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Midwives' perceptions of organisational structures and processes influencing their ability to provide caseload care to socially disadvantaged and vulnerable women

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ABSTRACT

Objective: this study examined midwives' perceptions of organisational structures and processes of care when working in a caseload model (Midwifery Group Practice MGP) for socially disadvantaged and vulnerable childbearing women.
Design: this study used Donabedian's theoretical framework for evaluating the quality of health care provision. Of the 17 eligible midwives, 15 participated in focus group discussions and two others provided written comments. Thematic analysis was guided by three headings; clinical outcomes, processes of care and organisational structure.
Findings: midwives believed they provided an excellent service to socially disadvantaged and vulnerable childbearing women. Midwives gained satisfaction from working in partnership with women, working across their full scope of practice, and making a difference to the women. However the midwives perceived the MGP was situated within an organisation that was hostile to the caseload model of care. Midwives felt frustrated and distressed by a lack of organisational support for the model and a culture of blame dominated by medicine. A lack of material resources and no identified office space created feelings akin to 'homelessness'. Together these challenges threatened the cohesiveness of the MGP and undermined midwives' ability to advocate for women and keep birth normal.
Key conclusions: if access to caseload midwifery care for women with diverse backgrounds and circumstances is to be enhanced, then mechanisms need to be implemented to ensure organisational structures and processes are developed to sustain midwives in the provision of 'best practice' maternity care.
Implications for practice: women accessing midwifery caseload care have excellent maternal and newborn outcomes. However there remains limited understanding of the impact of organisational structures and processes of care on clinical outcomes.

Introduction

A Cochrane Review of midwife-led versus other models of care for childbearing women recommended that all women should be offered caseload midwifery care (Sandall et al., 2013). Providing continuity of midwifery care through a caseload approach has been shown to be safe and satisfying for women with improved clinical outcomes and reduced rates of intervention (Sandall et al., 2013). In Australia, however, maternity care remains largely fragmented with antenatal care provided predominantly by either private obstetricians, public hospital clinic care (all antenatal care provided by medical practitioners or midwives clinics), or shared care with a General Practitioner (GP) (Sutherland et al., 2009). Regardless of where women receive antenatal care, the majority (97%) labour and give birth in either a public or private hospital, with care provided by unknown midwives working rostered shifts

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(Laws and Sullivan, 2009; Pairman et al., 2006). Likewise postnatal care is fragmented, chaotic and consistently falls short of women's expectations (Fenwick et al., 2010). This is despite the popularity of primary midwife-led models of maternity care (Bryant, 2009).

In response to the Australian Government's commitment to reform maternity services and women's demands, there are a growing number of midwife-led services offering women the opportunity to have their own, or named, midwife across the childbirth continuum. Midwives who work in this way commonly come together and work in partnerships, referred to in this paper as a Midwifery Group Practice (MGP). How midwives and maternity organisations transition towards caseload care and sustainability of caseload services has received limited attention. Most studies report outcomes for small caseload practices targeting specific groups of women (Kildea et al., 2010). The lack of understanding of organisational factors surrounding the provision of caseload midwifery care may well be one of the reasons why progress in Australia and other western countries (except New Zealand) in reorienting maternity care to a caseload approach has been slow (Newnham, 2010; Allen et al., 2012). It is therefore timely to explore the wider system issues that may be impacting on the development and establishment of caseload models of care.

Understanding the way organisational structures and processes can impact on midwives' 'ways of working' and enhance or hinder the quality of work/life for midwives as well as clinical outcomes for women may be the key to reforming maternity service delivery (Raisler and Kennedy, 2005). Therefore, the aim of this study was to examine midwives' perceptions of the organisational structures and processes of care and their impact on a caseload model for socially disadvantaged and vulnerable childbearing women.

Context: The Midwifery Group Practice

Until recently the majority of caseload models were only accessible to pregnant women considered at low risk of developing complications (Laws et al., 2010; Williams et al., 2010; McLachlan et al., 2012). As a result, women at risk of poor maternal and neonatal outcomes resulting from social disadvantage were often excluded from accessing midwifery models of care. In an attempt to address the inequalities experienced by socially disadvantaged and vulnerable childbearing women and improve clinical outcomes, a caseload MGP was established at a metropolitan hospital in the state of Queensland, Australia (a description of the model's characteristics is presented in Table 1).

The development and implementation of the service was championed by midwifery leaders from within the organisation, despite resistance from some medical leaders. A reference group consisting of consumers, professional organisations and community representatives supported the establishment of the MGP.

Initially six fulltime midwives commenced in the practice which expanded to 16 fulltime midwives within 18 months. Midwives were appointed to the MGP from within the organisation with the majority of midwives having no previous experience of working in a caseload model. The champions for the service initially provided high level managerial support. Over a period of some months however changes at the health service executive level saw these champions move into different portfolios and managers without the same level of caseload knowledge or experience assumed responsibility for the MGP.

The MGP midwives had their own caseload of women to whom they provided maternity care across pregnancy, birth and the early parenting period (usually up to six weeks post partum). This model provided women with access to their own 'named' midwife, facilitating the development of relationships built on trust (Leap et al., 2010).

Over a period of 27 months 813 women received maternity care in the MGP model. Women accessing caseload care self-referred or were referred to the service by health care workers, Drug and Alcohol/Methadone Program workers, Youth Services such as Young Parents Program, Youth and Family Service, refugee support workers, Aboriginal and Torres Strait Islander Health Workers and occasionally general practitioners. Some women were also referred at the time of their initial 'booking in' appointment at the hospital. Once the referral was received the woman's details and reason for referral were entered into the MGP waiting list database. MGP midwives then recruited women from this database according to identified needs priorities. Aboriginal and Torres Strait Islander women were given the highest priority. Some pragmatic factors were taken into consideration such as where the woman lived in relation to the hospital, as most antenatal and postnatal care was provided in the woman's home, requiring that midwives travel to these locations. During this study a minimum of 10–15 women per month remained on the waiting list without being allocated a place in MGP.

Women accessing the MGP were more likely to be Aboriginal and/or Torres Strait Islander, less than 21 years of age, have alcohol and drug dependencies, have a mental health history, come from a culturally and linguistically diverse background, have a higher body mass index, and smoke in the antenatal period in comparison with other childbearing women in the state (Menke, 2012).

Overall clinical outcomes for women in the MGP were positive with a statistically significant reduction in the total caesarean section rate compared with women receiving standard care at the same hospital and state-wide perinatal data. Furthermore in comparison with hospital and state data all degrees of perineal

Table 1
Characteristics of the Group Midwifery Practice.

Eligibility for the service	Young parents, women with substance misuse, past/current mental health issues, Aboriginal and Torres Strait Islander women and refugee women
Referral to the service	Self referral or referred by health care workers, Drug and Alcohol/Methadone Program workers, Youth Services such as Young Parents Program, Youth and Family Service, Refugee support workers, Aboriginal and Torres Strait Islander Health Workers and General Practitioners
Care components	Each midwife provided antenatal, intrapartum and postnatal care to a defined caseload of women, in partnership with one or two other midwives. All antenatal and postnatal visiting, as well as early labour care, is conducted in the woman's own home. Once a woman is in established labour she is admitted to hospital for her labour and initial postnatal care. Most women are discharged from hospital to their home four hours after the birth. Postnatal follow up continues in the woman's home and by phone, according to need, up to six weeks. Midwives use the Australian College of Midwives (ACM) Consultation and Referral Guidelines for collaborative partnerships with obstetric colleagues.
Employment conditions	Each full time equivalent midwife provided care for a maximum of 40 women per year. The average caseload was between three and four women per month. Midwives received an annualised salary and use of a mobile phone. They are partly reimbursed for the use of their private car for visiting clients. Midwives have four days off call per fortnight, and are otherwise on call for their designated case load and for their back up midwives' caseload at agreed times