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Midwives' experiences of working in team continuity of carer models: A qualitative evidence synthesis

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Introduction

UK maternity services are currently undergoing transformative reorganisation. Since the publication of *Better Births* (NHS, 2016) in England and *Best Start* (Scottish Government, 2017) in Scotland, there has been the ambition to provide the majority of women with midwife continuity of carer (MCOC). The aim of MCOC is for a meaningful relationship to develop between a childbearing woman and her named midwife, who, as part of a team of up to 8, provides all antenatal, birth and postnatal midwifery care (NHS, 2016). The UK has seen a rapid expansion of the number of new MCOC teams since 2016.

The term MCOC places the focus on the carer; there is expected to be an individual midwife who is a consistent presence throughout the pregnancy, birth, and postnatal period. When a single midwife has a caseload of women, often with another midwife for backup, who provides all of a woman's midwifery care, this is commonly referred to as 'caseloading' (Sandall, et al. 2016). However, MCOC has also been interpreted in different ways, and is used in NHS policy to mean consistency in either an individual midwife or the provision of care by a single clinical team (NHS, 2017). Various models and definitions are used in the literature and there is lack of consistency between them (NHS, 2017). Most NHS trusts are pursuing team MCOC rather than an individual caseloading model (Dunkley-Bent and McAree, 2020). It is unsurprising, given the ambiguity in definitions, that MCOC has been implemented in different ways with variations including the number of midwives providing care and the size of caseloads.

A Cochrane systematic review of 15 randomised controlled trials compared outcomes for women and babies who received MCOC models with other models of care (Sandall et al., 2016). While little is known about the mechanism, the review showed that MCOC provides a hugely significant range of clinical benefits compared with physician or obstetrician led care, with no adverse effects (*Fig. 1*). Although it was unknown whether such vast improvements would be seen in countries such as the UK, where all women have a named midwife and physician led care is rare, the review informed *Better Births*, and subsequent NHS implementation documents (NHS, 2017; 2021).

MCOC has been implemented in different countries in a multitude of ways. Midwives operate with different degrees of autonomy, differing relationships with medical colleagues, and serving differing populations (UNFPA, 2014). In Australia, legislative and educational changes have re-focused maternity services on MCOC. However, there is no central reporting of MCOC rates, with estimates that only 8–15% of women receive it (Styles et al., 2020). Lack of funding, staffing and support, alongside a well-established and well-funded private obstetric sector, have been cited as the reason why implementation has faltered (Hildingsson, et al. 2016; Dawson, et al. 2018). MCOC has been well established in New Zealand since the creation of Lead Maternity Carers (LMC) in 1990 (New Zealand Government, 1990). LMCs are usually midwives (though GPs or obstetricians can also practice in this role) who care for a caseload of women, either on their own, in pairs, or in teams. Women choose their provider, and MCOC lies at the heart of New Zealand's approach. LMCs are expected to be available around the clock for women on their caseload (Ministry of Health, 2021). This, combined with widespread staffing shortages, has led to concerns about the sustainability of the service (Dixon, et al. 2017; Eddy 2021). The UK has been short of midwives for decades and 83% of midwives believe their maternity service is operating with unsafe staffing levels (RCM, 2020). Concerns that the pace of

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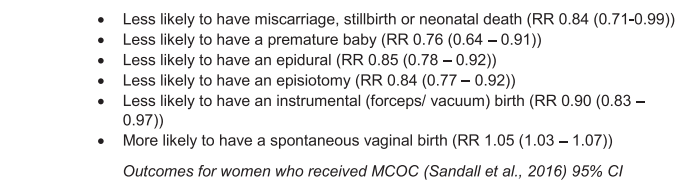

Fig. 1. Outcomes for women who received MCOC (Sandall et al., 2016) 95% CI.

change in the UK is compromising the safety of women and babies, has led to recommendations to suspend the implementation of MCOC until safe staffing levels are achieved (Ockenden, 2022).

The introduction of *Better Births* implies that there is a 'right' way to provide midwifery care, that the lessons of the past have been learned and that there is a robust evidence base for the implementation of MCOC. Although MCOC presents an opportunity to improve pregnancy outcomes, there are significant challenges when implementing changes that have previously been unsustainable and are undesirable to those midwives who prefer shift-based models of care. As multiple countries aim to expand the provision of MCOC teams, it is essential for the recruitment and retention of midwives to understand how to facilitate positive experiences of working in such teams and to ensure their sustainability. This qualitative evidence synthesis (QES) explores the experience of midwives working in MCOC teams following the publication of *Better Births*. By focusing on the period after 2016, it provides an insight into experiences that are relevant to midwives currently in practice and aims to more accurately reflect the experience of existing and future teams that meet the *Better Births* criteria.

Aims

- Identify personal or professional challenges or benefits that working in MCOC teams present.
- Establish midwives' perceived barriers or enablers to working in MCOC teams.
- Highlight any additional training and support needs for midwives working in MCOC teams.

Methods

The Cochrane guidance on methods for undertaking QES provided the methodological framework for the design and implementation of this review (Noyes, 2021). The SPIDER tool was used to aid the formation of a research question as its use in QES is well established (Cooke, et al. 2012). A protocol was developed a priori, and registered with the Open Science Framework (DOI 10.17605/OSF.IO/FTXJK).

Search strategy

A search strategy was developed in CINAHL with the assistance of an academic librarian. All searches and screening were undertaken by the first author. The search strategy included variations of keywords and their synonyms relating to, i) continuity of carer, ii) midwives' experiences and iii) qualitative research, using Boolean terms, combined with AND. Truncation and wildcard searches were used and adjustments made as per database requirements. Initial scoping searches returned a large number of papers exploring service users' experiences of MCOC. Therefore, the ADJ/N functions were used to return papers that focused on midwives' experiences. CINAHL, Medline (Ovid SP), Embase (Ovid SP), MIDIRS (OVID), Social Policy and Practice (OVID) databases were searched, as per the optimal strategy outlined by Bramer et al. (2017). Unpublished literature was sought using the ProQuest Dissertations and Thesis Database, British Nursing Database, HMIC database, and opengrey.eu. Citations from the selected studies were hand-screened to identify other potential studies. Google Scholar was searched using the term "midwife continuity qualitative" and the first 100 hits screened. All searches were conducted from 2017 until June 2021. Searches were limited to English language publications due to resource constraints. *Table 1* provides the terms used.

Eligibility criteria

The SPIDER framework was used to develop the eligibility criteria (*Table 2*).

Study selection and data extraction

Results were imported into EndNote X9 and deduplicated. Titles were screened for eligibility and obviously irrelevant results removed. Abstracts and then full texts were screened by the first author against the eligibility criteria. Any discrepancies were resolved by discussion with the second author.

Quality assessment

The quality of the included studies was assessed by the first author using the CASP qualitative checklist (CASP, 2018). The first study completed was also assessed by the second author. Our findings were discussed, and discrepancies resolved. Due to resource constraints it was not possible for all of the studies to be double assessed, but this initial discussion was continually reflected upon as subsequent checklists were completed.

Data analysis and synthesis

Thematic Synthesis was undertaken (Thomas and Harden, 2008). This was not a linear process, and there was significant revisiting of stages to become immersed in the literature, and ensure it was a comprehensive process (Flemming and Jones, 2020). Firstly, the results sections of studies were free coded line by line, while ensuring none were missed from other sections of the paper. Both MCOC midwives' quotes and the study author's interpretations of them were examined and coded. This process was repeated in a second reading of all papers, to ensure nothing was missed, that the codes were applied consistently and new ones created as necessary. The second step was to group the codes into sub-themes based on their meaning and relation to one another. This was complex as many of the codes and themes were overlapping. Therefore, there was an extended process of renaming and reorganising, which led to the third stage; the development of analytic themes. Rather than simply presenting an accumulation of the themes from the original studies, meanings were inferred and interpreted to create a broader picture encompassing all the studies. This was a cyclical process, repeated until analytical themes were generated that described and explained the sub-themes, and could be applied to the study question and aims. A diary was kept for audit and reflexivity. Theme development and refinement was regularly discussed with the co-author. NVivo software was used to manage and organise the data. The GRADE-CERQual tool was used to assess confidence in the QES (Lewin et al., 2018). Quality, coherence, relevance and adequacy of the data were assessed and an overall assessment made for each study as per Lewin et al. (2018a).

Results

The search strategies identified 1457 references (after deduplication). Fourteen studies representing 123 midwives were included

Table 1
Search terms used.

Terms for continuity of carer (combined with OR)	Terms for experiences (ADJ5/N5 midwi$) (combined with OR)	Terms for qualitative research (combined with OR)
Continuity	Experience$	Qualitative
Continuity of Carer	Perce$	Mixed-method$
Caseload$	Attitude$	Phenomenolog$
Case-load$	Chang$	Ethnograph$
Known midwife	View$	Discourse analysis
Relational care	Barrier$	Grounded theory
Team midwife$	Facilit$	Thematic analysis
	Transform$	Content analysis
	Transition$	Framework analysis
	Autonom$	Observation$
	Satisf$	Interview$
	Confiden$	Focus group$
		Mixed method$
		Descripti$

Table 2
Eligibility criteria.

	Inclusion	Exclusion
Population	Registered/licenced/professional midwives. This may include newly qualified midwives.	Lay/untrained/unqualified/student midwives or doulas. Studies with insufficient data from midwives to answer the review questions.
Phenomenon of interest	Working in a continuity of carer team. The *Implementing Better Births* definition of continuity of carer is used–A named midwife, usually working as part of a team of up to 8, with whom the pregnant woman can develop a trusting relationship, provides all midwifery antenatal, birth and postnatal care (NHS, 2017). Published after 2016.	Midwives not working in continuity of carer teams, or midwives working in teams that do not aim to provide all elements of maternity care.
Design	Studies that used appropriate qualitative methods such as interviews, focus groups or ethnographies. Studies which used established analytical techniques such as framework analysis, grounded theory or thematic analysis. Mixed-methods studies where the qualitative data was identifiable and appropriately analysed	Opinion pieces, commentaries, case studies. Quantitative studies. Mixed-methods studies where the qualitative section is not methodologically robust
Evaluation	Studies reporting midwives' perspectives and/or experiences of working in a continuity team. This may include the process of joining, transition period and becoming established in the role or leaving the role. It may include any mental, physical, social, personal or professional issues, and how it affected their, job satisfaction, professional confidence, and autonomy.	Studies where it is not possible to establish that the data is from midwives working in continuity of carer teams.
Research Type	Primary qualitative or mixed methods studies	–

in the QES (*Fig. 2*). The characteristics of the included studies are shown in *Table 3*. The countries represented were Australia (8 studies), New Zealand (1 study), Sweden (1 study), Scotland (2 studies) and England (1 study), another reported to be based in the UK, with no further location details. Various MCOC models were described in varying degrees of detail, depending on the focus of the study. In all included studies' participants were either working in pairs or teams of up to six. None of the included studies had teams as large as eight, as described in *Implementing Better Births* (NHS, 2017).

Quality assessment outcome

None of the studies were excluded based on the quality appraisal, details of which can be seen in *Supplementary File 1*. All studies gave clear aims, used appropriate design, methodology, recruitment strategies, data collection and made clear statements of findings. Sufficient detail was given to allow data analysis to be assessed as rigorous in 13/14 of the studies. The most common weaknesses were insufficient or absent information about the relationship between researcher and participants (11/14 did not meet this) and ethical issues (9/14 did not meet this criterion).

Findings from the thematic synthesis

Thematic synthesis led to the development of three analytical themes: *Leadership and organisation, The passionate professional, and Personalities and practicalities.* Additional illustrative quotes for each sub-theme are shown in *Table 4*. The GRADE-CERQual assessment (See *Supplementary File 2*) rated high or moderate confidence that these findings are transferable to midwives working in other MCOC teams.

Leadership and organisation

The hospital system

Positive experiences of management or organisational culture were described when joining an MCOC team that was well organised and adequately resourced. However, lack of staffing or managerial support and excessive bureaucracy were widely reported. Regulatory restrictions were most prevalent in the Australian studies, where midwives working in public MCOC teams felt limited by policies and guidelines, while private midwives had to arrange insurance and negotiate with hospitals to be allowed to practice

Table 3
Included studies – participant study characteristics.

Study	Participants	Country	MCOC Team features	Aims	Methods & Analysis
1. (Barker et al., 2019)	6 midwives (female, 35–55yrs old, 13–23yrs experience). All had worked in public MCOC teams	Australia.	No more than 3 per team. Private practice with access to public hospital.	Investigate the experiences of Australian midwives transitioning to private practice with visiting access.	Purposive sampling. Semi-structured interviews. Thematic analysis.
2.(Bradfield et al., 2019)	10 midwives (female, 35–57yrs old, 4 −34yrs experience)	Australia (Western).	Various, max 6 midwives per team.	Explore Western Australian midwives' experiences of being 'with woman' during labour and birth in a MCOC model.	Descriptive phenomenology. Purposive sampling. Interviews Phenomenological analysis.
3.(Catling et al., 2017)	11 midwives. (gender not reported, 24–61yrs old, 3months - 41yrs experience).	Australia (urban & rural).	Group and private practice. Teams of up to 6.	Explore midwifery workplace culture from the perspective of midwives themselves.	Purposive sampling. Semi-structured group and interviews using SCARF framework. Thematic analysis.
4.(Cummins et al., 2017)	13 midwives (gender not reported, age 21–46yrs, all <2yrs experience)	Australia (multiple regions).	Teams of up to 6.	Discover the mentoring experiences of new graduate midwives working in MCOC models in Australia.	Purposive & snowball sampling. Semi-structured interviews. Thematic analysis.
5.(Cummins et al., 2020)	20 midwives (gender not reported. age 20–60yrs. 8 New graduates, 12 experienced).	Australia (urban and rural).	MLC, working in pairs.	Explore the qualities of MCOC in Australia; identify the facilitators and barriers to the implementation and expansion MCOC.	Purposive sampling via midwifery managers. Separate focus groups for midwives rural and urban teams. QMNC Framework. Thematic analysis.
6.(Hunter et al., 2017)	11 midwives (gender not reported, age not reported, >8yrs experience).	New Zealand (urban and rural).	Group or partnered practice.	Investigate what sustains midwives who have worked in the LMC model of midwifery care for more than eight years.	Purposive sampling. Semi-structured interviews. Thematic analysis.
7.(Larsson et al., 2020)	4 midwives (gender, age, experience not reported).	Sweden.	Pilot of specialist team for women with fear of childbirth. 4 midwives. On call 0700–2200 only.	Examine how women with fear of birth and their midwives experienced care in a modified MCOC model.	Purposive sample. Semi-structured interviews. Thematic analysis.
8.(Lewis, 2020)	5 midwives (gender, age, experience not reported)	UK.	Pilot team. 4 midwives per team. MLC at home or MLU.	Explore the lived experience of midwives piloting a new MCOC model.	Purposive sample. Observations, whatsapp group, midwives' reflective diary, interviews. Normalisation process theory.
9.(McInnes et al., 2020)	6 midwives (gender, age, experience not reported).	Scotland.	Pilot team of 6.	In one Scottish health board, explore how MCOC works to inform sustainable on-going implementation and up-scaling.	Purposive sample. Mixed methods, team meetings, survey data, implementation meeting field notes, audit data, on-to-one interviews. Realist evaluation.
10.(Rayment-Jones et al., 2020)	11 midwives (gender, age not reported. <1 −25yrs experience).	England (London).	2 teams providing care in areas of social deprivation or social risk factors. 6 midwives in each team.	Explore the insights of midwives working in MCOC for women with social risk factors.	Purposive sampling. focus group interviews. Thematic analysis.
11.(Styles et al., 2020)	10 midwives (gender, age, experience not reported).	Australia (Queensland).	3 midwives per team. Mixed risk.	Explore the perceptions and experiences of midwifery and obstetric staff during implementation of MCOC.	Single site qualitative enquiry, Interviews and focus groups at 2 months and 2 years post implementation. Thematic analysis.
12.(Symon and Shinwell, 2020)	2 midwives (gender, age, experience not reported).	Scotland (Angus).	Homebirth team. 3 midwives.	Evaluation of how new mothers and midwives perceive the scheme Angus Home Birth scheme.	Used QMNC framework. Purposive recruitment. interviews. Thematic analysis.
13.(Tran et al., 2017)	4 midwives (gender and age not reported, 1–25yrs experience).	Australia (rural New South Wales).	2 teams of 3. MLC only, based around birth centre and homebirth.	Describe the development and current function of an MCOC service, to provide insight into the process of transition.	Purposive sample. Mixed methods-semi-structured interviews. Subtle realism. Thematic analysis.
14.(Vasilevski et al., 2020)	10 midwives (gender not reported, aged 25–44yrs, >12months experience.	Australia (Urban areas).	8 full time, 2 part time. Teams practice in pairs within team of up to 6. Mixed risk.	Evaluate women's satisfaction, and to understand the perceptions of part-time MCOC care from midwives in both part-time and full-time positions.	Purposive sample. Mixed methods survey. Content analysis.

Key to abbreviations: *MCOC* – Midwifery continuity of carer, *MLC* – midwife led care (low-risk pregnancies), *MLU* -midwife led unit (birth centre without obstetricians on duty).

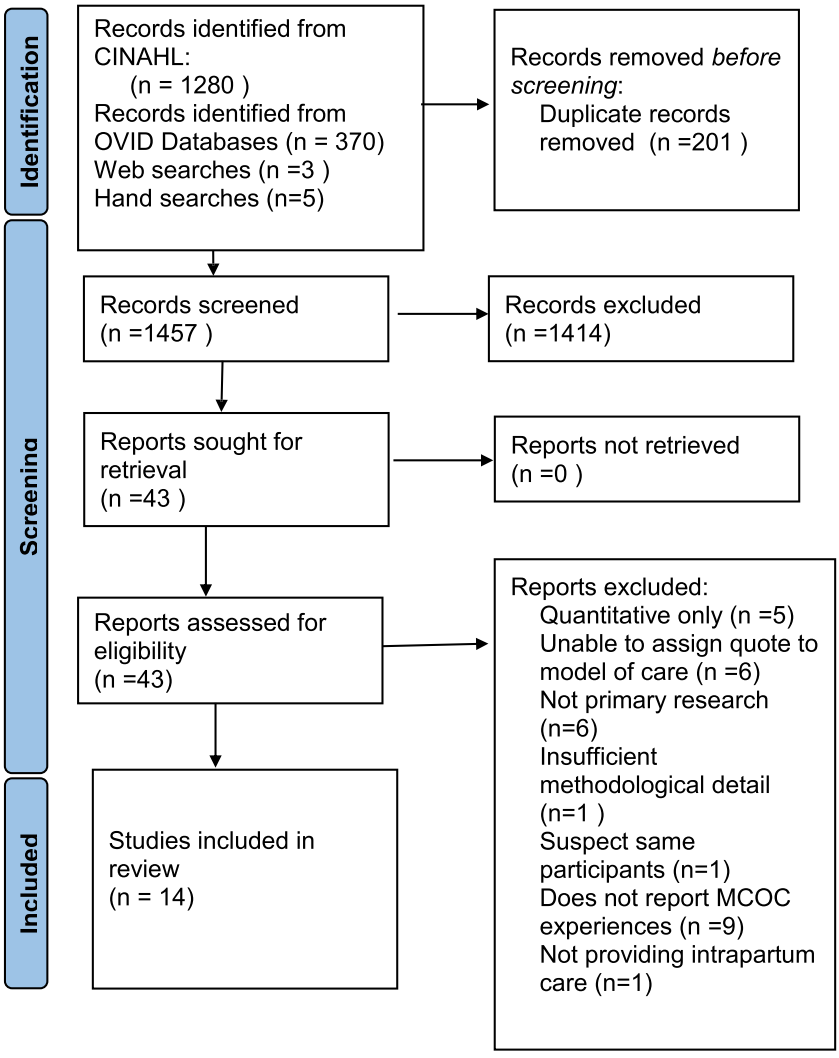

Fig. 2. Prisma study selection flow chart.

Table 4
Analytic themes and sub-themes.

Theme Sub-theme	*Leadership and organisation* The hospital system	Flexibility	Sustaining the model
Illustrative quotes	*"Within the public system you can't really work to your full scope. You're still limited by policies and guidelines rather than woman's choice" (Midwife Amy Interview, Barker et al., 2019)*	*"I think you have to run your team the best way works for you. I don't know if that's something we're allowed to do, and [the service director has] spoken to us before in regards to you have to work your team out to the best of your - that works for your team." (MW4 Interview, Styles et al., 2020)*	*"You can't hold those models – sustain them – if you don't have the support from management" (S5 interview, Catling et al, 2017).*
Theme	***The Passionate Professional***		
Sub-theme	**Philosophy of Care**	**Relationships with women**	**Using all my skills**
Illustrative quotes	*"[MCOC] has enabled me to see the true possibilities of midwifery. I feel fortunate that my partner and I complement each other's style of practise and we shared a common philosophy of midwifery." (Midwife interview, Vasilevski, 2020)*	*"I feel safer looking after women who I know because I know their history very well. I know them inside out. I know what their normal situation is, what their medical history is…" (P7 interview, Bradfield, 2019)*	*"Midwives described finally being able to use all their expertise, knowledge and skills to provide individualised care that was aligned to the woman's own preferences, needs and desires" (Author quote, Barker et al, 2019)*
Theme	***Personalities and practicalities***		
Sub-theme	**Being on call**	**Being part of the change process**	**Team work**
Illustrative quotes	*"There's a cost in terms of sleep and exhaustion and family time and being on call, yes there's lots of costs to do that" (P8 interview, Bradfield, 2019)*	*"There is a great sense of fatigue and 'you can't change things' and 'you can't change this' and 'it's always been like this', 'it doesn't matter anyway', 'I don't have a voice', 'we tried that it didn't work', that sort of story, that's the narrative, we just shrug our shoulders and do what we have to. Toe the line" (R3 interview, Catling et al., 2017).*	*"You know we kind of worked things around so if someone was not on-call but their woman was in labour—we might swap on-calls, we have done that a few times." (P4 Interview, Lewis, 2020)*

there. Furthermore, the ability for newly qualified and part-time midwives to work in MCOC teams was also restricted due to financial and contractual arrangements in Australia. Swedish midwives' ability to provide MCOC was restricted by regulations that limit their shifts to a maximum of 10 h, meaning they could not provide 24 hour cover (Larsson et al., 2020). This resulted in some women giving birth with a midwife they had not met before, which negatively affected the midwives' experience of the model of care. Bureaucracy associated with MCOC in the UK took the form of restrictive guidelines and government-set targets and timeframes, in addition to day-to-day micromanagement.

There were frequent examples of midwives new to MCOC being uncertain about organisational aspects, such as how the on-call system would work. Some midwives had welcomed this opportunity to organise themselves in a way that suited them as a team, while others felt unsupported and needed encouragement or explicit permission to have confidence in their newfound autonomy. Relationships with staff outside of the MCOC team made significant contributions to the midwives' experiences. Respectful and collegiate midwife-obstetrician relationships were reported by privately employed midwives and those with obstetricians attached to their team. While formal mentorship was valued by newly qualified midwives, experienced midwives appreciated and relied upon the informal peer support of their team.

> *"Some days someone might feel overwhelmed and another day somebody else feels a bit overwhelmed … Looking out for each other is probably the biggest thing to recommend going forward." (P3 Midwife Interview, Lewis, 2020)*

Flexibility

Improved flexibility in working patterns and practices was mentioned in 13 of the 14 studies. The flexibility of working in MCOC improved their ability to organise care to better suit women, reporting enhanced relationships and being able to offer targeted support. Flexibility also benefitted midwives as they were able to work from home, schedule work around other commitments such as family or personal appointments and work as a team to cover for each other if needed.

> "*It is so flexible. As long as we see the women… and get everything done for them … then you can literally do it in whatever time you want. Days, evenings, morning. Not just to suit you but to suit the woman too." (P3 Midwife interview, Lewis, 2020).*

Sustaining the model

All of the studies examine factors that aid or hinder the sustained provision of MCOC. Lack of adequate staffing and other resources was frequently reported. Teams experienced problems when staff went off sick or took annual leave. Although midwives reported lack of staff, there was no reported desire to alter team size to ease pressure. One study, of a team of four, reported that the midwives were unenthusiastic about larger teams; they felt this would diminish the team's personal relationships and level of knowledge about the women (Lewis, 2020). Suggestions for ensuring sustainability of MCOC teams included employing newly qualified midwives with reduced caseloads, employing more part time staff, improved support from managers and ensuring good team cohesion.

Reports of midwives working on their days off or taking on extra on-calls were very common. Sometimes this was due to inadequate staffing, though more often it was the midwives' desire to be available for the women, or an expectation that they should always be available, that drove them to over-work. Swedish working hours regulations were the only evidence of organisations restricting midwives' availability. In other countries it was up to individual midwives to place boundaries on their availability.

> *"I probably showed them a model that was too balanced towards just giving everything … (I wish I had) real time off and done more things with the family and showed them that there was life where the phone wasn't always there and the possibility of mum always having to rush away." (Holly, Midwife Interview, Hunter, 2017)*

The passionate professional

Philosophy of care

Midwifery values or midwifery philosophy were referred to by most authors and participants, without further explanation. Most discussed holistic, woman-centred care, with one of the central aims of the midwives being to facilitate women's choices in their care, including those that fell outside of their organisational guidelines. Midwives consistently described practicing in MCOC models as representing true midwifery, and they particularly valued their increased autonomy in clinical and working practice decisions. The importance of working in a team of like-minded midwives, obstetricians and managers, with a shared philosophy and common sense of purpose was widely reported. Many of the midwives described identifying as a particular 'type' of midwife, leading to a sense of being different, and 'other' to midwives who did not share their values. The midwives' deeply held philosophy placed them at odds with those working in traditional models of care, leading one to state that "*without it…you're not a midwife"* (P9, Midwife interview, Bradfield, 2019). This led them to work in an MCOC model, which reinforced their beliefs and underlined the differences in the approach to midwifery between them and hospital staff. As a result, relationships with core staff deteriorated–They reported being disrespected by core staff and feared ridicule for their woman-centred attitudes. They also experienced overt bullying, constantly had their care contested by medical staff, felt isolated while on the labour ward and experienced a general 'them and us' culture.

> "*You're never going to be, like, one team with the people in the hospital cause they're based in the hospital and that's what they do all the time and they don't, they're not with you all the time…I think it'll always feel like you're going into someone else's workplace" (Midwife interview 9, McInnes, 2020)*

Relationships with women

Midwives universally reported improved relationships with women due to working in MCOC teams. The participants described how, over time, a trusting relationship developed between the woman and the midwife. Several midwives reported feeling that this enhanced their relationship with women over time and facilitated safer care and better outcomes, as they knew her medical and social history. They frequently told of improved communication of all kinds, from information about fears of the birth, to mental health and domestic abuse. A member of the team being available for women to contact 24 h a day was seen as essential to this relationship. The midwives expressed how important it was to ensure women knew the boundaries of when it was appropriate to contact them outside of normal working hours, to ensure good work-life balance. It was reported as common for midwives new to MCOC teams to over-extend themselves, and that it took time, discipline, and the explicit support of managers, for each midwife to establish their own boundaries. MCOC was reported as being particularly useful for facilitating better relationships with women's

family and the wider community, especially where there is ethnic and cultural diversity or under-served populations.

> "*I work a lot with Indigenous women, facilitating those relationships during pregnancy has made birthing so much more easier and … opens you up to the community because they know who you are and who you represent" (P3, Midwife Interview, Bradfield, 2019)*

Using all my skills

The midwives expressed great satisfaction from being able to use the whole range of clinical and holistic skills they possess. The midwives in Barker et al. (2019) reported the same desire to practice to their full scope but had felt too restrained by their healthcare system in a public MCOC team. This contributed to their decision to leave public provision and establish their private practices.

> *"they experienced an ongoing frustration at what they saw as a 'discrepancy' between what they understood as good for women, good for birth and 'what actually happened in practice within the fragmented system" (Author Quote, Barker, 2020)*

Personalities and practicalities

Being part of the change process

Midwives greatly valued being actively involved in decisions about how teams would work, both in day-to-day operations, and how they would fit in with the wider maternity system. Their ability to change even minor aspects of their working lives contrasted with their previous experiences as core staff, where they described having emails ignored, not being consulted about changes, and not having time to participate in committees or working groups. Good, open channels of communication and regular negotiations with management and obstetric staff were important to support any changes, and ensure they felt listened to. Midwives recounted how, once they had decided to move to MCOC models, it took some time before they felt they had figured everything out. In addition to the bureaucratic and financial restrictions in Australia, Barker et al. (2019) reveal the need to embrace the uncertainty that came with setting up a new team, in terms of not knowing what will and will not work. Midwives needed time, and the trusting support from management, to test out models, to see what worked for them. Issues such as how the team cover staff absences took time to resolve. Some studies report midwives accepting that there is a process of trial and error in testing models of care; being open to change and problem-solving was regarded as essential. Others reported that midwives felt that they had minimal information or involvement in decisions about the practicalities of setting up a team and how their lives would be affected.

> *"People don't trust what's going on. […] This feels very invisible, even though there's lots of communication about it, it's the nuts and bolts, people want to know how is this going to affect me?" (Midwife Interview 3, McInnes, 2020)*

Being on-call

None of the studies examined models where the midwives worked shifts; they all had an on-call commitment. In all but one study (Larsson et al., 2020) the midwives provided cover 24 h per day. Some were on call for only their own women, while others could be on-call for any woman from the team's caseload. Having a flexible approach to being on-call was commonly reported, with midwives swapping between themselves or making themselves available beyond their usual commitment if they wished to. The downsides of on-call were acknowledged in terms of stress and exhaustion, and strained personal relationships. Several midwives found that the advantages of providing MCOC balanced out these disadvantages or that it was easier to manage than they had anticipated.

> *"I think really it's just about the on-calls; that was monumental because I was so worried, thinking that, like the midwives [standard care] are always saying that they get loads of phone calls…in the middle of the night. We don't get that, I am sure that is due to continuity" (P3, Midwife Interview, Lewis, 2020).*

Team work

Managing the team dynamic was described as something that required both a shared philosophy of care, and a culture of taking care of each other. This meant the midwives were aware of their colleagues' workloads and made practical efforts to help each other. The importance of peer support, camaraderie, and being available to offer moral support to team members, was regularly reported as essential for midwives' wellbeing.

> *"[we] look after each other really well…That's what enables us to keep going… we do often arrive in the hospital with food or just kind of say, "look, go lie down for an hour and I'll help out" (Carla, Midwife Interview, Hunter, 2017)*

Discussion

This QES examined midwives' experiences of working in continuity of carer (MCOC) teams since 2017. Benefits, barriers, and challenges of working in MCOC teams have been highlighted, and additional training and support needs identified. Fourteen qualitative studies were systematically reviewed, leading to the generation of three themes: *Leadership and Organisation; The Passionate Professional; Personalities and Practicalities.*

Leadership and organisation

This review found that the quality of management and leadership were central to the midwives' experiences of working in MCOC teams. Organisational issues differed, but insufficient staffing was common, making illness and annual leave cover unsustainably onerous. Lack of ongoing management support and inflexible rules were also suggested by midwives as threatening sustainability. Employers and organisations such as the Royal College of Midwives are raising expectations of improved work-life balance, autonomy and job satisfaction through MCOC working (RCM, 2017). It is vital for staff retention that the reality of MCOC lives up to these expectations. Poor working relationships with non-MCOC midwives and obstetricians were very commonly reported. The best working relationships occurred when the teams fundamentally altered the hierarchical midwife-obstetrician relationship, such as those that were privately employed, or had an obstetrician attached. Fundamental changes towards collaborative working relationships with a shared sense of purpose are likely required to achieve improved outcomes, and MCOC should not be treated as a panacea for all maternity care's problems (McCourt and Stevens 2006; Moncrieff 2018; Pace et al., 2021).

The recent move to large-scale implementation in the UK poses an unprecedented challenge to managers who have until now relied on highly motivated midwives volunteering for such roles (Moncrieff 2018). Many midwives are anxious about how MCOC could affect them personally; a survey of Scottish midwives reported concerns about being forced to work in MCOC, and having no choice or control about how the teams would operate

(Martin, et al. 2020). Midwives who are new to MCOC team models may experience the freedom of autonomous practice as a lack of support or guidance. Many midwives working in traditional models have had limited opportunities to organise their working lives, therefore it is foreseeable that they may be initially sceptical, feel unsupported, or over-extend themselves. Formal and informal mentorship for midwives new to MCOC, and ongoing peer support within the team, were highly valued by midwives in this review regardless of the midwife's length of experience. Managers need to be mindful that the skills required to work in MCOC teams are not only clinical, they also encompass organisation, team work and autonomous decision-making.

The passionate professional

The passion and commitment of MCOC midwives was universally reported, with many of them identifying as being fundamentally different from midwives who did not share their philosophy of care. There were frequent references to midwifery philosophy encompassing holistic MCOC care across the childbirth continuum, unequivocal support of women's choices, promoting physiological birth, and autonomous midwifery practice. It is clear that moving to a MCOC model requires midwives to approach their job in a different way, both philosophically and practically, and working with like-minded individuals is essential to team sustainability. Small teams found absences extremely challenging to cover, yet were resistant to working in a larger team as they felt this would be detrimental to relationships with women and the close working relationships they had developed as a team. Considering the importance MCOC midwives place on philosophy of care, it may be more important to prioritise shared values and team dynamics, rather than the number of midwives, when creating a new team. Good team cohesion allowed midwives to 'switch off' when not working as they trusted the rest of the team to provide high-quality care. Lack of protected time off has previously been reported as a risk factor for burnout (Young et al., 2015), but the importance of team cohesion in facilitating this was highlighted in this review. Midwives in this QES welcomed the flexibility that MCOC team working afforded, while acknowledging the challenges. Midwives need to place boundaries on their availability but managers should unambiguously permit, or even require, them to do this to prevent midwives over-extending themselves. A survey of Canadian midwives intending to leave the profession described a culture of self-sacrifice within MCOC (Stoll and Gallagher 2019). Feelings of guilt for not being available to attend a birth were common, so expectation-setting and an emphasis on team-work need to be clearly communicated.

In this review, midwives described how MCOC was not only a rewarding experience, but how their improved knowledge of families, communities and local services made their jobs easier and they felt clinically safer. This complements the evidence that MCOC may be of particular benefit to socially disadvantaged groups (Rayment-Jones et al., 2015). Surprisingly, the need to upskill was only mentioned in one study (Styles et al., 2020). Research has consistently shown that UK midwives feel they lack the skills necessary to safely work in MCOC: 25% felt they would need to update skills, with concerns that midwives working in core roles lack the broader knowledge and skills required to safely work in MCOC, while the specialist knowledge acquired by core staff may be lost as they become a 'jack of all trades,' (Taylor, et al. 2019; Martin, et al. 2020; Harris et al. 2020). Only five studies reported the size of the midwives' caseloads, and no midwives or authors discuss caseload size in relation to sustainability of the model. This is an interesting omission considering that widespread staffing shortages were reported. The midwifery staffing situation is so grave in the UK that safety concerns have led to the recent recommendation that MCOC teams should be suspended until safe staffing levels are achieved (Ockenden, 2022). It may be that, regardless of caseload size, on-calls will always be onerous, and other components of workload such as administrative tasks are also problematic.

Personalities and practicalities

Descriptions of kindness and generosity of MCOC midwives were common, but it is unclear whether this occurs as a consequence of working in MCOC teams, or whether it is an inherent characteristic of the team members. Many of the elements midwives felt were important for their relationship with women were common to their relationships with each other–Midwives "needed midwifing" (Cummins et al., 2017). Examples of good team work, such as swapping on calls to suit team members, required flexibility and autonomy that contrasted dramatically with their experience of traditional ways of working. As a result some of the midwives were distrustful of the more dynamic approach, or felt they were not being supported due to lack of management directives. Midwives need to have the willingness to embrace uncertainty when setting up a team with the trial-and-error approach described in the primary studies.

Strengths and limitations

This QES addresses a gap in the literature around midwives' experiences of team MCOC. This data is directly relevant to midwives, health service managers and policy makers. All the included studies were of successful pilots or of midwives working in established teams, suggesting publication bias. It may be that, by virtue of meeting the inclusion criteria, these teams were staffed by skilled or confident midwives, working in teams of optimum sizes, with manageable caseloads. However, it is surprising that so few MCOC midwives or authors acknowledge these variables.

The search strategy was devised to be as comprehensive as possible within the practical constraints posed, however, it is possible that some relevant studies may have been missed. Relatively few UK studies were found, and none of the studies included teams as large as eight. This may limit the generalisability of findings to UK MCOC team midwives. Potential limitations to generalisability lie in restricting data to English language publications. As QES requires an understanding of the nuance of language, this was a practical decision as both of the authors are English. Thus, perceptions about what MCOC is, and what the benefits and challenges are, are based in the English context and coloured by our experiences. The first author's experience as a midwife tasked with implementing continuity of carer in an NHS setting brings both useful insights and potential biases. Findings were discussed with the co-author (an experienced qualitative researcher) to clarify areas of uncertainty, ensure bias was minimised and aid refinement of themes.

Conclusion

Management styles and organisational cultures have a profound influence on midwives' experiences of MCOC team working. Adequate staff and resources are essential for safety and job satisfaction. Midwives need time and support to establish practical skills in team organization and may need explicit permission to set the necessary boundaries on their availability. Working in an MCOC team presents challenges, but these are often outweighed by the rewards. MCOC midwives are highly motivated and value professional autonomy, though the transition from core staff to MCOC midwife needs to be actively managed to avoid them experiencing autonomy as lack of support. The midwife-mother relationship is enhanced by MCOC, and midwives value providing flexible, holistic

care. Findings of challenging on-call arrangements and poor relationships with core staff have been widely reported. If midwives find that only their working hours change, while the organisational culture and philosophy of care is unchanged, substantial improvements in outcomes may not be achieved. This synthesis reinforces the evidence for what makes a good MCOC team- established teams are by their nature the successful ones. More could be learned by establishing common factors in what doesn't work, and understanding why teams are disbanded.

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The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

CRediT authorship contribution statement

Fran Leavy: Conceptualization, Methodology, Formal analysis, Investigation, Writing – original draft. **Heather Leggett:** Conceptualization, Methodology, Validation, Writing – review & editing, Supervision.

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Supplementary materials

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References

Barker, M., Fenwick, J., Gamble, J., 2019. Midwives' experiences of transitioning into private practice with visiting access in Australia–A qualitative descriptive study. Int. J. Childbirth 9 (3), 145–157.
Bradfield, Z., et al., 2019. it's what midwifery is all about"–Western Australian midwives' experiences of being 'with woman' during labour and birth in the known midwife model. BMC Pregnancy Childbirth 19 (1).
Bramer, W.M., Rethlefsen, M.L., Kleijnen, J., et al., 2017. Optimal database combinations for literature searches in systematic reviews–A prospective exploratory study. Syst. Rev. 6, 245.
CASP., 2018. CASP Qualitative Checklist. Available at: https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf Accessed 13/04/2021
Catling, C.J., Reid, F., Hunter, B., 2017. Australian midwives' experiences of their workplace culture. Women Birth 30 (2), 137–145.
Cooke, A., et al., 2012. Beyond PICO–The SPIDER tool for qualitative evidence synthesis. Qual. Health Res. 22, 1435–1443.
Cummins, A., et al., 2020. Exploring the qualities of midwifery-led continuity of care in Australia (MiLCCA) using the quality maternal and newborn care framework. Women Birth 33 (2), 125–134.
Cummins, A.M., Denney-Wilson, E., Homer, C., 2017. The mentoring experiences of new graduate midwives working in midwifery continuity of care models in Australia. Nurse Educ. Pract. 24, 106–111.
Dawson, K., et al., 2018. Operationalising caseload midwifery in the Australian public maternity system–Findings from a national cross-sectional survey of maternity managers. Women Birth 31 (3), 194–201.
Dixon, L., et al., 2017. The emotional wellbeing of New Zealand midwives–Comparing responses for midwives in caseloading and shift work settings. N. Z. Coll. Midwives J. (53).
Dunkley-Bent, J., McAree, T. 2020. Continuity of carer–Survey results and update. Better Births 5 Years On Conference. NHS England & NHS Improvement.
Eddy, A. 2021. Midwifery staffing at the CCDHB. [online] available at: https://www.midwife.org.nz/news/midwifery-staffing-at-the-ccdhb/.
Flemming, K., Jones, L.v., 2020. Using evidence from systematic reviews. In: Craig, J.V., Dowding, D. (Eds.), Evidence Based Practice in Nursing. Elsevier, pp. 109–125.
Harris, J.M., et al., 2020. Reflections on an educational intervention to encourage midwives to work in a continuity of care model - exploration and potential solutions. Midwifery doi:10.1016/j.midw.2020.102733.
Hildingsson, I., et al., 2016. Midwifery empowerment–National surveys of midwives from Australia, New Zealand and Sweden. Midwifery 40, 62–69.
Hunter, M., et al., 2017. Generosity of spirit sustains caseloading lead maternity carer midwives in New Zealand. MIDIRS Midwifery Digest 27 (1) 32-32.
Larsson, B., Rubertsson, C., Hildingsson, I., 2020. A modified caseload midwifery model for women with fear of birth, women's and midwives' experiences–A qualitative study. Sex. Reprod. Healthc. 24.
Lewin, S., B, A., Glenton, C., Munthe-Kaas, H., Rashidian, A., Wainwright, M., Bohren, M., Tunçalp, O., Colvin, C.J., Garside, R., Carlsen, B., Langlois, E., Noyes, J., 2018. Applying GRADE-CERQual to qualitative evidence synthesis findings. Implement. Sci. 13 (2).
Lewis, M., 2020. Midwives' experience of providing continuity of care in a pilot project–Findings of a prospective qualitative research study. Int. J. Childbirth 10 (3), 151–161.
Martin, C.J.H., et al., 2020. Midwives' views of changing to a Continuity of Midwifery Care (CMC) model in Scotland–A baseline survey. Women Birth 33 (5), e409–e419.
McCourt, C., Stevens, T., 2006. Continuity of carer–what does it mean and does it matter to midwives and birthing women? Can. J. Midwifery Res. Pract. 4 (3), 10–20.
McInnes, R.J., et al., 2020. Implementing continuity of midwife carer - just a friendly face? A realist evaluation. BMC Health Serv. Res. 20 (1), 304.
Ministry of Health. 2021. Choosing a lead maternity carer. [online] available at: https://www.health.govt.nz/your-health/pregnancy-and-kids/services-and-support-during-pregnancy/maternity-care.
Moncrieff, G., 2018. Can continuity bring birth back to women and normality back to midwives? Br. J. Midwifery 26 (10), 642–650.
New Zealand Government, 1990. Nurses Amendment Act. New Zealand Government.
Noyes J., B A., et al., 2021. Chapter 21–Qualitative evidence. In T. J. Higgins JPT, Chandler J, Cumpston M, Li T, Page MJ, Welch VA ed. Cochrane Handbook for Systematic Reviews of Interventions Version 6.2, Cochrane.
NHS., 2016. Better births - Improving outcomes of maternity services in England–A five year forward view for maternity care. Available at: https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf?PDFPATHWAY=PDF.
NHS., 2017. Implementing Better Births–Continuity of Carer. NHS, London.
Pace, C.A., Crowther, S., Lau, A., 2021. Midwife experiences of providing continuity of carer–A qualitative systematic review. Women Birth.
NHS. 2021. Delivering Midwifery Continuity of Carer at full scale Guidance on planning, implementation and monitoring 2021/22. Available at: https://www.england.nhs.uk/wp-content/uploads/2021/10/B0961_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf.
Ockenden D. 2022. Findings, conclusions and essential actions from the independent review of maternity services and the Shrewsbury and Telford Hospital NHS Trust. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf
Rayment-Jones, H., Murrells, T., Sandall, J., 2015. An investigation of the relationship between the caseload model of midwifery for socially disadvantaged women and childbirth outcomes using routine data – A retrospective, observational study. Midwifery 31 (4), 409–417.
Rayment-Jones, H., et al., 2020. Project 20–Midwives' insight into continuity of care models for women with social risk factors–What works, for whom, in what circumstances, and how. Midwifery 84, 102654.
RCM, 2017. Can Continuity Work For us? A Resource For Midwives. Royal College of Midwives, London.
RCM. 2020. *Fears for Maternity as Staffing Shortages Hit Safety and Morale Says RCM* [*online*] Available at: https://www.rcm.org.uk/media-releases/2020/november/fears-for-maternity-as-staffing-shortages-hit-safety-and-morale-says-rcm/.
Sandall, J., et al., 2016. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database Syst. Rev. (4).
Scottish Government., 2017. The Best Start–A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland [online]. Available at: https://www.gov.scot/publications/best-start-five-year-forward-plan-maternity-neonatal-care-scotland/pages/1/ [Accessed 18/06/2021].
Stoll, K., Gallagher, J., 2019. A survey of burnout and intentions to leave the profession among Western Canadian midwives. Women Birth 32 (4), e441–e449.
Styles, C., Kearney, L., George, K., 2020. Implementation and upscaling of midwifery continuity of care–The experience of midwives and obstetricians. Women Birth 33 (4), 343–351.
Symon, A., Shinwell, S., 2020. Qualitative evaluation of an innovative midwifery continuity scheme–Lessons from using a quality care framework. Birth 47 (4), 378–388.
Taylor, B., et al., 2019. Midwives' perspectives of continuity based working in the UK–A cross-sectional survey. Midwifery 75, 127–137.

Thomas, J., Harden, A., 2008. Methods for the thematic synthesis of qualitative research in systematic reviews. BMC Med. Res. Methodol. 8 (45).
Tran, T., et al., 2017. The development of a caseload midwifery service in rural Australia. Women Birth 30 (4), 291–297.
UNFPA, 2014. State of the World's Midwifery 2014. [online] available at https://www.unfpa.org/sowmy-2014.
Vasilevski, V., et al., 2020. Part-time positions in caseload midwifery group practice–Impact on satisfaction and quality of care. Women Birth.
Young, C.M., Smythe, L., Couper, J.M., 2015. Burnout: Lessons from the lived experience of case loading midwives. Int. J. Childbirth 5 (3), 154–165. doi:10.1891/2156-5287.5.3.154.