The experiences of the Broken Hill Midwifery Group Practice Midwives informing remote midwife-led models of care: An Appreciative Inquiry

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Abbreviations

AI	Appreciative Inquiry
BHMGP	Broken Hill Midwifery Group Practice
MGP	Midwifery Group Practice
PO	Participatory Observation

Tables and figures

(Please note figures are included in the Appendices)

Note on terminology

The terms 'caseload', 'caseloading', 'continuity' and 'Midwifery Group Practice' (MGP) are used interchangeably by the participants.
They each represent the same concept of women being cared for by a "known" Midwife.

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ABSTRACT

Introduction
Midwifery continuity of care models, or Midwifery Group Practice (MGP), are disproportionally available in metropolitan compared to non-metropolitan areas. Evidence shows MGP improves outcomes and experiences for women and Midwives, however historically MGP has been considered unsustainable for a rural/remote setting. In a remote mining town Far West of New South Wales, the Broken Hill MGP (BHMGP) was launched July 2015 in an effort to offer a gold-standard maternity service for the women and Midwives in the community.

Aim
To gain insight into the experiences of the BHMGP Midwives with the intent of making recommendations to improve the BHMGP itself, as well as assist other rural Maternity Services seeking to implement MGP.

Method
An Appreciative Inquiry methodology informed the collection of three data sets: one visual reflection focus group, eight individual interviews and anonymous individual survey. Data was coded and transcribed verbatim then thematically colour coded for analysis. To assist with researcher reflexivity, principles of Ethnography, specifically Participant Observation were used.

Findings
Four main findings are discussed: the experiences of Midwives in the BHMGP, recommendations to improve the BHMGP, recommendations for other rural and remote Health Services wishing to implement MGP and the future of rural and remote MGP. Each of these four areas of discussion contain specific themes and recommendations relevant to rural and remote MGP.

Conclusion
The experiences described by the BHMGP Midwives, while specific to the context of Broken Hill, contribute to the evidence supporting the implementation of rural and remote MGP. These descriptions enabled recommendations to be developed for the BHMGP and other rural and remote Health Services wishing to implement MGP. The future potential of rural and remote MPG is also described in the context of the experiences of BHMGP Midwives in terms of what can be learned from their experiences.

Implications
This study contributes to gaps in literature concerned with rural and remote MGP in Australia. By realising the study's objectives, a valuable contribution has been made to the BHMGP itself, other Health Services, the rural and remote Midwifery workforce and the communities it serves.

Key words
Midwifery Group Practice, rural, continuity, midwife, experience

EXECUTIVE SUMMARY

Recommendations for the Broken Hill Midwifery Group Practice:

1. Intensive, regular workforce planning will protect the Midwives.
2. It may not matter how positions are structured, instead what is vital is that the group is equitable, consistent and enforced. Midwives report either positions would be feasible but only if uniform expectations are applied to all staff regardless of FTE.
3. The BHMGP may benefit from considering "pods" as opposed to "buddies" between Midwives, however this will have implications on the 1:1 nature of the service.
4. The roster is vital to maintaining fairness in the group and should continue to be enforced strictly. Equal workload distribution is key.
5. Large productive office space and more IT resources (i.e. computers) are very important to the effective functioning of the BHMGP.

Recommendations for other rural and remote Health Services:

1. Midwives must be involved in the design of the MGP.
2. Communication is a fundamental value and compliance compulsory.
3. Frequent and compulsory Team Building activities once launched are beneficial, even if there appears to be reluctance from team members to participate.
4. Features of an effectively functioning rural MGP include: being an all-risk model, seeing the women for 6 weeks postnatally and a structured yet flexible roster where days off are protected and, where possible, Midwives are given additional days off to accommodate geographical isolation.
5. A caseload of 25-30 women per year for one FTE Midwife could be considered optimal for sustainability.

Background

Australian maternity services are undertaking large-scale reforms with the introduction of alternative models of care that contrast dramatically with traditional hospital-based, obstetric ones (Hartz et al. 2012). This is an effort to deconstruct the increasingly medicalised maternity care system that, despite the national rate of caesarean birth steadily rising to 30% in the last decade (Australian Institute of Health and Welfare [AIHW], 2013a, p. 18), has not demonstrated improvements in perinatal morbidity and mortality (AIHW, 2013b; Commonwealth of Australia, 2009). Midwifery Group Practice (MGP) is seen as one strategy to reverse this trend.

Women's pregnancy care in traditional hospital based maternity services is segmented into distinct portions with virtually separate services designed to provide care for specific components. For example, a midwife may be employed to work solely on the postnatal ward, labour ward or run antenatal classes. Obstetricians traditionally lead this fragmented, hospital-based service.

Effectively an opposite to this disjointed system is MGP, where women are allocated a 'known Midwife' who provides care throughout pregnancy, labour, birth and the postpartum period. This model has been shown to improve obstetric outcomes for women and their babies, and vastly improve patient experience measures (Brock, Charlton, & Yeatman, 2014; Hatem et al., 2008; Hodnett, 2008).

Evidence shows MGP Midwives also have improved work/life balance, higher employment satisfaction, and generally practice with greater autonomy than those in the hospital based system (Dale, 2010; Collins

et al., 2010; Lester, 2009; Fereday & Oster, 2008). For this reason, amongst Midwives, in particular New Graduate Midwives, MGP is seen to be a highly desirable job (Cummins, Denney-Wilson & Homer, 2015).

Historically, the barriers to ***any*** Health Service implementing MGP were resistance from the Obstetric profession (Munro, Kornelsen, & Grzybowski, 2013), concerns around Midwife skill levels, funding issues and a perceived lack of public interest (Sandall, Hatem, Devane, Soltani & Gates, 2009; Hatem et al., 2008; Hodnett, 2008). These have largely been addressed in urban setting with MGPs now common in many metropolitan health services (Hartz et al. 2012), often with large waiting lists. However, despite the evidence supporting MGP, the implementation of this model of maternity care has not translated to rural and remote health services (Tran, Longman, Kornelsen & Barclay, 2016). Therein is the rationale for this study – to contribute to the growing field of knowledge concerning rural and remote midwife-led models of maternity care.

The study

Appreciative Inquiry was used to explored the experiences of Midwives employed in the newly established remote Broken Hill Midwifery Group Practice (BHMGP). Participatory Observation also significantly informed the reflexivity, a deliberate means to address the researcher's close proximity to the participants. Data collection consisted of recorded semi-structured individual interviews, one visual reflection focus group and an anonymous survey. Data was then de-identified, coded, thematically analysed and triangulated for common themes between the three data sets. Extensive researcher journaling was also carried out.

Remote and rural MGP midwives face additional barriers and challenges unlike those in metropolitan settings, such as geographical isolation and workforce skills maintenance (Hundley et al., 2007). These challenges are more clearly understood by describing the experiences of those providing the service and also give insight into how novel models of care may impact on such challenges.

Findings

Four main findings are discussed: the experiences of Midwives in the BHMGP, recommendations to improve the BHMGP, recommendations for other rural and remote Health Services wishing to implement MGP and the future of rural and remote MGP. Each of these four areas of discussion contain specific themes and recommendations relevant to rural and remote MGP.

Conclusion

The experiences described by the BHMGP Midwives, while specific to the context of Broken Hill, contribute to the evidence supporting the implementation of rural and remote MGP. These descriptions enabled recommendations to be developed for the BHMGP and other rural and remote Health Services wishing to implement MGP. The future potential of rural and remote MPG is also described in the context of the experiences of BHMGP Midwives in terms of what can be learned from their experiences.

REPORT

Introduction

There is limited evidence concerning rural and remote Midwifery Group Practices (MGP) despite an evident need for methodologically rigorous research in such communities. MGP is considered the gold-standard for maternity care (Hatem et al., 2008; Hodnett, 2008), and until recently has only been located in urban areas (Tran, Longman, Kornelsen & Barclay, 2016). Advocacy for rural and remote communities access to such a model of care is an important underlying philosophical aspect of this research.

The purpose of the study is to gain insight into the experiences of Midwives working in the Broken Hill Midwifery Group Practice (BHMGP). Appreciative Inquiry (AI) and Participatory Observation were combined to provide the framework for the study's three objectives:

1. Describe the experiences of the BHMGP Midwives working in a midwife-led model of care in a remote Health Service.
2. Develop recommendations regarding improvements of the BHMGP.
3. Develop recommendations for other rural and remote Health Services implementing the same midwifery-led model of care.

Drawing on these two methodologies facilitated researcher reflexivity, ensured potential conflicts of interest were declared adequately and served as a protective measure for the Health Service where the study was conducted.

Literature review

Inherent within MGP is the concept of women-centred care. This implies the midwives within this model of care are focused on the entire continuum of pregnancy as a *normal*, significant life event for women who are mostly healthy and undergoing a normal physiological experience. This entails individualised care that recognises women's rights to self-determination and embodies the needs of the women, their babies, their support persons and the community (Nursing and Midwifery Board of Australia, 2006).

MGP is recognised as a safe, cost-effective, women-centred model of care, and arguably a viable means to address the rapid medicalisation of birth (Hartz et al. 2012, Hatem, Sandall, Devene, Soltani, & Gates, 2008). In the context of Australian maternity services, this review investigates evidence concerned with rural and remote hospitals establishing an MGP.

Current knowledge in the literature

1. The medicalisation of Australian maternity services

Women giving birth in Australia experience increasingly medicalised care during pregnancy and birth. This is exemplified by the national rate of Caesarean birth, which has steadily risen to around 30% in the last decade (AIHW, 2013a, p. 18). In spite of this, there has been no evident improvement in perinatal morbidity and mortality (AIHW, 2013b; Commonwealth of Australia, 2009). As a result of this trend governments are laden with heavy financial liability (New South Wales [NSW] Health, 2010), however it is arguably women who bare the greatest burden. Women experience increased morbidity and mortality associated with the rising rate of obstetric interventions (Hodnett, 2008). Research into the psychological impact of medicalised birth uniformly demonstrates the notion that pregnancy and birth is dismantled as a "normal life event" and replaced with ideologies of "risk" and "abnormality" (Nilsson, Lundgren, Karlström, & Hildingsson, 2012; Dahlen & Caplice, 2011, Parratt, 2002). However, there is no evidence to suggest low-risk women (women with no obstetric or medical complications) benefit physically or psychologically from medicalised birth.

2. The response to the medicalisation of Australian maternity services: The redesign of models of care

Maternity services are undertaking large-scale reforms in an effort to deconstruct this medicalised model and reverse the prolific obstetric intervention rates evident in women who are considered "low-risk" (Tracy et al., 2013; NSW Health, 2010; Hartz et al. 2012; Hatem et al., 2008; NSW Health, 2000). To do so, major state and federal reviews of maternity services in Australia have been undertaken (Commonwealth of Australia, 2009). A significant outcome of these reviews is the mandate supporting the implementation of MGP, described as "a fundamental aspect of midwifery practice that has been lost in the move to fragmented, hospital-based care" (Homer, Brodie, & Leap, 2009, p. 27).

Midwifery Group Practice (MGP) has been shown to be the gold-standardmodel of care with because of proven benefits and positive outcomes for women and their babies (Keygan, 2012; Homer et al., 2009a; Hatem et al., 2008). The evidence for decreased medical intervention, such as induction of labour, regional analgesia, instrumental and Caesarean birth, are well established nationally and internationally (Tracy et al., 2013; McLachlan et al., 2012; Hatem et al., 2008; Hodnett, 2008). This evidence has been incorporated into state and federal initiatives stipulating all women in Australia are to be able to access MGP (NSW Health 2010) as a viable means of addressing the needs of women (Keygan, 2012; Homer et al., 2009b).

Women have responded favourably to the shift away from medicalised care. Studies of maternal satisfaction demonstrate consistently positive experiences when having a 'known' Midwife (Brock, Charlton, & Yeatman, 2014; Hatem et al., 2008; Hodnett 2008).

Further, both rural and urban women report they are more concerned with staff familiarity, rapport and confidence in their skills, than simply being physically close to tertiary, specialist care should complications arise (Jenkins, Ford, Morris, & Roberts, 2014). As such, there is an overwhelming consensus that women respond favourably to the implementation of MGP, demonstrated by multiple qualitative studies of excellent reliability (Munro, Kornelsen, & Grzybowski, 2013; Bourke, Humphreys, Wakerman & Taylor, 2012; Dietsch, Shackleton, Davis, Alston, & McLeod, 2010; Smith & Askew, 2006).

3. The evidence disparity: Research into Australian Maternity services is 'metro-centric'

Research of maternity services has a tendency to 'cluster' in urban healthcare settings. This trend demonstrates a philosophical, social and resource skew in favour of metropolitan centres where women have greater access to innovative models of care (Walton, 2012). This is primarily because larger population numbers are conducive to feasible pilot and full-scale research. Conversely, the challenge of undertaking research in rural communities is often the small sample size, as well as the close proximity of the researcher to the participants, increasing social desirability bias (Roberts, 2014).

Studies of rural and remote maternity services that have been conducted are commonly concerning the resources and access (Tracy et al., 2006). A recurring theme is related to women's experiences of their choice, or lack thereof, for location of labour and birth (Dietsch, Shackleton, Davis, Alston, & McLeod, 2011; Dietsch et al., 2010; Smith & Askew, 2006). In the last 20 years, 50% of maternity units in rural and remote Australia have closed, with the majority of them in NSW (Australian Rural Nurses and Midwives, 2007). This was driven by the medicalisation of maternity services and the notion women were "safer" to give birth in metropolitan hospitals rather than smaller rural birth units (Dietsch et al., 2010; Kildea, Kruske, Barclay, & Tracy, 2010).

4. The access disparity: Models of care such as Midwifery Group Practice are 'metro-centric'

Women giving birth in rural and remote areas have significantly less access to health services generally than their urban counterparts (HealthWorkforce, 2013; Australian College of Rural and Remote Medicine [ACRRM], 2008). A woman residing in a remote community is therefore less likely to encounter innovative healthcare or developments such as MGP (Guest & Stamp, 2009).

While being expedited in metropolitan areas in response to rapidly increasing consumer demand, MGP in rural and remote areas is yet to reach the same prevalence. Persistent barriers such as vast geographical distances and small population numbers prevent women living in rural and remote communities from accessing the same services (Brown & Dietsch, 2013). As yet there does not appear to be one conclusive way to address these barriers, although advances in technology show promise.

Rural maternity services have less access to resources and facilities appropriately operated by an adequately skilled workforce (Bourke et al., 2012; ACRRM, 2008). This is further compounded by rural healthcare workers reporting significant barriers to effective collaboration (Munro et al., 2013). Small rural units may find that interpersonal conflict, poorly defined scope of practice and regulatory constraints inhibit effective professional relationships (Munro et al., 2013). Though there are very few studies of why this may be the case, it could be hypothesised that staff burnout, poor working conditions and the constantly 'revolving door' of agency staff may contribute.

The medical dominance of maternity services poses a significant barrier to metropolitan MGP as it does in rural settings (Brown & Dietsch, 2013). However it appears arguably more deeply engrained and difficult to navigate in a small rural hospital (Munro et al., 2013). This is despite evidence that midwifery-led care promotes normal birth (Commonwealth of Australia, 2009; ACRRM, 2008; Scherman, Smith, & Davidson, 2008). Given the view that MGP offers "safe" care in the holistic sense of the word (Fahy, 2012) with positive maternal and neonatal outcomes (Hatem et al., 2008), the overwhelming majority of the evidence asserts that women should have the right to access MGP, regardless of the country/city divide.

Gaps in the literature

1. The feasibility and sustainability of rural and remote Midwifery Group Practices

There is limited evidence examining the feasibility and implementation process of rural and remote MPG (Brown & Dietsch, 2013; Quinn, Noble, Seale, & Ward, 2013), however those that have been conducted show there are a number of reported advantages to establishing MGP in rural maternity units (Brown & Dietsch, 2013; Keygan, 2012). Stakeholders also appear to be motivated and appreciative of the notion that undertaking MGP means the health service is aligning with NSW Health policy directives (NSW Health, 2010) and women's preferences (Homer et al., 2009b).

Non-specific to MGP but related to midwifery are findings from other studies of rural midwives are applicable when establishing MGP. Many of these issues have been examined in isolation, such as workforce shortage (Francis & Mills, 2011; Francis et al., 2010), skills maintenance (Hundley et al., 2007), burnout (Mollart, Skinner, Newing, & Foureur, 2013; Jordan, Fenwick, Slavin, Sidebotham, & Gamble, 2013) and the need to perform dual role of Nurse and Midwife (Stewart, Lock, & Bentley, 2012; Yates & Kelly, 2011). All of these factors need to be considered in order to have an understanding of the barriers and enablers for rural MGP to be safe and viable.

There remains a significant gap in the number of studies regarding the outcomes for women and experiences of midwives in rural and remote MGP. Unlike in city units, where MGP is well established and large-scale evaluations have already been undertaken, rural maternity units are still at the preparatory, implementation phase. This serves to highlight how novel MGP is to rural and remote women and midwives. As more rural and remote MGPs are established, it would assist the establish the literature base for such concepts to be examined.

2. The experiences of midwives working in rural and remote MGP

While there is some research exploring *women's* experiences of their maternity care in mostly urban settings (Williams, Lago, Lainchbury, & Eagar, 2010), there is far less focused on the perspective of *midwives*.

There is inherent value in investigating how midwives perceive the model of care and environment in which they work. Doing so enables insight into midwives' experiences of working outside the "conventional" hospital framework. For example, the "on call" nature of MGP is often seen as the main barrier to midwives being willing to work in the model (Fleming, 2006). Therefore, understanding the required shift in mentality away from institutionalised shift-work will facilitate better understanding of the reasons staff may initially resist the implementation of MGP.

Studies in *metropolitan* MGP midwives report increased positive experiences of professional autonomy, job satisfaction and work/life balance (Dale, 2010; Collins et al., 2010; Lester, 2009; Fereday & Oster, 2008). This correlates with the findings of a longitudinal study that suggests when MGP model is first implemented, there appears to be a general improvement in perception of working conditions when measured over time (Collins et al., 2010). This is corroborated by other studies that report the flexible, self-governing philosophy underpinning MGP is conducive to a sustainable family life (Fleming, 2006).

Research topic

The experiences of the Broken Hill Midwifery Group Practice Midwives informing remote midwife-led models of care: An Appreciative Inquiry study.

Research aim

To gain insight into the experiences of Midwives working in a new midwife-led model of care, the Broken Hill Midwifery Group Practice (BHMGP) by combining the Appreciative Inquiry and Participatory Observation paradigms.

The objectives of the study are:

1. Describe the experiences of the BHMGP Midwives working in a midwife-led model of care in a remote Health Service.
2. Develop recommendations regarding improvements of the BHMGP.
3. Develop recommendations for other rural and remote Health Services implementing the same midwifery-led model of care.

Benefits of pursuing the research topic

There is a wide range of applications and benefits to addressing the topic of rural and remote midwife-led models of care. When implementing any new model of care, it is vital to undertake a process of evaluation to explore efficacy and safety. Stakeholders must be accountable for the outcomes, and there must be a demonstrated benefit to women, health care providers and the health service.

Understanding the necessary shift in mentality from institutionalised shift-work towards an autonomous work structure will facilitate better understanding of the reasons staff may or may not choose to work in MGP in a remote and rural setting. Exploring this dynamic would enable the model in a rural setting to be developed further to meet the needs of existing and prospective staff.

In Australia and internationally, many studies report the importance of women being within proximity to their family, community and the geographical location to sustains her sense of social and cultural safety (Walton, 2012; Patterson, Foureur & Skinner, 2011; Dietsch, Davis, Shakleton, Allston, & McLeod, 2008). Furthermore, there is no evidence suggesting women birthing in rural units are at any greater risk of adverse outcomes than those birthing in a tertiary hospital (Sandall, Devane, Soltani, Hatem, & Gates, 2010). Therefore, as evidence grows to support the implementation of rural and remote MGP, so too does the need to more thoroughly explore all facets relevant to their sustainability.

This study highlights two such topics for valuable future research. Firstly, an attempt to replicate the findings of Tracy et al. (2013) and McLachlan et al. (2012) in a rural setting would strengthen the evidence for MGP as a

means of improving birth outcomes for women living in rural communities. This would bolster advocacy efforts for women living in rural and remote locations to have equal access to gold-standard care.

Secondly, exploration of rural MGP midwives' perception of their *personal and professional boundaries* would be valuable. This is a pertinent issue for rural midwives as professional and personal roles are already often significantly blurred by the close social proximity between midwives and the community. The nature of this relationship could be seen as both a facilitator and hindrance to establishing rural MGP.

Context of the researcher

'Reflexivity' can be framed as "the process of reflecting critically on the self as the researcher, the 'human instrument'" (Guba & Lincoln, 2005). The nature of this study demands thorough and transparent examination of the researcher's reflexivity for a number of reasons:

- Their past role as Broken Hill Midwifery Group Practice Project Officer responsible for the design and implementation of the BHMGP
- Their current role of Clinical Midwifery Specialist 2 'Core Team Leader' - a managerial position not directly overseeing the BHMGP however working horizontally from the BHMGP Team Leader.
- They currently work clinically in the Broken Hill Maternity unit.
- Their personal affiliations with the BHMGP midwives.
- Broken Hill is a remote, isolated community of approximately 18,000 people, 1,200km from Sydney and is "close-knit" in nature.

Careful consideration has also been given the researcher's professional perspectives. Firstly, the researcher practices clinical Midwifery from a perspective of 'wellness', as opposed to a Medical model. This philosophical stance beholds the belief that all women have a right to access care that fosters individuality, normality and holistic health, as well as an inherent belief in the positive value of MGP.

Secondly, the research design captures the valuable union between research and clinical practice (Carter & Little, 2007). The researcher's 'emic' perspective (Ritchie & Lewis, 2009) and knowledge of the innermost workings of the Broken Hill Maternity Unit, have been drawn on as a means to strengthen the philosophical justification and integrity of the study, rather than threaten validity. This 'emic' perspective is intended to be viewed as a strength

Measures in place to facilitate reflexivity of the study include:

1. Transparency in declaring dual role throughout the entire study.
2. Primary Investigator keeping extensive field notes and journaling.
3. Repeated review and discussion with mentors and supervisors regarding the entire research process.

Context of the research methodologies

Developed in the 1980's, Appreciative Inquiry (AI) is intended to be a means of systematically discovering of what "gives life", mainly to organisations (Cooperrider & Whitney, 2005). From the perspective that the act of asking questions can elicit new ideas, which are themselves a powerful force for change, AI is a mechanism for improving organizational structures. Kessler (2013) states, "*Teams, organisations and society evolve in whatever direction we collectively passionately and persistently ask questions about*."

Participatory Observation (PO) entails the "systematic description of events, behaviours and artifacts in the social setting" (Kawulich, 2005). 'Immersion' in the subject matter or with the participant enables the researcher to describe a phenomenon with detail otherwise not noted. PO has been incorporated to address the researcher's close proximity to the participants, informing strategies to improve rigor and providing guidance to best realise the epistemological aspirations of the study (Ezzy & Rice, 1999).

Combining these methodologies is intended to address issues related to conducting research in rural communities, such as confidentiality, researcher bias and preventing maleficence.

Ethics approval

Ethics from the Greater Wester Human Research Ethics Committee was granted (LNR/16/GWAHS/23) on the 30th March 2016. Site Specific Approval was granted (LNRSSA/16/GWAHS/29) on the 30th March 2016.

Method

Study design and methodology

The study draws on two methodologies to appropriately explore the research topic. Firstly, AI, a strengths-based research design, has shaped data collection and analysis for internal validity. Secondly, the influence of PO, historically founded in Ethnography, has been engaged to assist with researcher reflexivity. The two methodologies ensure harmony between the researcher's epistemology, purpose and subsequent design of the study by:

- Framing data collection, analysis and final report through a non-judgmental lens
- Guiding the researcher to be open to, and interested in learning new concepts and knowledge
- Encouraging thought to be given to the integrity of data when the researcher is themselves immersed in the subject matter
- Being a means to frame findings and meaning
- Serving as a guide to explore the subsequent limitations of the findings

Sampling

The sample is comprised of Midwives working in the BHMGP. This sampling strategy was purposeful and convenient.

All Midwives employed in the BHMGP were eligible to participate. Any other sampling method was considered a threat to the data's validity due by generating an even smaller sample size and skew findings.

Participant recruitment

BHMGP Midwives were sent an introductory email to notify them of the upcoming research. The researcher then attended a BHMGP weekly meeting to conduct an information session, where the study was explained in full with a script and a PowerPoint session. At this stage, Participant Information Statements and Participant Consent Forms were distributed. The PIS was explained and the options available for consent described clearly.

There were four options for this study population to consider in regards to consent:

1. Decline – take no action after the information session
2. Consent A – participation in data collection and analysis
3. Consent B – participation in data collection however data NOT included in analysis and report

Sensitivity around consent in this study was paramount to decrease the threat to participants' emotional and professional safety, as well as protecting the team dynamic. The additional option (Consent B) allowed for Midwives to participate to maintain 'face' and team cohesion but gives them the option of complete confidentiality should they feel uncomfortable with their contribution being made public. This is further argued to be a vital part of the primary investigator using 'intimate' knowledge of the BHMGP as a means to strengthen the study design.

Creating an opportunity to gather genuine 'collective, group' data with the team dynamic 'intact' was important, however not at the potential expense of participants feeling pressured to do so. Giving participants the option of Consent B potentially cost the final data analysis in terms of presenting it in its

entirety. However the researcher strongly felt this actually maintained integrity and principles of non-maleficence, and demonstrated the additional precautions that are needed to be taken when researching in a remote team environment. This further reinforces the methodological approach of the researcher.

Inclusion and exclusion criteria

Inclusion criteria was any Midwife employed in the BHMGP at the time of recruitment. Inclusion in the study was entirely voluntary with no consequence for those who do not wish to partake.

Exclusion criteria was any Midwife in the sample population who was no longer employed in the BHMGP at the time of recruitment. This was purely for logistical reasons, as participation in the group session would have been unfeasible. Those in managerial positions were not included in the study due to the potential this may have had on changing the candid dynamic of the focus group.

Data collection

Data collection occurred during paid, 'clinical' hours midweek. This was appropriate as BHMGP Midwives are expected to schedule 'Professional Development' activities as part of their weekly hours, and this decreased the burden on their personal time.

Three data sets were collected to allow for triangulation of themes during analysis, as well as produce a more comprehensive view of the phenomenon being examined (Sargeant, 2012).

1. Individual interview

To improve internal validity, an independent expert in qualitative research conducted the individual interviews. Individual interviews were structured to follow the phases described in AI: *Discovery*, *Dream* and *Design*. The fourth phase of *Destiny* is discussed in the final report (Richer, Ritchie & Marchionni, 2009).

Interview semi-structured questions were designed with advice from mentors and research experts. Each of the interviews was audio recorded and transcribed verbatim by the researcher.

2. Visual reflection focus group

The focus group facilitated a general discussion following AI principles, while asking the midwives to visually draw the concepts they had formulated.

Unlike the interviews that were conducted by an independent expert, the primary researcher facilitated the focus group. Again, aligning with the study's epistemological philosophy that reality is constructed and the researcher is inherently embedded in the study, this portion of data collection was designed to remove the researcher from the conversation flow, yet be positioned as an 'active observer'. This facilitated the researcher's participation in a non-threatening, yet engaged manner.

The visual representation focus group was a cost effective and efficient means to supplement the interview and survey data (Josh, 2015). The focus group was also an effective way to investigate group interactions. The drawings served as a way for participants to reflect on their experiences, providing further insight and context to the two other data sets (Josh, 2015). The drawing data was intended to initiate discussion in the focus group while distancing the primary investigator from the dialogue except to practically guide the group. The drawings were also a means to explore more abstract concepts, encourage in-depth, personal reflection and offer the Midwives an opportunity to explore their thoughts in a novel way.

3. Anonymous survey

The third data set, the anonymous survey, was another strategy to give participants a third 'voice' or means to express their thoughts, with a higher degree of anonymity.

Data analysis

Data analysis occurred once all three data sets were collected. The researcher attended to the data analysis, with the analysis independently reviewed at various stages to ensure rigor.

Thematic analysis of qualitative interview data seeks to *describe* rather than explain the experiences of participants, and themes were not considered to have 'emerged' but as having been *interpreted* by the researcher (Braun & Clarke, 2008).

To develop a grasp of the interview data, the researcher completed verbatim conversational data transcription, followed by colour coded thematic collation. This interpretation led to a deeper understanding of the data. In the findings, use of direct quotes also enabled 'rich description' and the authenticity of the data to be protected from misinterpretation. The focus group dialogue was also transcribed verbatim and the pictures drawn by participants collected. Transcripts are only available to the primary researcher, the research team and the participants should they request it.

The anonymous survey was intended to triangulate findings and increase validity of the study by highlighting discrepancies or incongruences in the two other data sets. This was an attempt to determine if participants had altered their interview and focus group responses to please the primary investigator.

The focus group data was used to generate a WordCloud (http://www.wordle.net/) for each section of the report. This visually demonstrates connections between the phases of the AI framework in the data as well as being yet another means for the participants voice to be presented without researcher interpretation or bias.

Findings included distinct segments for 'Researcher reflection' to give contextual background for reader understanding and provide an opportunity to offer additional insights.

Findings

The final data set

Out of a sample population of nine, eight participated in the study, one declined (Table 1). They all were female, and comprised the following skill mix: Two New Graduate Midwives, one Registered Midwife year two, two Registered Midwife year three, two Registered Midwife year six and one Registered Midwife year eight or more.

Each Midwife was employed in a permanent role and all but one had been involved since the BHMGP's inception.

Three of the participants would be considered 'settled' in the community (i.e. "locals") with established lives and families here, while the remaining participants had been in Broken Hill for, on average, three and a half years. Three of the participants had young children at the time of data collection.

One Midwife was excluded from the population sample who had arrived to undertake employment in the BHMGP after recruitment had taken place.

Table 1. The final data set

Individual Interviews	8 participants Average length 32 minutes (116 pages of transcription)
Focus Group	8 participants 16 pages of drawings Length 47 minutes (14 pages of transcription)
Individual anonymous surveys returned	7

1. DISCOVERY: Midwives describe their experiences (Appendix 1)

1.1 The experience of being involved in starting the BHMGP

Midwives allude to the fact that working in MGP was their "dream job" and the opportunity to be present at the inception of an MGP was a welcome privilege.

"…being in the MGP has given me a job that I wanted from when I started my training, so this was kind of, this was my dream job, is being an, a caseload midwife in a, um, rural unit."

In both the drawings and the group discussion, elements of 'buzzing energy' are presented as the MGP first launched:

"…at first there was excitement and anticipation, some uncertainty, and this says [indicating to picture] "oh yeah! We're going… we're finally doing this", but then like "oh, but what are we actually doing?"

When questioned further on the point of if Midwives can actually completely comprehend what working in an MGP entails prior to doing it, the focus group participants agreed this was not possible. It is something they felt they needed to learn by the lived experience.

In their interviews, each Midwife described their theoretical grasp of the philosophical foundations of the model of care with words like "*supportive*", "*holistic*" and "*collaborative continuity of care*". All but one of the Midwives had completed their training within the last six years, and were able to recall the evidence basis of midwifery continuity models, with a common sentiment that they were now working in the model that is considered gold-standard.

"…this is what we theoretically learnt at university of how to, um, that it is the optimal way of caring for women during their pregnancy, and intrapartum and postnatally. Um, but where I trained I didn't get to see it very often so it's been very good to bring what I learnt theoretically into practice and I can see it's everything it says it is."

This sense of drawing on what they had been taught as the "ideal" in their recent University education, appeared to provide some confidence for stepping into the role. While they may not have been practically prepared, they felt they had the knowledge basis to build upon.

"I trained in a tertiary facility in Sydney… and so my practice before as a student, my, even though I had this midwifery philosophy that I was learning, my placement and everything I did clinically, was in a very medicalised environment, um so, coming out here I have become, I guess more midwifery focused and more low risk and comfortable with normal."

None of the Midwives in any of the three data sets made comment about feeling "at risk" or "unsafe" in the model despite being a junior team. Although simply *not* mentioning this does not infer that the model had somehow innately negated any inherent risks or feelings of unsafety, it is also prudent to remember the methodology of the study is a strengths-based one. However, for the purpose of *describing the Midwives' experiences*, this is significant. Midwives who feel supported in their practice can care for women safely despite not having a significant number of years of clinical experience.

> ***Researcher reflection**: The BHMGP was established with only one of the 11 Registered Midwives ever having worked in a continuity of care model. Four of the 11 were New Graduate Midwives and the team included one Student Midwife who was to undertake her entire training in the BHMGP. Five of the 11 were Bachelor of Midwifery graduates (as opposed to Nurses who had then qualified as Midwives). There has been much discussion about the suitability of 'junior' Midwives working in such models and a 'lack of expertise' often cited as the reason an MGP is unsustainable in a rural setting where often staff are considered far more junior than their city counterparts.*

The Midwives discussed the sense of reality vs. the ideal of MGP, and how these differ. One Midwife alluded to the fact that their newly designed t-shirts had the incorrect spelling on them (Figure 1, Appendix 1) at the launch and used this as an analogy to describe the transition from concept to reality.

"…I thought our idea was pretty close to perfect, but like our first emblem we got on our shirt, nothing's perfect, it was knowing and being know… not known… So I think by nature there will always be speed humps, but ultimately I think we're pretty close to it and that 100% perfect would be impossible." (Figure 2, Appendix 1)

> ***Researcher reflection****: The impact of having the Midwives directly involved in the design and implementation of the BHMGP has been a reoccurring theme across all data sets. Firstly, the Midwives commented frequently on what that process* ***felt*** *like personally and there is a shared sense of camaraderie and investment in the BHMGP because of these feelings.*
>
> *The stories retold such as the bungled shirt logo, the confusion of learning how to use the very old model phones initially allocated to them and the week of orientation have become allegories within the groups' identity upon which they reflect with pride and ownership.*

There was general agreement that it took the group around six months to establish clear boundaries with women and to fully develop an appreciation for the concept of 'burnout':

"You said it [at the start] and we were like 'yeah whatever' [group laughter] … "

> ***Researcher reflection****: The BHMGP was established with components of a structured roster as well as traditional MGP flexible working arrangements. This balance between a roster and a truly autonomous MGP lifestyle was important to assist the new inexperienced team in establishing boundaries and protecting from burnout.*
>
> *The intent of the researcher conducting this focus group and not an external expert is demonstrated here. Having been involved in this process of the group establishing itself allowed the researcher to detect subtle nuances and "in jokes" to be picked up on and then encourage elaboration. This led to the unplanned discussion around the group learning to establish its boundaries with women.*

The midwives passionately described and pictorially drew the close relationships they develop with women as being central to the model. Around half of the Midwives also voiced that they recognise it took them some time to "let go" of the notion of "their women" and truly share that relationship with the rest of the MGP team to allow themselves days off.

"It's like you let it take over your life a little bit and you didn't mind because you wanted to be available and all that, but now it's at a point where you can't cos you have to let go to get that balance back a little bit."

There was a relative parallel in the Midwives developing their own sense of professional identity simultaneously as the BHMGP's evolved. As a group, the Midwives discussed how the identity of the group was formed over around 6 months, while in interview, a similar time frame was commonly noted for the time it took the Midwives to build their own confidence and concept of their practice.

The challenges faced by the Midwives in establishing their confidence in the BHMGP was varied, likely personality dependant. For some it was developing an understanding of the new processes such as paperwork, diaries and diverting phones that were the priority. For others, it was more clinically based concerns, especially for the new graduates and student who highlighted the value of the Mentor system in place to support them.

1.2 The experience of being in the BHMGP 12 months later

The interviews and focus group yielded similar common themes (Figure 3, Appendix 1) as to how the midwives describe working in the BHMGP currently, also confirmed by the survey. One of the most dominant themes concerned the use of the same word used to describe the start of the MGP as now, "overwhelmed, but a *different* overwhelmed" (Figure 4, Appendix 1).

> ***Researcher reflection**: The value in having three data sets was demonstrated here as it allows for a clear theme to be distilled from what may be taken as an otherwise one dimensional theme. The Midwives simply describing themselves as "tired" currently can be interpreted in a number of ways, largely with negative connotations.*
>
> *However, when considered in the context of the survey and the individual interviews, it's possible for a deeper and perhaps more accurate understanding to this notion of 'fatigue'. The Midwives will describe being tired, yet more energised in their work; fatigued but more motivated; "overwhelmed but a different overwhelmed". Without having multiple opportunities to explore this concept it would be likely an inaccurate understanding of the Midwives' experience would be presented.*

For the Midwives' work life balance, despite stating they are 'tired' and feel this strong sense of responsibility, there is an equally reported measure of enjoying the satisfaction from their work.

"I think the responsibility that we've got, and now we've relaxed with it, makes sure that the women are cared for even when you're not here…"

"It just, it feels so purposeful and so meaningful, every minute that I work, rather than you know sometimes you just go onto shifts and you just, um, either there's not much to do or there so much to do that you don't feel like you're doing anything effectively. And I never feel like that here."

This different sense of 'tired' may be explored in terms of the new sense of onus the Midwives feel in this model of care. One tangent of the focus group conversation explored the sense of responsibility the Midwives now feel that the MGP is "established" and out of its infancy stage. The burden of coordinating a woman's care is more pronounced, however the Midwives report the benefit is that their skills are improved by following through the care of a complex woman they may have previously only met once.

"I feel like I've grown so much as a Midwife, I feel that I've learnt so much more, because you're seeing the women, like you're doing every aspect, they'll ask you a question that you don't know the answer to so you go find out because you'll see them again."

> ***Researcher reflection**: The BHMGP is an "all risk model", with every woman booked into the Broken Hill Health Service eligible to be cared for in the program. This is in the context of the Clinical Capability of the Maternity Unit, whereby clear and strict guidelines exist around which women and babies can be safely cared for at the Health Service before transfer is indicated.*
>
> *As such, the BHMGP Midwives are now in continual contact with those considered "high-risk" for Broken Hill's clinical role delineation. This exposure to the "high-risk" population has allowed for the opportunity to extend their skills and knowledge, and take on the responsibility of coordinating complex care, often across state borders with a Tertiary referral centre.*

When asked to describe how working in the MGP *positively* impacts on their practice and skill development, all eight Midwives in the interviews were able to do so. A recurring theme of "having time" and the repetitive, cyclical nature of their interactions with women were reported to contribute most to skill development:

"It allows me to take my time to learn and understand the women in my caseload, and it gives me time to do appropriate, like, well, thinking and discussing with other Midwives or whoever's relevant. As well as reading things about background information or about their story… it just allows me to expand my knowledge in a very… just in a way that gives me the time to do it, and I think safely."

The Midwives also report a significant increase in their sense of confidence they feel with this continued contact with the same women, able to draw upon experiences looking for patterns and relationships between clinical presentations:

"…it's helped my practice where I've been able to use my experience to help women cope with symptoms by saying 'it's normal and I've seen this and yeah … it's helped my confidence as well."

Across all three data sets, the impact of having access to work in an MGP in regards to decisions around relocating from or remaining in Broken Hill were clear. There was a sentiment for the potential of MGP to impact on not only the retention of Midwives in Broken Hill, but also within the model of care itself. Particularly in the survey, a distinct theme concerned a desire to either remain in Broken Hill to continue work in the BHMGP, or if they were to relocate, it would be to another MGP. This notion has wider possible implications for retention of Midwives in the profession as a whole; if Midwives are working in models of care that are designed to support a good work life balance and maximise workplace satisfaction, they are more likely to remain in the profession:

"I would like to avoid fragmented midwifery care for the rest of my career if possible now as I know how [good] midwifery practice can be."

"I am happy working in the BHMGP and don't want to go back to routine shift work in a larger facility/medicalised maternity service."

"I would look for employment in group practice if I were to leave Broken Hill."

There is not only a sense of achievement having been involved in the establishment of the BHMGP, but a sense of value derived from how the group has sustained itself and evolved.

"I think the women that do birth here get the best that public health in NSW has to offer for maternity services, I really do believe that."

Summary of Midwives' experiences in the BHMGP:

1. MGP is the model of care newly qualified Midwives learn at University and state they feel comfortable with.
2. Junior Midwives can work in MGP if they feel supported and have adequate risk management strategies in place.
3. Burnout to some degree is inevitable, it should be prepared for and does not mean a failure of the model.
4. The Midwives will feel fatigued and tired but this will be counteracted by the great increase in workplace satisfaction.
5. Midwives feel their clinical skills improve dramatically when working in MGP.
6. Midwives suggest MGP has the potential to retain Midwives in the Midwifery profession.

2. DREAM: Recommendations for the BHMGP

The second phase of Appreciative Inquiry involved asking participants to project to an ideal future and describe what the "perfect Broken Hill Midwifery Group Practice" would entail. This portion of data was collected across the individual interviews, the focus group and in the anonymous survey in an attempt to offer the Midwives a number of occasions to describe this phase.

The Midwives were able to articulate both what the perfect BHGMP would entail, as well as how working in such a "perfect" model of care would impact on them personally. All of the responses indicated that the BHMGP Midwives feel the current design of the BHMGP meets the needs of local women:

"…I feel like the women are, the women are benefiting the most… their outcomes, that the women are coming in and having you know, normal births and great experiences, and even if they don't get that normal birth, they're very happy with their experience in the long run because I feel the clinical decisions are made with the women which wasn't always the case beforehand."

Much of the workplace satisfaction the BHMGP Midwives report is derived from within this commonly shared perception that *women's needs* are being met. However, the Midwives discussed both as a group and individually at what cost running such a service can come if the Midwives are not adequately protected and rested:

"I think for the women it works extremely well the way it is, um, maybe for the staff sometimes it's just, it does ask a lot of them."

The primary change the Midwives would make to the BHMGP to move it closer to the more 'ideal' is to have regular, intensive workforce planning for the short and long term:

"…we've been through this extra run of 'on calls' cos we've been down staff or people have been sick or on extended leave, when we're supposed to be doing two on calls every eight weeks for the weekends, and we've been doing two every four weeks, it's made us extra tired."

"It was intense… it was only when Rita (a long-term agency position, pseudonym used) came that all of a sudden everyone went "I've done it, I'm over it, I'm exhausted, I can't do this anymore."*

Having unplanned leave is absolutely unavoidable in any setting, and any management team must address these scenarios as best they can when they occur. However, the Midwives voiced a common thought that a stricter approach around the way planned leave is taken would serve to protect the group as a whole and decrease the responsibility individual Midwives feel to take on additional hours.

The Midwives discussed the notion of working full time and part time in the BHMGP. While the participants agreed as a group that full time staff are important to the smooth functioning of the group, when questioned individually, three mentioned the need to develop part-time options, for those wishing to undertake part-time work in other settings, as well as for those returning from Maternity Leave.

In the focus group more than half of the Midwives verbalised that full-time positions are the only way to sustain the integrity of the 1:1 relationships with the women as well as the effective functioning of the group. However, as the BHMGP workforce is facing a significant number of women who themselves are now choosing to start their own families, there was a growing sense of the need for a conversation about part-time positions.

"…definitely everybody be on the same FTE I would say."

"Returning to work in all other areas of the hospital you can choose to be part time in any capacity you want…"

"I feel unsure about the future re: part time options after having a baby."

This was a sensitive topic for the BHMGP Midwives to discuss as women, Midwives *and* social peers. The participants in the study, while not only "chronologically young" but are also part of a newly established group, were comprised of women at differing stages of their personal lives. There is a sense of obligation and responsibility to be a fully *present*, full-time member of the team for ease of workflow, however also an equal

measure of the firm belief that young women (as is often the population) working in MGP must be supported to balance this 'obligation' with their family life.

What was clear however was it is probably less important how the working hours are structured, and more vital to have just very clear, 'strict', uniform guidelines around how they are implemented. When looked at objectively, the Midwives were more concerned overall with equity and balance, than bothered by an individual structuring of their work/life balance to suit themselves and their young family. This is a complex issue not yet resolved and warrants further investigation.

***Researcher reflection**: A personal declaration as it feels relevant to the study's findings, is that the researcher is herself pregnant and has a personal interest in the evolution of part-time roles in the BHMGP for both herself and her colleagues who are seeking family-friendly roles. There are also a number of Midwives pregnant at the time of the study.*

This portion of the data collection proved to be a little 'difficult' for the Midwives to discuss candidly as there is much sensitive consideration given to each individual Midwife's personal circumstances. The Midwives are personally invested, as well as professionally, in their team members, and as a result, strong feelings about the structuring of full time vs. part time BHMGP roles was more openly alluded to in the individual interviews and surveys.

In the thought journal of the researcher, the following comment is made after transcribing one individual interview:

"Everyone is so very, very keen to comment on the need to look at part-time vs full-time roles and how these work, but are reluctant to voice an opinion strongly one way or another for fear of sounding 'self-interested', uncaring to new mothers (absurd as we are all Midwives!) or unsupportive of others who are wishing to have multiple roles outside of the MGP."

The Midwives made mention repeatedly of the need for healthy buddy relationships within the BHMGP. Four of the Midwives suggested that shifting the group structure away from buddies (working in pairs to support one another's caseload) towards small pods or teams may address the significant pressure a buddy feels when their pair is sick or on leave. They also suggested that personally, a small team of three or four Midwives may decrease the, at times significant, sense of responsibility the Midwives feel:

"I feel [sigh], really responsible and I know a lot of girls are going beyond, um with the one on one and not being able to, to go away without feeling guilty about them, like births…. I think it's my biggest downside of it, because I get too attached…"

Interestingly, while this is a relatively commonly shared thought, this is also what the Midwives report as being the strength of the BHMGP – that women do get such individualised, personal, attentive pregnancy care. However, in light of sustainable models of care, particularly in the rural and remote setting, perhaps more consideration needs to be given to altering from buddies to pods to ensure there is a balance between the women's and the Midwives' needs.

All but two of the Midwives reported the BHMGPs semi-structured roster to be of great value to protecting the midwives in their burnout and fatigue management. However, this is only effective in light of adequate staffing being available so that Midwives don't have extended periods of weekends on call. Again, reiterating the importance of maintaining, as full as possible, compliment of staff.

> ***Researcher reflection****: The Midwives are responsible for their caseload from Monday to Friday. On the weekend, they all divert their phones to a first on call who covers births and urgent assessments, supported by a second on call.*
>
> *This roster was designed to alleviate a possible sense of guilt and obligation Midwives may feel to attend births when they are well over their hours. Largely this seems to have been effective as they report feeling the roster 'protects' their weekends and none of them would want to do away with it if given the opportunity.*

Of high importance is the need for protected workspace and resources. All participants reported feeling a sense of frustration at the current allocation of office space. The report feeling the limited desk space, access to computers and adequate clinical rooms as having a significant impact on their day to day work efficiency and effectiveness. Access to adequate IT resources, such as wireless connections to the hospital network while working in the community on laptops or iPads would facilitate the 'mobility' of the workforce the BHMGP is striving to achieve. At present the Midwives report the most overarching pressing practical issue they have is related to access to IT and adequate office space in order to complete their work:

"…we could fit a computer for each Midwife, um, I just feel it would be a much more productive environment."

"I feel like clinical space is a massive issue, and office space, and I feel like that would make our work so much more productive in terms of... because we spend so much time doing paperwork and computer work…"

All of the interviewed Midwives stated if they were designing an MGP from the start in a similar setting, they would not make it vastly different to the design of the BHMGP. They report overall it would be similar with adjustments to things like incorporating early pregnancy care, introducing parenting groups, securing more clinic space and even more consideration being given to applicants when recruiting.

All seven Midwives report in anonymous survey the BHMGP influences their decision in regards to future employment choices.

Recommendations to improve the BHMGP:

1. Intensive, regular workforce planning will protect the Midwives.
2. It may not matter how positions are structured, instead what is vital is that the group is equitable, consistent and enforced. Midwives report either positions would be feasible but only if uniform expectations are applied to all staff regardless of FTE.
3. The BHMGP may benefit from considering "pods" as opposed to "buddies" between Midwives, however this will have implications on the 1:1 nature of the service.
4. The roster is vital to maintaining fairness in the group and should continue to be enforced strictly. Equal workload distribution is key.
5. Large productive office space and more IT resources (i.e. computers) are very important to the effective functioning of the BHMGP.

3. DESIGN: *Recommendations for other rural and remote Health Services wishing to implement an MGP*

When asked how they would go about designing an MGP for another rural Health Service, the Midwives comment how much being involved in the process affected their investment in the MGP when it eventually launched and this they would replicate:

"…this is pretty much exactly what I think I envisioned for our MGP… it's very similar to what I'd experienced and how I thought, like, it worked best."

Generating this buy-in from the Midwives was a key step to building the identity of the team and creating positive, strong channels of communication between the Midwives and with the Obstetricians.

The Midwives described what they would wish or give to every other MGP in the country if they could, both tangible and intangible things. In all three data sets, the Midwives mention the main trait they would wish to other MGPs is effective communication, framed by how they perceive themselves as communicating well with one another:

"We air our grievances openly…people being able to say exactly what they think…gets things out in the open… you know where you stand…dynamic conversations about decision making..."

Clear, structures, and *compulsory* communication methods seem to be effective at helping the Midwives feel secure and supported in their practice and each mentioned the morning group SMS as the most effective way of checking in with one another. Communication can be seen as a fundamental component to junior Midwives feeling supported and secure in their clinical practice.

Team building activities are also described by the Midwives as important to maintaining the integrity of the group, developing respect for one another and encouraging positive interpersonal relationships amongst the team. Many of the Midwives say they would ensure every MGP has access to frequent team building activities that everyone participates in.

> *Researcher reflection: This was an interesting finding as often at the time of Team Building there is some reluctance to participate, with most suggesting it is difficult to schedule the time into their daily diary. However, it is significant to note that a number of the Midwives spontaneously suggested these activities are actually very important to the group and valued.*

In terms of the structure of an MGP, the Midwives in the BHMGP would encourage any other rural Health Service to consider all women to be eligible (an all-risk model), offer women postnatal care for 6 weeks post the birth, make use of a semi-structured roster and consider participating in a system of 'exchanges' where Midwives may relocate for up to 6 months at a time for exposure to other models and rural communities.

The main feature that appears to make an MGP desirable to work in however is flexibility. Midwives in a rural and remote setting need flexibility to sustain working in such a model. Geography affects every aspect of rural life, and this should be built into the MGP, for instance, should a Midwife wish to make a day trip to a larger town centre for a leisure day, this often involves a large number of hours driving, therefore requiring additional days off to make this possible. Or if a Midwife has family away from the town, it can often be a number of days driving to see them. These sorts of things need to be considered when designing an MGP to allow Midwives time to rest and recuperate adequately. A manager who understands these pressures is vital.

Recommendations for other rural Health Services wishing to implement an MGP:

1. Midwives must be involved in the design of the MGP.
2. Communication is a fundamental value and compliance compulsory.
3. Frequent and compulsory Team Building activities once launched are beneficial, even if there appears to be reluctance from team members to participate.
4. Features of an effectively functioning rural MGP include: being an all-risk model, seeing the women for 6 weeks postnatally and a structured yet flexible roster where days off are protected and, where possible, Midwives are given additional days off to accommodate geographical isolation.
5. A caseload of 25-30 women per year for one FTE Midwife could be considered optimal for sustainability.

4. DESTINY: The future for rural and remote MGP

When asked to project to how they would feel working in a 'perfect' MGP that entailed all of the above and more, the words used to describe the feelings are supported, energetic, and rested (Figure 5, Appendix 2). The Midwives frame the evoked feelings in terms of their proximity to the women; they would ideally be embedded ***next*** to women, alongside them or with them (Figure 6, Appendix 2).

The Midwives described the impact an "ideal" MGP could make to a rural community, focusing on the positive contribution to not just obstetric outcomes, but also improving whole community health:

> *"…the perfect MGP would be, um, about building stronger families, strong communities, everyone working together… women-centred, evidence based, and also from the full spectrum, from preconception to early parenthood."*

This extends to all social groups in the community, a number who were specifically mentioned, such as low socioeconomic groups, women having babies who are less than 20 years old and those with significant social complexities. In particular though, there was much discussion about the desire of the "perfect" MGP to effectively partner with the Indigenous community and existing Health Services to offer Indigenous women continuity of Midwifery care as well. The "most ideal" MGP would be able to bridge organisations and cultural barriers to ensure Indigenous women and their families also benefited from an MGP.

In terms of investing in the future, all MGPs would involve a component of "growing their own", training local people who are likely to remain in the community, and not shy away from having students trained entirely in the MGP. This builds on the philosophical foundations the Bachelor of Midwifery students in particular received and allows students the opportunity to learn practical skills in the context they learn about.

It is this drive to remain midwife and women focused that is fundamental to the "perfect" MGP", ensuring that the rural workforce can sustain the model of care and that the model is designed to meet the needs of the women. This MGP would be designed to be unique to the particular community in which it is established and not merely a replicated version of another services model. Novel and innovative designs of MGPs will lead the profession closer to realising the "perfect MGP" and contribute to a more sustainable rural and remote midwifery workforce.

Summary of the future for rural and remote MGP:

1. MGPs would be designed to align Midwives alongside women, with women.
2. MGPs would aim to improve not only women's health but that of the entire community.
3. MGPs would partner effectively with Indigenous organisations.
4. MGPs would "grow their own" and train local students in the MGP.
5. Rural and remote MGPs would be unique to the community in which it is established and meet the individual needs of the community.

Strengths and limitations

There are obvious limitations of this study, which are the small, isolated sample size and this being a relatively distinct example of an MGP. This may mean the findings cannot be explicitly generalised to other Health Services due to the unique composition and nature of the study population. However, there remains inherent value in the reporting on organizational observations and recommendations for this model of care in terms of gaining insight into the experience of those involved.

To combat the main limitations of the study, i.e. the threat of potential bias and lack of applicability, a number of strategies were used to improve reflexivity. The methodology was designed to address this, with independent researchers utilised as mentors, researcher journaling, and multiple data sets for consistency. Furthermore, the process of gaining consent was sound and reflected the researcher's commitment to non-

maleficence. Participants were able to decline or participate in a "masked" manner with their data being omitted with the intent of maintaining group dynamic.

This small sample size within a close-knit team and community also reflects the challenges the researcher had in reporting certain aspects of the data. For confidentiality, sensitivity and integrity to be maintained, particular topics, examples and identifiable situations had to be excluded which may have ultimately proven very telling or useful in achieving the study objectives.

A strength of the methodology is using Appreciative Inquiry, which served as a protective buffer in the event unfavourable or undesirable findings were reported. This approach is solution focused and therefore the reporting of recommendations serves to offer solutions of how to address concerning findings, not merely report on them.

The second obvious limitation of this study is the potential for findings to be presented in a way that are biased and one sided given the researcher's previous role of Project Officer who established the BHMGP. There is clear potential for reporting to be prejudiced and subjective, and the participants voices not to be heard.

The findings are also respectful and sensitive to the Health Service and other Non-Government Organisations that supported the implementation of the BHMGP, and this should be considered when reading the findings. Being located in Broken Hill, this study has a uniquely 'rural' voice and focus, and one that even though it is distinctly individual to this community of Midwives, will hopefully reflect some truths in other rural settings.

Conclusion

By and large the Midwives describe their experiences in positive terms, however don't shy away from explaining the impact their employment in the BHMGP has had. The central focus of the Midwives is to offer a woman-centred service, and when they feel they are achieving this, this is a source of pride, workplace satisfaction and sustenance. The Midwives are resilient in their dedication to offer such a service to the women of Broken Hill, and steadfast in their commitment to work in a continuity of care model as they have personally experienced the benefits for those they care for.

The recommendations for the ongoing improvement of the BHMGP are related to resources and staffing. This study also suggests the BHMGP itself is an extremely desirable service to be able to offer the community.

For other rural and remote Health Services wishing to implement an MGP, this study serves the purpose of demonstrating that junior midwives in a remote location are capable of building and sustaining this type of model of maternity care for rural communities. Furthermore, it makes recommendations for building sustainable rural and remote MGPs, such as involving staff in the design to make sure their needs are met, instilling a strong foundation of communication within and beyond the team, employing strategies to ensure staff burnout is decreased with novel ways of encouraging adequate down time, and fostering team building activities from the start to create a culture of collaboration and safety.

This study contributes to the identified gaps in literature concerned with rural and remote MGP in Australia. By realising the study's objectives, a valuable contribution has been made to the BHMGP itself, other Health Services, the rural and remote Midwifery workforce and the communities it serves.

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Appendices

Appendix 1: DISCOVERY: Midwives describe their experiences

Figure 1. Focus Group word cloud #1 - Describing experiences at the commencement of the BHMGP

Figure 2. *Focus Group: depiction of the incorrect logo, "perfect would be impossible"*

Figure 3. Focus Group word cloud #2 - Describing the BHMGP currently

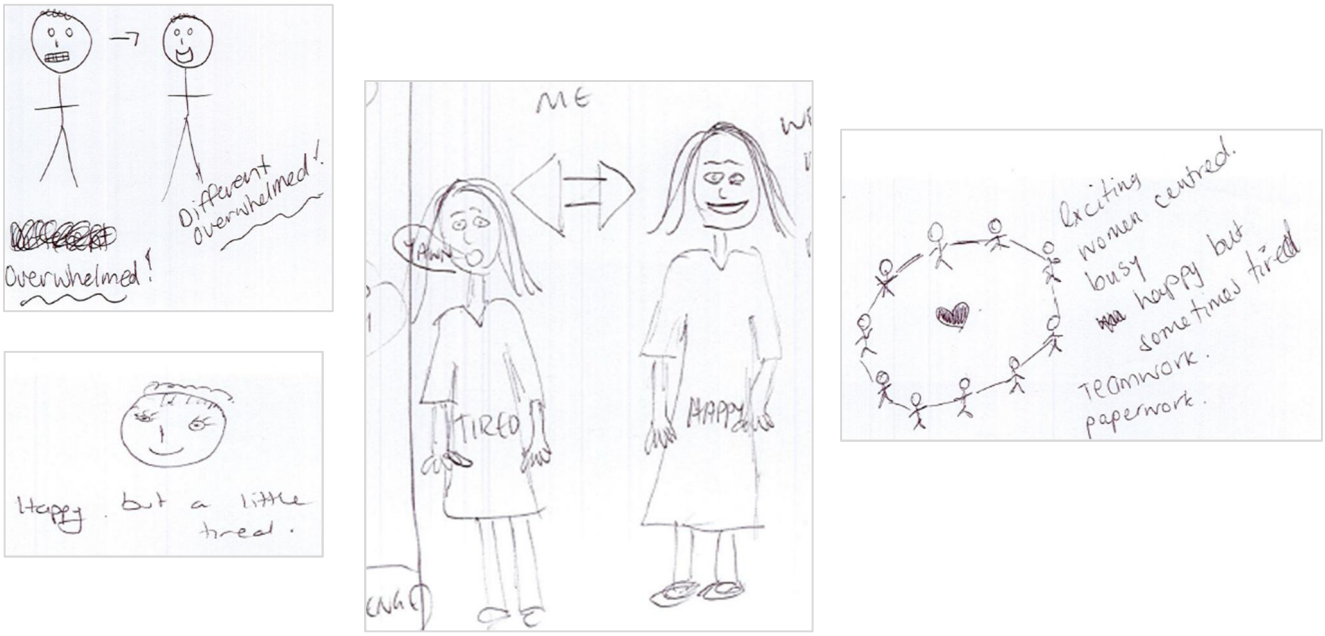

Figure 4. Focus Group: A "different sort of tired"

Appendix 2: DESTINY: The future for rural and remote MGP

Figure 5. Focus Group word cloud #3 - Describing the 'perfect' rural and remote MGP

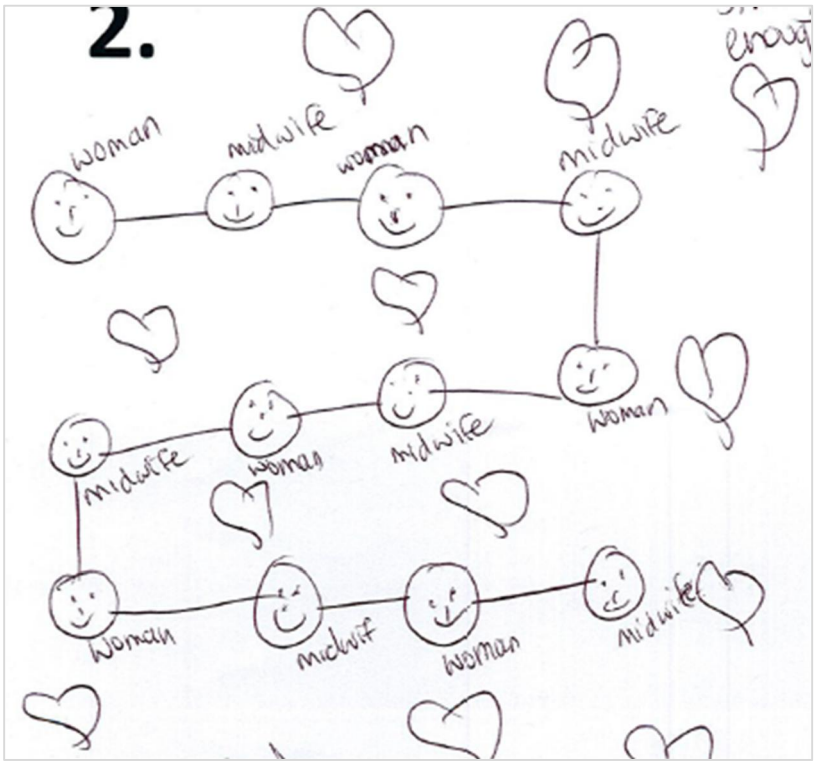

Figure 6. Focus Group: The way a Midwife perceives the "perfect" MGP partnering with women