attending some of their planned supportive study days (Clements, Fenwick & Davis 2012). The new graduates have also complained they are not consolidating skills across all areas of midwifery as they remain in one area for three or four months which was not enough (Clements, Fenwick & Davis 2012). Ongoing funding of mentorship programs like the one described in New Zealand is a challenge (Lennox, Skinner & Foureur 2008; McKenna 2003). Health services and organisations may argue there is not enough funding to support a formalised mentoring program and hence an ad hoc program is utilised. Support for mentoring and support is needed to support new graduate midwives to work in midwifery continuity of care models and this may mean diverting funds from traditional transitional models.

Essential component 3: Prepare graduates to work in midwifery continuity of care models

Managers and midwives working in the continuity of care models need to actively seek out students and new graduates who they think will be suited to work in this way.

By embedding valuable continuity of care experiences into the midwifery curriculum, new graduate midwives in Australia complete their degrees prepared to work in these models (Carter et al. 2015; Dawson et al. 2015; Gray, Taylor & Newton 2016). The findings from our study (Cummins, Denney-Wilson & Homer 2015) add to the growing evidence that new graduate midwives are well prepared to work in midwifery continuity of care models due to their experience as midwifery students.

Managers may only actively seek out students and new graduates to work in the models during times of staff shortages (Cummins, Denney-Wilson & Homer 2016a). However, attracting enough midwives to work in these models can be a major barrier to their implementation or expansion (Dawson et al. 2016). Employing new graduate midwives into these models may be one answer to meeting staffing demands (Hartz et al. 2012), and also seeking out students who are interested and those who have had clinical experience in a continuity of care model can be helpful.

Fears have been raised that new graduate midwives lack confidence or experience to work in midwifery continuity of care models without completing the transition to practice program or without several years of experience (Cummins, Denney-Wilson & Homer 2016a). Managers and other key stakeholders who do employ and support new graduate midwives can see that new graduates are able to move directly into the models as they have met the registration standards and licensing requirements to be registered as a midwife and they will always work as part of an integrated team – usually on the usual hospital birth unit (Cummins, Denney-Wilson & Homer 2016a; Nursing and Midwifery board of Australia 2017). Support and mentoring again is required to help build the confidence of new graduate midwives so that they can

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484 effectively and quickly transition into working in midwifery continuity of care
485 models.
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489 ## Essential component 4: Provide and access collaborative and reflective team
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491 ## meetings
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493 *Collaborative and reflective team meetings need to regularly occur in order to*
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495 *provide education and emotional support for new graduate midwives who work in*
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497 *continuity of care models. These need to involve all staff in the model, as well as a*
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499 *supportive obstetrician. Care planning for women and concerns of the new graduate*
500 *midwives should be addressed in these meetings.*
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503 New graduate midwives who attend regular group meetings seem to have the
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505 confidence to reflect on their own performance and interactions with others through
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507 collaborative, reflective team meetings (Lennox, Jutel & Foureur 2012). Attending
508 regular team meetings offer an opportunity for new graduates to discuss any
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510 concerns, reflect on their practice and collaborate with their peers. These meetings
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512 consist of all the midwives in the group, the manager, a clinical support midwife, an
513 educator and sometimes an obstetrician.
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516 New graduate midwives often find it easier to discuss a woman's care with an
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518 obstetrician who regularly supports the continuity of care model and the midwifery
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520 team. Collaboration is enhanced through this relationship (Beasley et al. 2012;
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522 Cummins, Denney-Wilson & Homer 2015; Edmondson & Walker 2014; Hartz et al.
523 2012). It is imperative for new graduate midwives and managers/other key
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525 stakeholders, who support them, to seek out obstetricians who are collaborative and
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527 supportive of continuity of midwifery care. The majority of new graduate midwives
528 are employed in a public hospital but not all models have access to a named
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530 obstetrician and the level of medical support that can occur in the continuity of care
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532 models varies. Having a named obstetrician in one organisation was useful (Beasley
533 et al. 2012; Hartz et al. 2012) and could be replicated to enable new graduate
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535 midwives to work in continuity of midwifery care.
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Essential component 5: Having an approachable/available manager, educator or clinical support midwife

Managers, educators and clinical support midwives should be approachable and available for the new graduate midwives to facilitate collaboration, communication and address any concerns.

Managers of maternity units have demanding and stressful roles and often the needs of new graduates may not always be a priority (Clements, Fenwick & Davis 2012). Having a good understanding of midwifery continuity of care models can also be very important for managers as it helps support the models more generally (Kay 2010 ; Menke et al. 2014).

Historically in Australia, the leaders in midwifery have had a nursing background and may not always have experience in expanding midwifery services (Cummins, Denney-Wilson & Homer 2016a). In our study, managers who understand the flexible way midwives work in midwifery continuity of care models, and were approachable and available, were seen as visionary leaders and this was fundamental to enabling new graduate midwives to work in midwifery continuity of care models.

Visionary leaders practice a transformational leadership style (Taylor, Corneilus & Colvin 2013). Transformational leadership is characterised by facilitating change in an organisation (Taylor, Corneilus & Colvin 2013). Their vision for improvement and change, is often shared with the midwives who work in the models (Rainey 2013). Visionary leadership is needed to enable new graduate midwives to work in midwifery continuity of care models.

In Australia, visionary leaders in midwifery over the last two decades have engaged in research and worked with consumers to raise the profile and visibility of midwifery (Bogossian 1998; Brodie 2002; Brodie & Barclay 2001; Teakle 2013). Visionary leaders have tried and tested a range of strategies to implement continuity of care into practice and many of these have also been applied to new graduates.

For example, rotating new graduate midwives into midwifery continuity of care models, as part of the transition to practice program, has been adopted to introduce the employment of new graduate midwives into midwifery continuity of care models. The majority of these new graduates remained working in the midwifery continuity of care models after the rotation was complete addressing the staff shortages (Cummins, Denney-Wilson & Homer 2016a). The midwives were highly satisfied and decided to stay working in the models rather than continue with the transition to practice program.

Visionary leaders will attract and retain midwifery staff, including new graduate midwives, to work in the expanding continuity of care models based on a shared philosophy and vision. Both the new graduate midwives and the more experienced midwives who work in the midwifery continuity of care models are usually protective of the woman centred philosophy and are committed to working in this way (Cummins, Denney-Wilson & Homer 2015). Midwives are more likely to leave the profession if they cannot develop meaningful relationship with women as is facilitated more easily through midwifery continuity of care (Curtis, Ball & Kirkham 2006; Stevens & McCourt 2002; Sullivan, Lock & Homer 2011). Having the opportunity to work in a relationship-based model may attract new graduate midwives to apply for these positions, address staffing shortages and provide high levels of job satisfaction for the midwives (Cummins, Denney-Wilson & Homer 2015, 2016a).

Other barriers to employing new graduate midwives to work in midwifery continuity of care models are the persistent cultural myths that surround graduates from the different midwifery education programs - Bachelor of Midwifery (BMid); Graduate Diploma or Masters; and, Double Degree (Nursing and Midwifery). All graduates are able to work competently as a midwife once they have graduated and registered as a midwife with the Nursing and Midwifery Board of Australia (Australian Nursing and Midwifery Accreditation Council 2014; Nursing and Midwifery board of Australia 2017). All new graduates have low levels of confidence when they begin practise

with increasing levels over the first months especially with mentoring and support (Davis et al. 2011).

Another cultural myth is the need for new graduates to have a number of years' experience to be able to provide midwifery continuity of care. There is evidence that the new graduate midwives are well prepared to work in the models, they consolidate skills and knowledge better when they know the woman and they are well supported by the small team of midwives they work alongside (Cummins, Denney-Wilson & Homer 2015). Visionary leaders will demystify the belief that new graduate midwives are unable to provide midwifery continuity of care without years of experience and they do not distinguish between graduates from different programs recognising all new graduates need nurturing and support.

Conclusion

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

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Figure 1

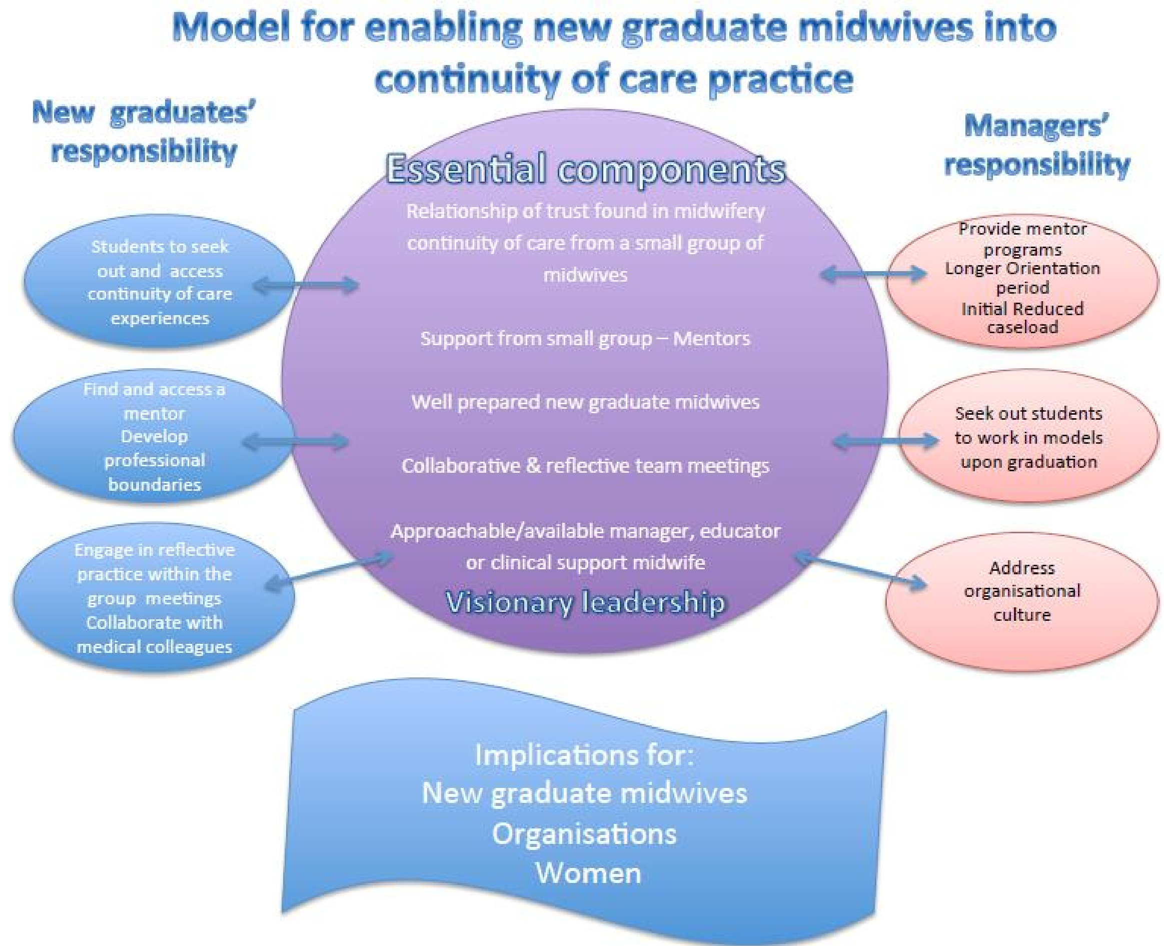

Table 1

INTERPERSONAL CONTINUITY OF CARE THEORY			
My Findings		Conceptual model	
Phase one	Findings synthesised with existing literature	Essential elements	Responsibilities
The importance of the relationship with the woman • Having trusting relationships • Consolidating skills through continuity • Finding satisfaction though continuity • Defining professional boundaries through continuity	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 My study found new graduates confidence grows when they know the woman. The midwives experience increased satisfaction. Professional boundaries are an integral part of continuity of care . New graduates working in this way are challenged.	Provide new graduates with opportunities to work in midwifery continuity of care models	Students to seek out and be offered clinical experience in continuity of care models to obtain the continuity of care experiences New graduate midwives need to develop professional boundaries
The importance of the relationship with the small group of midwives • Feeling supported from the group • Sustaining continuity model • Prepared to work in continuity	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 My study found new graduate midwives were dependant on collaborative and reflective meeting and developed professional relationships with the midwives and medical colleagues	Provide support from the small group including mentors Leads to well prepared graduate midwives Ensure collaborative & reflective team meetings	New graduate midwives need to find and access a mentor New graduate midwives need to engage in reflective team meetings and collaborate with medical colleagues

Table 2

DIFFUSION OF INNOVATION THEORY			
My Findings		Conceptual model	
Phase Two	Findings synthesised with existing literature	Essential elements	Responsibilities
Innovation is the employment of new graduate midwives working in midwifery continuity of care models. • 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	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. 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 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.	Prepare new graduate midwives through providing continuity of care experiences to students Having an approachable/available manager Aim for visionary leadership	Managers should seek out students to work in models upon graduation Managers will schedule and attend the meetings, and provide learning plans to support new graduates as they transition into the models. Mangers will provide a longer orientation period and initially a reduced caseload Managers need to address organisational culture

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

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