

Our reference: **CHSFOI24-25.32**

Dear [REDACTED]

DECISION ON YOUR ACCESS APPLICATION

I refer to your application under section 30 of the *Freedom of Information Act 2016* (FOI Act), received by Canberra Health Services (CHS) on Wednesday 21 May 2025.

This application requested access to:

'Under the Freedom of information Act 2016 I would like to be provided with a copy of the report for the internal review of planning for the expansion of continuity of care access and increase of continuity of care targets and models of care in midwifery conducted by CHS and finalised in 2025 and referred to by the Minister for Health in the ACT Legislative Assembly.'

I am an Information Officer appointed by the Chief Executive Officer of Canberra Health Services (CHS) under section 18 of the FOI Act to deal with access applications made under Part 5 of the Act. CHS was required to provide a decision on your access application by **Friday 4 July 2025**.

I have identified **three** documents holding the information within scope of your access application. These are outlined in the schedule of documents included at Attachment A to this decision letter.

Decisions

I have decided to grant full access to the three documents.:

My access decisions are detailed further in the following statement of reasons and the documents released to you are provided as Attachment B to this letter.

In reaching my access decision, I have taken the following into account:

- The FOI Act;
- The contents of the documents that fall within the scope of your request;
- The *Human Rights Act 2004*.

Charges

Processing charges are not applicable to this request.

Disclosure Log

Under section 28 of the FOI Act, CHS maintains an online record of access applications called a disclosure log. The scope of your access application, my decision and documents released to you will be published in the disclosure log not less than three days but not more than 10 days after the date of this decision. Your personal contact details will not be published.

<https://www.health.act.gov.au/about-our-health-system/freedom-information/disclosure-log>.

Ombudsman review

My decision on your access request is a reviewable decision as identified in Schedule 3 of the FOI Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601
Via email: ACTFOI@ombudsman.gov.au
Website: ombudsman.act.gov.au

ACT Civil and Administrative Tribunal (ACAT) review

Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Allara House
15 Constitution Avenue
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
<http://www.acat.act.gov.au/>

Further assistance

Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on (02) 5124 9831 or email HealthFOI@act.gov.au.

Yours sincerely



Katie McKenzie
General Manager
North Canberra Hospital

28 May 2025



Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access.

Personal information or business affairs information will not be made available under this policy. If you think the content of your request would contain such information, please inform the contact officer immediately.

Information about what is published on open access is available online at: <http://www.health.act.gov.au/public-information/consumers/freedom-information>

APPLICANT NAME	WHAT ARE THE PARAMETERS OF THE REQUEST	FILE NUMBER
	Under the Freedom of information Act 2016 I would like to be provided with a copy of the report for the internal review of planning for the expansion of continuity of care access and increase of continuity of care targets and models of care in midwifery conducted by CHS and finalised in 2025 and referred to by the Minister for Health in the ACT Legislative Assembly	CHSFOI24-25.32

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Midwifery Continuity of Care Expansion Report

Executive Sponsor: Michelle Thinius

Author: Alice Cotter

February 2025



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Information about the directorate can be found on the website:

www.canberrahealthservices.act.gov.au



Acknowledgement of Country

Canberra Health Services acknowledges the Ngunnawal people as traditional custodians of the ACT and recognises any other people or families with connection to the lands of the ACT and region. We acknowledge and respect their continuing culture and contribution to the life of this region.

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1. Executive Summary:

[Maternity-in-Focus-ACT-System-Plan-2022-2032](#) consolidates national and local strategies and recommendations in response to the [Inquiry into Maternity Services in the ACT](#) (ACT Legislative Assembly, 2020). Its purpose is to create a more sustainable, inclusive, and quality maternity care system that is woman and person-centred, equitable, and evidence based. The plan responds to challenges such as increasing demand for services, the need for expansion of continuity of care, workforce challenges, and the need for more informed, respectful, and individualised care. By outlining clear goals and actions, Maternity in Focus aims to improve maternal and newborn health outcomes, satisfaction, and workforce well-being, making the ACT's public maternity system the best in Australia.

This report was produced to address action points 8.1 and 8.3 of Goal 8 from the [Maternity in Focus: First Action Plan 2022-2025](#), 'To expand midwifery-led and midwifery-coordinated continuity of care models to improve access, increase equity, and enhance outcomes.'

The primary objective is to develop a new sustainable Midwifery Continuity of Care (MCoC) service to improve access for Aboriginal and Torres Strait Islander people, vulnerable and disadvantaged populations, as well as women and birthing people with medical complexities. It is important to emphasise that the proposed new service will not replace existing continuity models but will serve as an additional option for both midwives and women.

The objective also included developing a service that offers midwives sustainable working arrangements, designed to enhance their wellbeing and job satisfaction. The development of this service aims to support the achievement of the Maternity in Focus goal, of 50% of women having access to a MCoC model by 2028.

The development of this MCoC service was guided by a comprehensive literature review (Attachment B) and extensive consultation with stakeholders and maternity care experts at the local, national and international level. These consultations sought to ensure that the service developed is woman and person centred, meeting the needs of the women who will utilise it and the staff who will work within it.

The proposed new MCoC service provides midwives with the opportunity to work in a continuity of care setting without the prolonged on-call requirements, which were identified as a major barrier during consultation. It will also create more opportunities for new graduate and early-career midwives to work in a continuity setting. This initiative will help strengthen the midwifery workforce in the ACT while expanding maternity care options for women and families.

This report documents the key findings from the consultation process, outlines a proposed new service arrangement for the delivery of MCoC for implementation across Canberra Health Services (CHS), and provides recommendations to support its successful adoption.

This report uses the terms 'woman' throughout. This should be taken to include people who do not identify as women but who are pregnant.

2. Recommendations:



Recommendation 1: Endorse the proposed new service arrangements for MCoC.

Recommendation 2: Seek funding to support the implementation and evaluation of the new service.

Recommendation 3: Implement the service, initially for a 24-month trial period at one CHS site.

3. Background:

Midwifery continuity of care (MCoC) models consistently demonstrate improved health outcomes and higher levels of satisfaction for women, when compared with standard maternity models of care (Sandall et al., 2024). MCoC supports a woman and person-centred approach to care, promoting informed decision making and self-determination. MCoC involves midwives providing women with ongoing and supportive care throughout pregnancy, labour, birth, and the postpartum period. MCoC care can improve care coordination for women, strengthen advocacy and support informed decision making. MCoC models are cost effective (Baird et al., 2024) and midwives working within these models report higher job satisfaction and lower rates of burnout, contributing to the model's sustainability (Hewitt et al., 2024).

Worldwide there is an acknowledgement of the benefits of MCoC and strategies are being deployed to upscale access (COAG, 2019; National Health Service [NHS], 2021; Scottish Government, 2017; Welsh Government, 2019; World Health Organization [WHO], 2024). Despite the overwhelming evidence to support MCoC, currently only 14.8% of all Australian maternity models of care delivery are classified as MCoC (Australian Institute of Health Welfare [AIHW], 2023). In the ACT public sector in the 2023-2024 financial year, 18.6% of women and birthing people received MCoC through the Centenary Midwifery Program (CMP) at the Centenary Hospital for Women and Children (CHWC) and the Continuity of Midwifery Care Service (CMCS) at North Canberra Hospital (NCH).

Improving access for women to MCoC, is central to the ACT Government's maternity system reform, and is seen as critical to improving health outcomes for women and increasing consumer satisfaction with their maternity care. The ACT Government through the [Maternity-in-Focus-ACT-System-Plan-2022-2032](#) has made a commitment that over 50% of women and birthing people will have access to MCoC by 2028, and to review the feasibility of 75% having access by 2032 (ACT Health, 2022).

3.1 Maternity in Focus

Maternity in Focus consolidates findings from the following six documents.

- [ACT Government Response to the Legislative Assembly's Inquiry into Maternity Services in the ACT](#)
- [Woman-centred care: Strategic directions for Australian maternity services](#)
- [National Stillbirth Action and Implementation Plan](#)
- [Australian National Breastfeeding Strategy: 2019 and beyond](#)
- [Evaluation of the Publicly Funded Homebirth Trial in the Australian Capital Territory](#)
- [Safer Baby Bundle](#)



The [Maternity in Focus: First Action Plan 2022-2025](#) set specific goals to improve maternity care services in the ACT. Goal 8, as outlined below, refers specifically to MCoC.

Goal 8: Expand midwifery-led and midwifery coordinated continuity of care models, to improve access, increase equity and improve outcomes.

8.1 Expand continuity of care, with appropriate postnatal transition to improve access for Aboriginal and/or Torres Strait Islander peoples, individuals experiencing vulnerability or disadvantage and those with complex medical needs or disability.

8.3 Grow a sustainable continuity of care workforce through a clinical education plan that increases opportunities for upskilling and transition to practice in this model.

4. Aim:

Develop a new, sustainable MCoC service, expanding midwifery-led and midwifery coordinated continuity of care models to improve access, increase equity and improve outcomes.

Supporting the achievement of the Maternity in Focus target: 50% of women or birthing people having access by 2028 and exploring the feasibility of 75% of women having access by 2032.

5. Methods:

Review existing evidence for different MCoC models, with a focus on models designed for vulnerable or disadvantaged populations and individuals with complex health needs.

- Conduct a literature review of available research (Attachment B).

Assess how maternity services in Australia and internationally are implementing and sustaining different MCoC models.

- Consult with maternity care professionals in Australia and abroad, working in or managing MCoC programs.
- Conduct interviews to gather insights into the challenges, successes, and sustainable factors of existing MCoC models.
- Ascertain different models of MCoC implemented in other jurisdictions.
- Identify barriers that other jurisdictions have faced when expanding MCoC models and how they were overcome.

Assess the current capacity of MCoC models in the ACT.

- Review current capacity of MCoC models in the ACT including staffing and numbers of women or birthing people currently being cared for through the service.

Engage with the local maternity workforce.

- Utilise focus groups and workshops to engage with midwives, managers, and other relevant stakeholders in the ACT public maternity service, to identify barriers and enablers to working within MCoC models.



- Ascertain from current midwifery staff, desired roster practices and ways of working which would better support them to work in a continuity model.
- Explore staff interest to work in a continuity model and education and clinical development requirements to support them to achieve this.

Engage with consumers:

- Engage with consumers through the Maternity in Focus Consumer Advisory Group ensuring that any proposed new work arrangements do not diminish the experience of the consumer.

Outline a new sustainable and innovative MCoC service which could be implemented across CHS.

- Using the evidence gained from the literature review and consultation process, design a new MCoC service which could be implemented across CHS.
- Develop an evaluation framework (Attachment B) for the proposed new service to ensure that it meets the identified objectives.

6. Current State:

Canberra Health Services (CHS) provides public maternity care for women during their pregnancy, birth, and the early postnatal period. Public maternity care is currently provided within the hospital grounds, at the woman's home or at outreach clinics.

MCoC is currently provided through the Centenary Midwifery Program (CMP) at Centenary Hospital for Women and Children (CHWC) and the Continuity Midwifery Care Service (CMCS) at North Canberra Hospital. Both services offer Midwifery Group Practice (MGP) caseload care to a designated caseload of women.

The Maternity Care Classification System (MaCCS) defines MGP caseload care as 'Antenatal, intrapartum and postnatal care is provided within a publicly funded caseload model by a known primary midwife with secondary backup midwives providing cover and assistance, in collaboration with doctors in the event of identified risk factors. Antenatal care and postnatal care is usually provided in the hospital, community or home with intrapartum care in a hospital, birth centre or home. This category provides continuity of carer across the whole maternity period'.

6.1 MCoC at CHS:

The current capacity of continuity services at CHS is outlined below.

Service Delivery (2023-2024 Financial Year)

963 (18.6%) women received midwifery-led or coordinated continuity of care through CHS.



In February 2025, there were 818 women on the waiting list who had indicated a preference for MCoC at CHS. Demand far surpasses capacity of the current programs to care for this number of women. This demand reflects how popular the current services are with women and families in the ACT, and the need to expand to meet the needs of the ACT community.

Workforce Requirements to Meet 2028 Targets

To achieve the Maternity in Focus goal of 50% of women having access to continuity of care by 2028, it is estimated an additional 24.24 funded full time equivalent (FTE) midwives are required. In addition, there are vacancies in currently funded FTE which would need to be filled to meet the targets.

Table 1: FTE of midwives required to meet 50% target

	Current funded FTE	Total FTE required to reach 50%	FTE deficit
CHWC	32.55	47.6	15.05
NCH	14.31	23.5	9.19
Total	46.86	71.1	24.24

6.2 Areas for expansion of MCoC at CHS for priority populations

The following highlights opportunities for CHS to expand MCoC to increase services for women or birthing people who experience vulnerability or disadvantage, Aboriginal and Torres Strait Islander people and women with complex medical needs.

Aboriginal and Torres Strait Islander People: The lasting effects of over two centuries of colonisation in Australia have contributed to significant inequities in pregnancy and birth outcomes for First Nations families. First Nations mothers face a maternal mortality rate three–five times higher than other mothers, while their babies are two–three times more likely to be born prematurely, have low birth weight, or not survive their first year of life (Haora et al., 2023).

Each year, approximately 200 babies who identify as First Nations are born in the ACT. CHS would like to further adapt our maternity services, to meet the unique needs of First Nations women and birthing people. Currently some First Nations women and families receive care through existing continuity services, others receive care through the Maternity Care Team. CHS is working with Maternity in Focus to co-design a new service which will increase access to culturally safe MCoC which will enhance the health and wellbeing of First Nations families.

Women from culturally and linguistically diverse (CALD) backgrounds, including refugees and asylum seekers living in high-income countries consistently experience poorer perinatal outcomes compared to women born in the host country (Rogers et al., 2020). Women



with a CALD background also report greater dissatisfaction with their maternity care due to barriers such as language, cultural differences, and inadequate access to culturally appropriate services (Riggs et al., 2017; Small et al., 2014). In the ACT, 23% of the population was born overseas, and 25% speak a language other than English at home. In the ACT the most common countries of birth after Australia were India, England, China, and Nepal (Australian Bureau of Statistics, 2020).

Currently CHS offers women with migrant backgrounds care through the Culturally and Linguistically Diverse (CALD) clinic at CHWC, which offers antenatal care by one or more midwives supported by interpreter services. Women receive some continuity of care in the antenatal period and intrapartum and postnatal care is provided by the Maternity Care Team. NCH does not offer any specific tailored service for women and birthing people who are CALD at this time.

Women experiencing vulnerability or disadvantage: Health inequalities are avoidable disparities in health outcomes that arise from the unequal distribution of resources, power, and income within society (Khan, 2021). These inequalities often disproportionately affect vulnerable populations, leading to significant differences in access to care, quality of care, and overall health outcomes (Khan et al., 2023). Vulnerable populations during pregnancy include, but are not limited to, women living in poverty, experiencing homelessness, substance misuse, recent migrants, asylum seekers, refugees, ethnic minorities, Indigenous peoples, women under 20 years of age, victims of domestic abuse, and individuals with disabilities (Rayment et al., 2023; Rogers et al., 2020). Women and their babies who are vulnerable or disadvantaged face higher rates of maternal and perinatal morbidity and mortality (Faulks et al., 2023). Vulnerable women and their babies experience significant health inequity during pregnancy and birth (Faulks et al., 2023; Heys et al., 2021).

At CHWC and NCH, women who are considered vulnerable or disadvantaged are offered continuity of antenatal care through the Pregnancy Enhancement Program (PEP). There currently is no targeted continuity of care program that provides full continuity for women who are considered vulnerable or disadvantaged. Some women from this group will receive care through CMCS or CMP. Current challenges exist in identifying women who experience vulnerability or disadvantage, due to inadequate details in maternity referrals. This limits this cohort of women having access to a continuity service.

Women with complex medical conditions: Women with pre-existing or pregnancy related medical conditions have worse perinatal outcomes (de Wolff et al., 2021; Felker et al., 2024) and are more likely to experience mental health issues during pregnancy and in the postpartum period (Hinton et al., 2023). Women experiencing medical complexity receive care from a variety of maternity care services across CHS depending on their clinical need. At CHWC, CMP offer continuity of care to some women with medical complexities, at NCH CMCS is a low-risk model which excludes women experiencing medical complexities. For those requiring specialist input, the Maternal Fetal Medicine (MFM) unit at CHWC provides care to women who fit their eligibility criteria (This includes women who have experienced perinatal loss in a previous pregnancy), and a limited number of these women receive continuity of antenatal care through the MFM midwife.



7. Consultation

Extensive consultation was undertaken for this project, engaging with midwifery managers, academics, consumer networks, and maternity experts at local, national, and international levels. At the local level, stakeholders included the Australian Nursing and Midwifery Federation (ANMF), the University of Canberra, Maternity in Focus Project Team, the Australian College of Midwives (ACM), midwifery, medical and allied Health staff at CHS. Nationally and internationally, consultation involved midwifery directors, managers, academics, and clinical midwives with experience in MCoC models, as well as the Maternity Choices Consumer Network. Findings from the consultation process are outlined below.

Table 2: Methods of consultation

Stakeholders	Method	Number of individuals
Local external	Face/face or online interviews	13
NCH Staff	Face to face interviews, focus groups and online interviews.	65
CHWC staff		58
National	Online interviews	28
International	Online interviews	14
TOTAL		178

7.1 Staff consultation

A total of 123 staff members from NCH and CHWC were consulted. 99 of those consultations were undertaken with staff working clinically and those working in managerial positions across maternity areas (CHWC 56, NCH 43).

Consultations were conducted through focus groups, one-on-one interviews face/face or online, using a semi-structured approach guided by the following key topics:

- Desire to work across the full scope of practice.
- Interest in working in continuity of care models.
- Perceived challenges to working in continuity.
- Enablers to working in continuity models.
- Learning and clinical development needs which would support individuals to work across their full scope of practice and/or in a continuity model.



- Preferred rostering patterns.

The consultations revealed several key themes, which are outlined below.

- **Scope of practice:** Midwives expressed a strong desire to work across their full scope of practice. Most believed that the only viable way to achieve this was by participating in one of the continuity programs, such as CMP or CMCS.

Conversely, those who did not wish to work across their full scope of practice were typically midwives with long-term experience in a single area, often in outpatient settings. Their preference for remaining in a specific role was influenced by their familiarity with the work, work life balance and the stability it provided.

- **Interest in continuity of care:** The midwives surveyed expressed a strong interest in working within a continuity of care model and felt it would increase their job satisfaction. They identified barriers that hindered their ability to transition into or sustain work in such models.
- **Challenges:** The most cited challenge to working in a continuity of care model was the need to work in an on-call capacity due to:
 - Caring responsibilities for young children and difficulty arranging childcare.
 - Living more than 30 mins away from the hospital.
 - Fear of impact on work life balance.
 - Inability to 'switch off' when on call, creating stress and anxiety.
 - New graduates reported feeling burnt out by being on call as a student, which was a deterrent to working on-call in the future.
 - Fear that being on call would impact other family members.
 - Inability to work nights due to health reasons.
 - Unpredictability of working days.
 - Difficulty in maintaining boundaries between work and home life leading to burnout.
 - Working 'unsocial' hours.

Early career midwives felt they lacked the necessary clinical skills and experience, perceiving the responsibility as overwhelming. In contrast, many senior midwives reported feeling deskilled in certain areas due to prolonged periods of working in a single clinical setting. The most cited area of perceived skill deficiency was birthing. Some midwives were reluctant to work in this setting due to previous negative experiences, while early career staff expressed concerns about their limited exposure to normal labour and birth, leaving them feeling unprepared for this aspect of care.

The requirement in current continuity services to work every second weekend was a barrier frequently mentioned, as was the lack of part time positions offered which would allow midwives to work less than 0.7 FTE. Some staff suggested they would increase their hours if they worked in a flexible continuity service. Additionally, several midwives reported that they had applied for roles in one of the continuity models, but they were not the chosen candidates for the position.



Enablers: Staff expressed what they felt would enable them to work and thrive in a continuity setting.

- Being well supported was commonly cited as an enabler to work in any continuity setting. Having a Clinical Development Midwife (CDM) available 24/7 to support both early career and experienced midwives was seen as essential. Additionally, early career midwives expressed a desire for mentorship from an experienced midwife working in continuity. Supporting staff to undertake supernumerary shifts in specific areas where staff needed to upskill, including Digital Health Record (DHR) refresher training, were suggested. Additionally, professional development opportunities such as perineal suturing would support midwives to work to the full scope of practice.
- Flexible rostering patterns which gave midwives the option to influence or choose their shift pattern. Some staff preferred 12hr shifts, although there was no clear preference between set or rotating shifts, as individual preferences varied.
- Midwives wanted to be supported to practice autonomously and have freedom to organise their own working days.
- “Knowing” the women they cared for.
- Workload: Staff wanted to work within a model which was fully staffed so they were not constantly covering shortfalls. Current continuity staff suggested a ‘float’ midwife be employed to cover sick leave and other unplanned leave, or alternately one midwife each month within the continuity team have a reduced caseload to support the team when unplanned leave occurred.
- Working in a model that didn’t require being on call for prolonged periods.
- Working in a MAPS model.

The consistent themes across the consultations were that midwives have a desire to work across their full scope of practice in a continuity setting and want greater autonomy in their clinical work, organisation of their workdays and rosters. To achieve this, they wanted more support to upskill in all areas of maternity care and to have access to a CDM 24/7. Staff felt knowing the women they cared for would increase their job satisfaction.

The on-call requirement was consistently identified as the primary challenge to working within MCoC models. Most of the midwives who did not want to work across their full scope of practice wanted to work in a MAPS model, due to the regular working hours and the increased continuity it offered.

7.2 Consumer Consultation

Consumers were extensively consulted in the development of the [Maternity-in-Focus-ACT-System-Plan-2022-2032](#), which serves as the foundation for this project. Maternity in Focus was created in response to consumer demand for improvements in maternity care systems, both locally—through the [Report on the Inquiry into Maternity Services in the ACT](#), and nationally via the [Woman-centred care: Strategic directions for Australian maternity services](#). A key theme emerging from consumer contributions was the desire for greater access to continuity of care.



As part of this project, the Maternity in Focus (MiF) Consumer Advisory Group was consulted. The MiF Advisory Group was established in late 2023, with consumer representatives selected from individuals who had accessed public maternity services in the ACT within the past three years. Membership was designed to ensure diverse representation, including individuals with lived experience of perinatal mental health challenges, disability, Culturally and Linguistically Diverse (CALD) backgrounds, LGBTQIA+ communities, and Aboriginal and Torres Strait Islander backgrounds.

The MiF Consumer Advisory Group recognised the need to expand MCoC services, particularly for Aboriginal and Torres Strait Islander women and those experiencing vulnerability or disadvantage. However, concerns were raised regarding awareness and accessibility, specifically how women from vulnerable populations would learn about and access both the new service and existing continuity of care options. Additionally, the group emphasised the importance of inclusive consultation, ensuring that these women are actively involved in the service's development process.

Moving forward, the MiF Consumer Advisory Group will serve as the primary consultation body, guiding the development and implementation of the new MCoC service, to ensure it aligns with the needs and priorities of the ACT community.

Representatives from Women's Health Matters and Maternity Choices Australia were also consulted regarding this project.

7.3 National Consultation

28 maternity care professionals from organisations in South Australia, the Northern Territory, New South Wales, Victoria and Queensland were interviewed. These included midwifery directors, managers, academics and clinical midwives who worked within or had experience surrounding MCoC models. Questions were asked surrounding the challenges, successes and sustainable factors of the models that operated (specifically in relation to recruitment and retention of staff) and the barriers faced when expanding continuity models.

Table 3: Different models of MCoC

Model of care	Number
MGP Caseload care	18
MAPS	4
Midwifery Team Care	2

Representatives from 24 health services were consulted, the majority were MGP caseload care services, four MAPS services, and two team midwifery care services (Outlined in Table: 3 above). Seven operated in rural, remote, or regional settings, while the remaining were in urban areas. The services ranged from offering 30% - 100% of women continuity of care.



The MGP models varied in size, ranging from three to 34 FTE midwives, with team sizes varying from three-eight midwives. FTE arrangements ranged from 0.5 to 1.0.

There was significant variation in how the different MGP groups functioned, particularly in rostering and team organisation. One MGP model did not assign women to a primary midwife but instead allocated them to a small team. In this model, midwives were rostered on-call for 24-hour shifts to provide labour and birth care, as well as postnatal visits in the community. At the same time a different midwife was scheduled for antenatal clinic appointments.

Some models incorporated a designated 'non-call' day each week, during which midwives worked standard 9am-5pm shifts. This allowed them to undertake antenatal and postnatal visits for women without the risk of needing to reschedule.

Additionally, several services implemented a triage system where one midwife managed all incoming calls. If a woman was in established labour or required assessment, the triage midwife would contact the primary midwife to attend. Overnight, the triage midwife handled calls, conducted early labour assessments for women when necessary, and notified the primary midwife to attend once the woman was in established labour.

Management of induction of labour (IOL) care for women varied across services. Some provided comprehensive care from prelabour induction preparation to postnatal care. Others did not participate in the induction process and only attended once the woman was in established labour. Some models began the induction process for the woman but did not provide further care until labour was established.

The expectation of midwives differed between services in regard to unplanned pregnancy assessments. Some organisations required midwives to complete unplanned assessments for women only after 36 weeks, or only if they were labour related. Some midwives were not expected to provide assessments overnight. Others did not perform any unplanned assessments, including those related to labour. Several interviewees felt reducing or removing the need for midwives to perform unplanned assessments in their settings led to a reduction of burnout and promoted staff retention.

The two organisations that had team models had midwives working in groups of 8-10. Women were not allocated to an individual midwife, but to the team. Midwives in one service were rostered to provide care in the antenatal clinic, birth suite and the postnatal ward through rostered shifts. The other model provided antenatal and intrapartum care only through rostered shifts in birth suite and the antenatal clinic. Both models covered birth suite 24hrs day 7 days per week. Neither model provided care for unplanned assessments. Similarly, the MAPS models did not provide care for unplanned assessments, but in some services midwives carried a phone where women could call for non-urgent queries during office hours. Midwives would triage calls and give advice accordingly.

Eligibility criteria varied significantly across the programs. Some were restricted to low-risk women, while others accepted women of any risk profile. In certain organisations, women were required to have at least one consultation with a medical or obstetric doctor to confirm their



eligibility. One program exclusively cared for women from identified priority groups, predominately vulnerable and disadvantaged women.

Obstetric collaboration: Across all models, 10 out of 18 organisations had a designated named obstetric doctor responsible for collaboration when required. In other services, midwives consulted with a rotating obstetrician or GP Obstetricians.

Factors influencing sustainability of continuity services

Through the consultation the key factors supporting sustainability included:

- Strong and supportive midwifery leadership at all levels of the organisation which, understood and valued continuity services.
- Midwives developing relationships with women.
- Management facilitating a yearly workshop where they invite midwives to develop ways to improve their service and implement change.
- Organisational support through funding for midwives to attend conferences or other professional development opportunities.
- Having a dedicated Clinical Development Midwife (CDM) allocated to the model.
- Enabling midwives to work autonomously-Acknowledgment from management of midwives' ability to work independently and autonomously.
- Promoting flexible working arrangements and allowing midwives to dictate their own working days and rosters.
- Midwives supported to look after women in subsequent pregnancies who they had cared for before in the service.
- Team cohesiveness- allowing midwives to decide who they work with and ensure midwives working together have the same philosophy of care.
- Limiting requirement of continuity midwives to attend unplanned assessments for women. 13 out of the 18 organisations reviewed did not require continuity midwives to attend a woman for all unplanned assessments (For example decreased fetal movements, vaginal bleeding in pregnancy or abdominal pain). They felt this reduced burnout among staff.
- Supported new graduate positions in continuity programs.
- Facilitating staff to complete regular clinical supervision.
- Completing a staff wellbeing survey yearly.
- Effective integration of continuity service within core services.



- Midwives having an allocated day per week when they were not on call for labour and birth, but they could complete antenatal or postnatal visits.
- One midwife triaging all team phone calls after hours. Limits amount of phone calls midwives receive after hours disrupting sleep and supports wellbeing.
- Having a clear process for consultation and referral.
- Having access to allied health and community supports for women who required these services.
- Ensuring continuity in medical collaboration by assigning a consistent named doctor for each service or team, rather than rotating between different doctors. This was noted to foster stronger relationships, improve communication, and enhance care coordination.

Key challenges to sustainability were:

- Lack of support from wider organisation.
- Midwifery management in continuity services who did not have experience working in continuity services previously.
- Limited awareness across the broader service regarding the role and responsibilities of continuity midwives.
- No cover for unplanned leave or annual leave.
- Midwives having to do unplanned assessments after hours.
- No dedicated manager for the model.
- Lack of CDM support.
- In Queensland, the enterprise agreement requires all midwives regardless of FTE to work 10/14 days on call. For part time midwives this has led to burnout.
- Young workforce leading to large amounts of birthing leave in the service.

Only two of the surveyed continuity programs reported difficulties in retaining staff, while all others were fully recruited, with most having a waiting list of midwives interested in joining their services.

One organisation attributed its recruitment challenges to team dynamics, noting that it did not have a dedicated Midwifery Manager for its continuity services. The other organisation, located in a remote area, experienced temporary staffing shortages due to maternity leave, which has since been resolved. Across all programs, the most common reason for staffing shortages was vacancies caused by birthing leave.



One organisation that recently established both MGP and MAPS models in regional areas reported an unprecedented number of applications following the introduction of continuity positions, despite historically struggling to recruit midwives.

Other organisations also noted high demand, with some receiving large volumes of applications for a limited number of positions. One urban organisation, for example, reported receiving 30 applications during its most recent recruitment round.

Employing new graduate midwives was frequently cited as key to building a sustainable workforce. Twelve of the 18 programs supported new graduates in continuity roles. Many felt this was key to sustain their work force by 'growing their own'. They reported most graduates stayed working in the model after their new graduate program had finished. One organisation which piloted a team of four new graduates that worked together, compared the clinical outcomes of the graduate group with the experienced midwife teams in their MGP. They showed reduced interventions during labour and birth (Caesarean section rates and induction of labour) and increased skin/skin contact and breastfeeding rates for women cared for in the new graduate group, compared to the groups of experienced midwives.

Scaling up continuity services:

The most commonly cited challenge to expanding continuity of care programs across every service was a lack of funding. Despite this, one service prioritised continuity services for funding over other areas within the organisation, using the funds which were available to support the expansion of their MCoC program. This was enabled by a supportive executive leadership team who understood the value of continuity services.

Another service secured funding by structuring its program to provide care for all vulnerable or disadvantaged women, thereby justifying additional government financial support. This service also reallocated FTE from core services to expand the program.

The inability of midwives to work across their full scope of practice was a challenge voiced by several services. One service addressed this by implementing a rotational program, allowing 80% of midwives to gain experience across different areas of maternity care and develop their skills. Additionally, midwives were invited to participate in individual learning needs assessments through an online survey, which helped identify specific areas where they required further support and then an individual plan was made.

7.7 International consultation:

Fourteen maternity care professionals from 10 different health services across New Zealand, the United Kingdom (UK), the Netherlands, Canada, and the United States (USA) were consulted through online interviews. All services reviewed were in urban settings. Questions were asked regarding the challenges, successes, and sustainable factors of the MCoC services, and the barriers faced when expanding continuity models of care.

Eleven different models of care were identified from the professionals interviewed. These differed significantly in structure and approach.



Table 4: Models of care by country

Model of Care	New Zealand	UK	Netherlands	Canada	USA
MGP Caseload	1	1			
MAPS	2				
Midwife Team Care	1	2	1	2	1

A summary of each service is provided in Appendix 2.

Factors influencing sustainability of continuity services

Key factors supporting sustainability were:

- Support from the wider organisation.
- The core service having adequate staffing.
- Having regular team meetings for case reviews, reflection, and team building.
- Clear communication pathways within MCoC teams.
- Like minded midwives working together.
- The opportunity to develop relationships with women and families.
- Flexible working arrangements.
- Midwives not being required to work on-call for prolonged periods.
- Self-rostering.
- Regular clinical supervision.
- Working 12hr shifts.

Key challenges to sustainability were:

- Lack of funding: One of the models was set up with temporary funding, and while it functioned well, and staff satisfaction was high the service was ceased due to a lack of ongoing funding.
- Understaffing of core services: Continuity midwives being frequently required to support core services by taking on clinical shifts in inpatient settings, disrupting their primary responsibilities and adding to their existing workload.
- Unsustainable workload: huge demands in one service meant caseloads far surpassed what was deemed appropriate. For example, in one service each midwife was originally intended to manage a caseload of 36 women per year. However, caseloads frequently exceeded 100, compromising the quality of care placing significant stress on midwives.
- Undervalued: Staff felt undervalued by the wider organisation.



- Lack of understanding from wider organisation of the role of a continuity midwife
- Midwives developing burn out from working in an on-call capacity.
- Scaling up continuity services: Only one of the eleven MCoC services surveyed had been successful in expanding the service at scale. The primary barriers to expansion of services across all settings were;
 - Lack of funding.
 - Midwifery shortages.
 - Burnout across the wider organisation impacting ability to recruit and retain staff.

Four of the services in Canada, the Netherlands and New Zealand were run by privately practicing midwives, who were paid per episode of service either from women's insurance company or by the government (Although these midwives are privately practice, they provide a publicly funded service to women). They did not desire to expand their services as creating larger groups would reduce continuity, although they did face issues sustaining their services. In Canada, surveyed midwives reported experiencing burnout due to the pressures of the COVID-19 pandemic and the need to take on high caseloads to maintain a sufficient income. These challenges have significantly impacted their willingness and ability to work in continuity of care settings. They have seen a shift from midwives offering continuity of care, to midwives only offering antenatal and postnatal care. The on-call component of providing intrapartum care was cited as the primary factor. The midwives that did work in continuity settings primarily worked in small teams of four, where women were not assigned an individual midwife. This was to reduce the amount of time midwives were on-call. They felt this model offered women continuity while facilitating a better work life balance for midwives. Although some midwives thought this model may increase burnout as midwives were on call for larger amounts of women, who they may not have developed a relationship with (Which is protective of burnout).

Three maternity care models from the UK were consulted, where national maternity care reforms, such as Better Births in England and Best Start in Scotland aim to improve maternity services by expanding access to MCoC. The original target was to make MCoC the default model of care by 2021. However, this goal has since been reassessed, as implementing and scaling up MCoC services across the UK has proven challenging (NHS, 2021). An independent report, commissioned by the NHS The [Independent evaluation of implementation of Midwifery Continuity of Carer](#), outlines the key barriers and enablers encountered in meeting these targets.

One of the consulted services in the UK has successfully implemented a MCoC model in which 100% of women have a named midwife. This service operates under a rostered team model, where each woman is assigned a primary midwife and a backup midwife, with no on-call requirement (see Appendix 2 for details). Initially, the model trialled MGP caseload care, followed by on-call teams, but staff found the on-call component unsustainable. As a result, the service transitioned to the current rostered system. The implementation process took 12 months. The service reports high levels of job satisfaction among midwives and they are fully recruited, with a surplus of applicants in their most recent hiring round. Women also expressed high satisfaction with their care, though the service acknowledged the need for further



improvements to increase intrapartum continuity for women. The level of continuity is reduced when compared to MGP caseload care, which the service acknowledged.

Key factors to the successful implementation and expansion of this service in the UK are summarised below:

- Prior to implementation, most midwives already worked across all areas of maternity care, making it easier to transition to the new model as they were already practicing across their full scope.
- Midwives underwent a learning needs assessment to identify areas where they needed support to upskill.
- Information sessions were conducted to explain the new model and how it would operate, ensuring clarity and engagement among all staff not only those who would be working within the model.
- Phased approach to implementation, teams of 7–9 midwives were introduced one at a time.
- Midwives had the choice to join the new model and were also permitted to select their own team members.
- Staff were encouraged to voice their opinions about what worked and what didn't, allowing the model to be continuously refined to meet the needs of both midwives and the women and families they cared for.
- The new model was found to be cost effective to implement, costing equivalent to standard care services previously offered.

All services were trying to develop a service that balanced offering women continuity of care while maintaining staff wellbeing.

8. Discussion

8.1 Why do we need to expand access to MCoC models?

In response to consumer demand, and the demonstrated benefits for women and birthing people, the ACT Government has committed to expanding midwifery-led and midwife-coordinated continuity of care models. This expansion aims to improve access to MCoC models, enabling 50% of women to have access to MCoC by 2028. In the 2023–2024 financial year, 18.6% of women received MCoC in the ACT Public Maternity Service through CHS, highlighting the need for significant changes in how care is delivered to achieve the *Maternity-in-Focus* goal of 50%.

MCoC provides optimal health outcomes for women and their babies, while significantly enhancing women's satisfaction with their maternity care (Sandall et al., 2024). The importance of MCoC is emphasised in key national and local maternity strategies, including the [Woman-centred care: Strategic directions for Australian maternity services](#) and the [Maternity in Focus: First Action Plan 2022-2025](#), both of which highlight the critical need to prioritise and expand MCoC services to reduce intervention rates and improve maternal satisfaction.



Midwives benefit significantly from working in continuity of carer models, which are associated with reduced rates of burnout and increased job satisfaction (Hewitt et al., 2024). The recently published [Midwifery Futures](#) report (Homer et al., 2024) surveyed 3,286 midwives in Australia and found that one-third of midwives were considering leaving the profession. The survey also found that midwives working in Midwifery Group Practice (MGP) or team midwifery care were less likely to express an intention to leave. Notably, the report highlighted that many midwives aspire to work in continuity of care models, with 37.5% of respondents indicating MGP as their preferred care model. Similarly, 80% of midwifery students expressed a desire to work in continuity of care models, a sentiment echoed by newly qualified midwives.

[The Future of the Midwifery Workforce in Australia](#) position paper identified the limited availability of opportunities for midwives to work in continuity of care models as a significant factor negatively affecting workforce sustainability (Council of Deans of Nursing and Midwifery [CDNM], 2023). The [Midwifery Futures](#) report also emphasised upscaling MCoC models as key to creating a sustainable workforce in Australia.

Expanding access to MCoC models within the local setting will enhance staff wellbeing, contributing to the sustainability of the maternity care workforce by promoting staff retention. For women, increased access will lead to improved health outcomes, enhanced experiences of maternity care, and greater equity in service provision. Furthermore, MCoC models are cost-effective, reducing overall expenditure for the health service.

The submissions made by consumers during the Inquiry into Maternity Services showed that women in the ACT seek equitable access to continuity of care with a known midwife, and consultation has highlighted midwives are willing to work within continuity models.

Through the current MCoC programs at CHS women benefit from "gold standard care" provided through MGP caseload models. Consistently, consumer feedback highlights the overwhelmingly positive experiences of women and families engaged in these services.

'I can't rate my overall experience of this service and (midwife name) specifically, highly enough. I am absolutely certain that having the one midwife relationship throughout my pregnancy and present at my labour had significant impact on my eventual birthing experience in the most positive of ways, and I wish that this program was available to more birthing people in the ACT'

'Being in the program and particularly having my care provided by (midwife) made me feel so safe and supported throughout my pregnancy, labour and postpartum care. It was so nice to get to know the (midwife) and know that she knew me and about my pregnancy and it was easy to trust her (midwife name) made me feel so safe and relaxed during labour. I felt like I could just focus on breathing and know that she would manage any complications, and I didn't have to worry'

The above feedback echoes countless compliments received regarding the continuity of care programs.

It is important to emphasise that the proposed new service will not replace existing continuity models but will serve as an additional option for both midwives and women.



This report highlights that midwives are eager to work within a continuity of care model; however, the on-call requirements of the current model present a significant barrier. The newly proposed service eliminates the need for prolonged on-call periods, making it more accessible for a greater number of midwives to engage in continuity of care. Additionally, the proposed new service creates more opportunities for new graduate and early-career midwives to work in a continuity of care setting.

8.2 Review of the evidence regarding MCoC models

Despite compelling evidence supporting MGP caseload care, many local staff have identified the on-call requirement as a significant barrier to participating in MCoC models. To address this challenge, alternative MCoC models that minimise or eliminate prolonged on-call periods were explored. This involved a review of the literature and investigations into practices in other jurisdictions where alternative models have been successfully implemented.

The MAPS model was evaluated as an alternative, as local staff identified it as an appealing alternative to MGP caseload care. However, it is important to note that this model does not meet the definition of midwifery-led or coordinated continuity of care as defined by Maternity in Focus (See appendix 1), as women are not supported during labour and birth. Midwives working within MAPS models in other jurisdictions reported high levels of job satisfaction, which contributed to improved staff retention. Research also found the MAPS model to be acceptable to both midwives and women, with studies highlighting high satisfaction rates among women receiving care through this model and midwives providing it (Dharni et al., 2021; Cummins et al., 2022; Cummins et al., 2024).

There is currently limited data on perinatal outcomes associated with the MAPS model, and one study demonstrated MAPS model of care does not result in equivalent clinical outcomes for women and their neonates compared to MGP caseload care (Mollart et al., 2025). Further research is essential to evaluate the potential benefits of the MAPS model for women and babies, particularly regarding clinical outcomes and cost savings for health services. Given the limited supporting evidence and the misalignment with the established definition of continuity of care, expanding continuity through the MAPS model does not meet the goals set out in Maternity in Focus. In the future, implementing a MAPS service may warrant consideration, pending stronger evidence demonstrating its impact on clinical outcomes and maternal satisfaction.

Midwifery team care, a major model category within the MaCCS definitions (see Appendix 1), was also evaluated as an alternative option of MCoC. The systematic Cochrane review [Midwife continuity of care models versus other models of care for childbearing women](#) (Sandall et al., 2024) examined outcomes of 18,533 women cared for in MCoC models (including MGP caseload care and team midwifery) compared to standard care models. Of the 17 trials reviewed, ten focused on outcomes related to team midwifery. Sub-analysis indicated no significant differences in outcomes between the team midwifery and MGP caseload care models, demonstrating that team midwifery is effective in delivering improved clinical outcomes (Sandall et al., 2024).



Internationally, many jurisdictions have adopted variations of team-based care to enhance service sustainability, balancing the need to provide women with continuity of care while supporting the wellbeing of midwives. Notably, midwives in the Netherlands report lower rates of burnout compared to their counterparts in other countries, a trend which may be attributed to the prevalence of team midwifery (Kool et al., 2023). This suggests that team-based care models may play a role in preventing midwife burnout while maintaining quality care for women and families.

As it pertains to team midwifery, there is evidence that continuity of care rather than continuity of carer contributes to women's positive experiences (Homer et al, 2019; Sandall et al., 2024). The small team environment allows midwives to work closely to develop their shared philosophy of midwifery care while ensuring consistency of information and messaging to women. Having a small team care for a woman, ensures women do not have to repeat their history or story to multiple different care providers. The benefits of a team model for midwives include having some of the positive aspects of relationship-based care and being able to work across the full scope of practice. Research suggests being on call is a barrier for some midwives working in continuity of care models and team midwifery care offers an alternative option (Cummins et al., 2024; Taylor et al., 2019). Team midwifery is also cost effective (Sandall et al, 2024).

8.3 Proposed new MCoC service

Consultation with local staff at both CHS Maternity sites revealed that while midwives expressed a strong desire to work within a continuity model of care, the on-call component of traditional models was a significant barrier. In response to the findings from the consultation, a new MCoC model has been developed to address these concerns, enabling midwives to work in a continuity service without prolonged on-call requirements. Research indicates that what women value most about MCoC models is the relationship they build with their midwife, which fosters increased feelings of trust, empowerment, and confidence in their care (Perriman et al., 2018). This new service is designed to support women and midwives to develop meaningful relationships, enabling the delivery of individualised, woman-centred care while providing sustainable work arrangements for the midwives.

This model is designed to serve priority populations of women who currently lack access to MCoC. At least 50% of the women using the new service will be from a recognised priority group. Changes to the referral process currently underway will prioritise women who experience vulnerability or disadvantage.

This model draws inspiration from successful international MCoC models but has been adapted to align with the specific needs and context of the local workforce. It incorporates elements identified as priorities during consultation, including increased autonomy, working across the full scope of practice, and the ability to build meaningful partnerships with women and their families. It also considers the evidence highlighted in the literature, which demonstrated that team midwifery care improved clinical outcomes for women and birthing people compared to standard models of care.

Dedicated positions for new graduates will be integrated into the new service. The [Midwifery Futures](#) report demonstrated 80% of student midwives expressed a desire to work in a MCoC



model, 33% of new graduates felt confident to do this straight after graduation, yet only 13% of midwives working in MCoC models are new graduates. Early career midwives are more likely to report burnout and a desire to leave the profession (Harvie et al., 2019; Cull et al. 2020). MCoC models are protective against burnout (Fenwick et al., 2018), hence increasing access for early career and new graduate midwives in a MCoC service will promote a sustainable workforce.

Feedback from recent graduates locally highlighted challenges in accessing roles within continuity models. Other services nationally indicated employing graduates has been key to developing a sustainable workforce. This service aims to provide new graduates with supported opportunities to develop their skills in continuity of care, promoting career development while addressing workforce sustainability and retention.

This new model would fall under the *Team midwifery care* model within the Maternity Care Classification System (MaCCS), although women will have a named midwife leading or co-ordinating their care. A brief summary of the proposed model is outlined below.

8.3.1 Service description:

Each woman will be assigned a named primary midwife responsible for coordinating or leading her maternity care. The aim is for the majority of a woman's antenatal care to be provided by her primary or 'buddy' midwife. Labour, birth, and postnatal care will be delivered collaboratively by the primary midwife with the backup of a small team (four midwives). Care for women will be supported by the larger multidisciplinary team, including obstetricians and allied health professionals, as needed. Midwives will remain the care provider for women with complexities working with the multidisciplinary team in line with the [National Midwifery Guidelines for Consultation and Referral](#) (Australian College of Midwives [ACM], 2021). This service will offer 24hr care to women, delivered through rostered day shifts and rostered on call overnight. Incorporating the rostered-on call component ensures a team midwife is always available to care for women in the service and promotes continuity.

Governance: This service will fit within the current governance and reporting structures of the Women and Children Division's at CHS. The Clinical Midwife Consultant/ Manager will oversee the service and report directly to the Assistant Director of Midwifery at both sites. Risk and incident management will be monitored through Quality and Safety Meetings and the Maternity Morbidity & Mortality Meetings. Performance will be measured by benchmarking against peer health services through Women's Healthcare Australasia (WHA) and the Health Round Table (HRT).

Team structure:

The proposed staffing profile for the new model will include a Clinical Midwife Consultant Manager to implement and manage the service, and teams made up of four midwives. Each midwife will be required to work a minimum of 0.8 FTE with additional on call. The configuration of each team will consist of one Registered Midwife Level 2 and three Registered midwives level 1. Each team will have a position protected for a new graduate midwife.



The Registered Midwife level 2 leading the team will have key responsibilities, including managing the team roster, conducting professional development plans for members of the team, and mentoring the new graduates within the team. To account for these additional duties, the Level 2 Midwife will take a reduced caseload of 80%, ensuring they have the capacity to effectively fulfil their leadership and mentorship roles.

Caseload and demographic of women:

Midwives in this model will care for women with all complexities, with a caseload of 36- 40 women per year based on 1.0 FTE. This caseload will vary depending on the complexity and care needs of the women.

To promote equity in service provision, the service aims to allocate at least 50% of its caseload to women from identified priority groups. Ideally the caseload will include 50% primiparous women focusing on “Getting the first birth right” (Wong et al., 2015).

Roster (Appendix 3):

Midwives will work a combination of rostered shifts and on-call including:

Community day shift: 08:00-16:30

Each midwife will work four 8hr community day shifts per month. Midwives will provide routine antenatal care to their caseload of women and attend postnatal outpatient visits for the team as required at the women’s home. Midwives will coordinate their own workload and book their own appointments. Anticipated workload on these days is approximately 5-6 antenatal appointments and 2 postnatal home visits (This is based on a caseload of 34 women per year per 0.8 FTE). Antenatal care should be provided in community clinics where possible. There will be flexibility for midwives to swap their community clinic day with the day shift midwife, if a woman from their caseload is in labour to support continuity.

Day shift: 7am-7:30pm

Each midwife will work 8x 12 hr days shifts per month. Midwives will carry a phone where team women can call with concerns. On a day shift midwives will provide labour and birth care and attend to women who require unplanned antenatal assessments from 36 weeks gestation. If not caring for a woman in labour, the day shift midwife will attend team women on the postnatal ward, completing a postnatal visit and supporting discharge where appropriate. Additionally, they will support the midwife who is working in the community clinic by assisting with postnatal home visits if they have capacity. If not required for clinical work, midwives will review and action pathology and ultrasound results for the team, complete mandatory online education, participate in quality improvement projects, compile team data required for evaluation, undertake clinical supervision and support other team members as necessary.

Night on call: 19:00-07:30am

Midwives will be rostered on seven on call 12 hr periods overnight per month in addition to their rostered hours. This is to support women under team care during labour and birth and for



unplanned assessments after 36 weeks gestation (labour related only overnight). They will be paid the close call allowance as set out in the [ACT Public Sector Nursing and Midwifery Enterprise Agreement 2023-2026](#) (ACT Government, 2024). Based on a team caseload of 12 women per month, there is approximately a 20% chance that a midwife will be called in overnight to support a woman in labour or birth. The on-call component is designed to address the unpredictable nature of labour and birth, ensuring a team midwife is always available to provide care as needed.

Team midwives will collaborate with the team leader to develop a roster that accommodates individual preferences while maintaining fairness and equity for all team members. Flexibility with rostering is encouraged, but midwives will be expected to work a variety of shifts to provide care across their full scope of practice.

Collaboration and referral: Collaboration and referral will follow the [National Midwifery Guidelines for Consultation and Referral](#). Weekly Obstetric collaboration will occur, preferably with a named Obstetric Consultant for each team.

Costing:

The below tables outline an estimated costing for two teams of four midwives, including a Clinical Midwifery Manager.

Table 5: Costing

Staff	FTE (Including backfill)	Total salary with on costs and allowances	Equipment	Total costs
1x RM 3.2	1.05	\$203,574		
2x RM 2.4	1.96	\$454,142		
2x RM1.8	1.96	\$431,224		
2x RM 1.4	1.96	\$363,290		
2x RM 1.1	1.96	\$345,282		
Total	8.89	\$1,797,512	\$6252	\$1,803,764

Benefits:

- Women and babies will experience improved health outcomes and a reduction in interventions during labour and birth.



- Women's satisfaction with their maternity care will increase.
- New graduate and early-career midwives will have greater access to work in a continuity of care service, opportunities are limited in the current model.
- In the consultation process midwives stated being on call is a major barrier to them working in the current continuity of care model. The new service provides an alternative for those midwives.
- Continuity of care will enhance care coordination, ensuring consistent and accurate information is shared with women.
- Pathology and radiology results will be reviewed promptly, reducing the risk of missed or delayed follow-ups.
- Women and families in the ACT will have increased options for maternity care that suit their needs and preferences.
- The service will prioritise inclusivity, ensuring that 50% of women receiving care come from identified priority groups.
- Midwives will have the opportunity to work across their full scope of practice, enhancing job satisfaction and enhancing workforce sustainability.

Limitations:

- To protect continuity and ensure team size remains small, midwives will need to work 0.8 FTE in this service. This may not suit midwives who wish to work less hours.
- Midwives' exact salary per fortnight will be variable, due to unpredictable nature of on call shifts.
- Weekly meetings may be difficult for all team members to attend due to rostered shift pattern.
- For the service to be operational, minimum staffing levels must be met. If recruitment falls short and two full teams cannot be established, the service will not be able to commence.

Other considerations:

- Once per week a team midwife who is rostered on the day shift will provide childbirth education classes from 5:30pm -19:30 PM. Additionally, once per month a 'meet the midwives' afternoon tea will be run to facilitate women meeting team members.
- Team midwives will have a weekly meeting with the manager and all those rostered on will attend if possible.



- Midwives will be supported to attend clinical supervision regularly to support reflective practice.
- CDMs who work on call or across all shifts should be available at each site to support midwives who are transitioning to a continuity service.
- Prior to commencing in the new proposed service staff should have individual learning plans created which will support their upskilling across all areas of maternity (if required), to ensure they can confidently transition to work across their full scope of practice.
- In line with UK *Better Births* Guideline (NHS, 2021), the service will aim for 50% of women to have their primary midwife or buddy midwife present for labour/birth. With the other 50% being cared for by a midwife from the team. 75% of planned antenatal and postnatal care is to be provided by the primary midwife or buddy midwife.
- In the initial phase, two teams of four will be required to support each other (Plus an additional 0.8 FTE Registered Midwife to support backfill requirements). If more than one team midwife is required to provide labour and birth care, the 2nd team midwife who is also on call can be called in for support. In the event both midwives are providing labour care, and a third midwife is required, birth suite will be required to support the team until a team midwife is available.
- In the case of unplanned leave, the casual pool of midwives will be utilised. If no backfill is found, the Maternity Care Team will be asked for support.
- As the new service evolves there will be opportunity to make changes to roster patterns to suit the needs of staff while meeting the care requirements of women. Staff will be asked to provide feedback as part of the evaluation process and changes made as required.

8.4 Implementation plan and evaluation

The service will be implemented through a phased approach over 24 months with evaluation points at three, six, 12 and 24 months. The proposed project plan is detailed in Appendix 4.

An Evaluation Framework (Attachment B.) has been developed to evaluate the service and ensure it meets the objectives outlined. Evaluation is essential to ensure the new service meets the needs of women and staff. If evaluation findings are positive, it will support upscaling the implementation across CHS, and lead to the new service being a permanent option for women in the ACT.

9. Conclusion:

The desire of women and families in the ACT for equitable access to MCoC is well-documented. The *Maternity in Focus* initiative is dedicated to addressing the need to improve clinical outcomes and increase women's satisfaction with their maternity care. *Maternity in Focus* also



acknowledges the need to support the wellbeing of maternity care professionals by developing more desirable working arrangements to enhance workforce sustainability.

The findings of this report support the introduction of a new MCoC service, which could be implemented across CHS to meet the *Maternity in Focus* goals. This service will provide an alternative model for midwives, addressing workforce needs while simultaneously improving access and increasing equity to woman-centred MCoC for women in the ACT.

The following recommendations support the implementation of this proposed new service:

Recommendation 1: Endorse the proposed new service arrangements for MCoC.

Recommendation 2: Seek funding to support the implementation and evaluation of the new service.

Recommendation 3: Implement the service, initially for a 24-month trial period at one CHS site.

DRAFT

10. Acknowledgments:

Person	Title/Area	Organisation
Alana Harrower	Best Start Project Lead	Forth Valley NHS, United Kingdom
Alison Clarke	Perinatal Loss Coordinator	Canberra Health Services
Alison McBride	Head of Midwifery	Forth Valley NHS, United Kingdom
Allison Waldron	Acting Midwifery and Nursing Director-Operations	Women's and Children's Hospital, Adelaide
Alison Wong	Director of Organising and Membership	Australian Nursing and Midwifery Federation
Alix Bacon	Midwifery lecturer and Private Practice Midwife	University of British Columbia, Canada
Amy Lynch	Birth Centre Manager	Royal Free Hospital NHS, United Kingdom
Amy Rignano	Acting Midwifery Director	Northern Adelaide Local Health Network
Angela Swift	Registered Midwife, Midwifery Group Practice	Metro North Health
Annette Wilson	Midwifery Group Practice Midwife	Thursday Island
Anna Glasgow	Midwifery Unit Manager, Midwifery Group Practice	Gold Coast Health
Annie Peters	Associate Midwife Manager-Midwife Group Practice	Monash Health
Azure Rigney	Queensland Branch President, Advocacy Manager	Maternity Choices Australia
April Jardine	Maternity Unit Manager	Castlemaine Health
Ashleigh Grimes	Registered Midwife	
Carolyn Hilsabeck	Midwifery Unit Manager: Midwifery caseload practice, M@H, Papoose, Dragonfly Midwifery	Western Sydney Local Health District
Cecilia Jevitt	Professor of Midwifery	University of British Columbia, Canada
Cherise Smith	Coordinator- Women's Individual Needs Clinic	The Royal Women's, Victoria
Daniella Keane	CHWC Delegate	Australian Nursing and Midwifery Federation
Deborah Davis	Clinical Chair, Midwifery	University of Canberra
Deborah Earl	Independent Midwife	Midwives for You Private Practice, New Zealand
Di Wing	Clinical Midwifery Consultant	Metro North Health



Person	Title/Area	Organisation
Donna Garland	General Manager	South East Sydney LHD
Elissa McTaggart	Clinical Midwife Manager- Birth Suite and ANC	North Canberra Hospital, Canberra Health Services
Elizabeth Bennett	Midwifery Group Manager	Yorke and Northern Local Health Network
Elizabeth Bishop	Assistant Director of Midwifery	North Canberra Hospital, Canberra Health Services
Emma Taylor	Project lead-Maternity Models of Care	Weribee Mercy Hospital
Erin Corelli	Senior lecturer	Yale University, USA
Felicity Hamilton	Team Leader Critical Care Social Work	North Canberra Hospital, Canberra Health Services
Fiona Le Mesurier	Clinical Nurse Consultant MACH	Canberra Health Services
Grace Naylor	Midwifery Unit Manager Birth Centre	St Georges NHS, United Kingdom
Grace Valenti	Midwifery Unit Manager	Sydney LHD
Hana Sayers	Clinical Midwifery Consultant Continuity Services	North Canberra Hospital, Canberra Health Services
Helen Stephenson	Acting Clinical Midwifery Manager, Centenary Midwifery Program	Centenary Hospital for Women and Children, Canberra Health Services
Isabella Smart	Midwifery Manager Community Midwives	Counties Manukau District Health Board, New Zealand
Ivette Gonzalez	Social Worker	North Canberra Hospital, Canberra Health Services
Jacqueline Smith	Director of Nursing and Midwifery Services	Metro South Health
Jamie Smith	Caseload Midwife	Counties Manukau District Health Board, New Zealand
Janette Jakob	NCH Delegate	Australian Nursing and Midwifery Federation
Jemma Cooper	Registered Midwife, Papoose Program	Western Sydney LHD
Jennifer Eling	Clinical Midwife Consultant Ward 3S	North Canberra Hospital, Canberra Health Services
Jessica Clark	Registered Nurse/ Midwife	Centenary Hospital for Women and Children, Canberra Health Services
Jessie Price	Assistant Director of Midwifery-Maternity in Focus	ACT Health Directorate
Judy Ryall	Executive Director of Nursing and Midwifery	North Canberra Hospital, Canberra Health Services



Person	Title/Area	Organisation
Judy Williams	Registered Midwife, CMCS	North Canberra Hospital, Canberra Health Services
Julianne Nissen	Acting Assistant Director of Midwifery	Centenary Hospital for Women and Children, Canberra Health Services
Kai Hodgkin	ACT Branch President	Australian College of Midwives
Katya Turner	Self Employed Midwife	Auckland, New Zealand
Karel Williams	First Nations Community Representative and Midwife, Maternity in Focus Advisory Group and Birthing on Country Cultural Advisory Group	ACT Health Directorate
Kately Boyle	Registered Midwife PAPOOSE Program	Western Sydney LHD
Kelly Lennon	Principal Advisor Midwifery, NSW Nursing and Midwifery Office	NSW Health
Kelly Mconville	Community Midwifery Associate Manager	Counties Manukau District Health Board, New Zealand
Keryn Lavercombe	Clinical Midwifery Manager Postnatal	Centenary Hospital for Women and Children, Canberra Health Services
Lauren Parker	Clinical Nurse Manager, Special Care Nursery	North Canberra Hospital, Canberra Health Services
Lauren Scott	Acting Continuity of Care Project Officer	Metro North Health
Leonie Hewitt	Associate Lecturer	Flinders University
Lindsay McDonald	Registered Midwife, CMP	Centenary Hospital for Women and Children, Canberra Health Services
Lisa Garland	Acting Midwifery Unit Manager-Midwifery Group Practice	Metro North Health
Louise Edmonds	Senior Manager Strategic Projects	North Canberra Hospital Canberra Health Services
Louise Keyes	Director of Midwifery	Centenary Hospital for Women and Children, Canberra Health Services
Louise Mason Saunders	Former MGP Manager	Sunshine Hospital, Victoria
Lyndal Honeyman	Midwifery Lecturer	Victoria University Wellington
Margareet Van Davalaar	Private Practice Owner	Praktijk de oorsprong, The Netherlands
Marjorie Atchan	Senior Lecturer in Midwifery	University of Canberra
Mana Montazer	Acting Clinical Midwifery Manager Postnatal Ward	Centenary Hospital for Women and Children, Canberra Health Services
Melissa Gaudry	Clinical Midwifery Manager Antenatal and Gynaecology Ward	Centenary Hospital for Women and Children, Canberra Health Services



Person	Title/Area	Organisation
Mercedes Reyen	Clinical Coordinator of the Young Mums Program	The Royal Women's Hospital, Victoria
Merri Andrews	Senior Health Promotion Officer	Women's Health Matters
Michelle Thinius	Executive Director of Women and Children	North Canberra Hospital, Canberra Health Services
Monica Scott	Practice Support Midwife	University of Canberra
Mundeep Clarris	Midwifery Unit Manager- Midwifery Group Practice	Metro South Health
Murad Al Eker	Director of Obstetrics and Gynaecology	North Canberra Hospital, Canberra Health Services
Noelyn Perriman	Senior Lecturer in Midwifery	University of Canberra
Paula Nunn	Midwifery Group Practice Coordinator	Bendigo Health
Rebeccah Bartlett	Director Inpatient Services Digital Health Record	ACT Health Directorate
Rebecca Clark	Childbirth Education Coordinator	Centenary Hospital for Women and Children, Canberra Health Services
Rebecca Crawford	Pregnancy Enhancement Program Midwife	Centenary Hospital for Women and Children, Canberra Health Services
Rebecca Strong	Rostered Team Midwifery Team Leader	North Canberra Hospital, Canberra Health Services
Rebekah Bowman	Midwifery District Manager	Southern NSW LHD
Roslyn Wooley	Clinical Flow Manager and Rostered Team Midwifery coordinator	North Canberra Hospital, Canberra Health Services
Sally Bacon	Clinical Midwife Manager Birth Suite and MAU	Centenary Hospital for Women and Children, Canberra Health Services
Samantha Lawry	Maternal and Fetal Medicine Department Midwife	Centenary Hospital for Women and Children, Canberra Health Services
Sarah Collett	Social Worker	North Canberra Hospital, Canberra Health Services
Sarah Nicholson	Deputy Chief Midwife	Counties Manukau District Health Board, New Zealand
Sheree Barr	Midwifery Unit Manager	Southern NSW LHD
Xaviera McGuffin	Midwifery Group Practice Midwife	Waminda
Vanessa Erglis	Associate Midwifery Manager	Gold Coast Health



11. Appendices:

Appendix 1:

Definitions:

Continuity of care- Continuity of care is a philosophy that involves shared understanding of care pathways by all health professionals involved in a woman's or pregnant person's care, with the aim of reducing fragmentation of care and conflicting advice.

Continuity of carer- Continuity of carer means care provided by a known healthcare provider over the full length of the episode of care. Relational continuity is provided by the same named care provider being involved throughout the period of care even when other care providers are required. Other care providers may be involved in the provision of care, either in a support capacity to the named care provider or to collaborate in the provision of care, however the named care provider remains involved to coordinate and provide ongoing care throughout.

Midwifery antenatal and postnatal service (MAPS): Falls under *Public Hospital Maternity care* category within MaCCS. Women have a primary midwife allocated for the antenatal and postnatal period, with a designated 'back up' midwife to provide care when needed. Labour and birth care are provided at the birth site of a woman's choice by midwives working in the existing, standard maternity services. The MAPS model of care has a focus on outpatient services. Women birth with and receive any inpatient/ unplanned care by midwives who work within the existing standard birthing unit/ maternity wards.

Midwife-led continuity of care: Care provided to a woman or pregnant person by a known (primary) midwife throughout pregnancy, labour, birth and in the postnatal period. [The implication is for women with a low risk profile].

Midwife coordinated continuity of care: Care provided to a woman or pregnant person by a known (primary) midwife who will coordinate care across the multidisciplinary team, as required, throughout pregnancy, labour, birth and in the postnatal period. [The implication is inclusive of all risk profiles].

Maternity Care Classification System: Major model category definitions

Public hospital maternity care: Antenatal care is provided in hospital outpatient clinics (either onsite or outreach) by midwives and/or doctors. Care may also be provided by a multidisciplinary team. This is the broadest model category and includes a range of models of care from those led by midwives that target low risk women to those led by obstetricians that target women with obstetric risk factors such as diabetes. Intrapartum and postnatal care is provided in hospital by midwives and doctors in collaboration. Postnatal care may continue in the home or community by hospital midwives.

Shared care: Antenatal care is provided by a community maternity service provider (doctor and/or midwife) in collaboration with hospital medical and/or midwifery staff under an established agreement. Can occur both in the community and in hospital outpatient clinics.



Usually includes an agreed schedule of antenatal care between the two providers. Intrapartum and early postnatal care usually takes place in the hospital, by hospital midwives and doctors, often in conjunction with the community doctor or midwife (particularly in rural settings).

Midwifery group practice caseload care: Antenatal, intrapartum and postnatal care is provided within a publicly funded caseload model by a known primary midwife with secondary backup midwives providing cover and assistance, in collaboration with doctors in the event of identified risk factors. Antenatal care and postnatal care is usually provided in the hospital, community or home with intrapartum care in a hospital, birth centre or home. This category provides continuity of carer across the whole maternity period.

Private obstetrician specialist care: Antenatal care is provided by a private specialist obstetrician. Intrapartum care is provided in either a private or public hospital by the private specialist obstetrician in collaboration with hospital midwives. Postnatal care is usually provided in the hospital by the private specialist obstetrician and hospital midwives and care by midwives may continue in the home, hotel or hostel. Most models in this category provide continuity of carer across the whole maternity period.

Public hospital high risk maternity care Antenatal care is provided to women with medical high risk/complex pregnancies by public hospital maternity care providers (specialist obstetricians and/or maternal-fetal medicine subspecialists in collaboration with midwives). Intrapartum and postnatal care is provided by hospital doctors and midwives. Postnatal care may continue in the home or community by hospital midwives. This category is *not* used for obstetric-led clinics (models of care) such as those designed for women with diabetes or with risk factors such as high body mass index. Models requiring obstetric input but not multi-disciplinary specialised care are classified as *public hospital maternity care*

Remote area maternity care: Antenatal and postnatal care is provided in remote communities by a remote area midwife (or nurse) or group of midwives, sometimes in collaboration with a remote area nurse and/or doctor. Antenatal care may also be provided via telehealth or fly-in-fly-out clinicians in an outreach setting. Intrapartum and early postnatal care is provided in a regional or metropolitan hospital (often involving temporary relocation prior to labour) by hospital midwives and doctors.

General practitioner (GP) obstetrician care: Antenatal care is provided by a GP obstetrician. Intrapartum care is provided in either a private or public hospital by the GP obstetrician in collaboration with the hospital midwives. Postnatal care is usually provided in the hospital by the GP obstetrician and hospital midwives.

Combined care: Antenatal care is provided by a private maternity service provider (doctor and/or midwife) in the community. Intrapartum and early postnatal care is provided in a public hospital, by hospital midwives and doctors. Postnatal care may continue in the home or community by hospital midwives. Usually exists without a shared care agreement, so there is no agreed schedule of visits between providers and the private provider does not provide any care in hospital.



Private midwifery care: Antenatal, intrapartum and postnatal care is provided by a privately practising midwife or group of midwives in collaboration with doctors in the event of identified risk factors. Antenatal, intrapartum and postnatal care could be provided in a range of locations including the home. This category is used when the designated maternity carer is a privately practising midwife but is not used if the model of care is shared care between a private midwife and a hospital as part of a formal arrangement.

Team midwifery care: Antenatal, intrapartum and postnatal care is provided by a small team of rostered midwives in collaboration with doctors in the event of identified risk factors. Intrapartum care is usually provided in the hospital or birth centre. Postnatal care may continue in the home or community by the team midwives.

Private obstetrician and privately practising midwife joint care: Antenatal, intrapartum and postnatal care is provided by a privately practising obstetrician and midwife from the same collaborative private practice. Intrapartum care is usually provided in either a private or public hospital by the privately practising midwife and/or private obstetrician in collaboration with hospital midwifery staff. Postnatal care is provided in hospital and may continue in the home.

Appendix 2.

Consultation summary: International models of MCoC

Team Group Practice (Nijkirk, Netherlands).

Date: 18/09/2024

Name of interviewee: Margareet Van Davalaar

Antenatal, intrapartum and postnatal care are provided by a team of 5 self-employed midwives who work in private practice. Women do not have a named midwife, and care is provided collectively by the group. Midwives work on a rostered basis to care for 22-34 women per month covering antenatal clinic, postnatal visits and rostered on call for designated periods (24 or 48 hrs) to provide intrapartum care and unplanned assessments. Antenatal care is provided in the community; intrapartum care at home, birth centre or hospital; and postnatal care until 6 weeks at home with support of a home care nurse. Additionally, midwives conduct childbirth education classes for women under the team's care. Appropriately trained midwives within the team also offer ultrasound for pregnancy specific needs for women under the team's care. Obstetric collaboration occurs by phone call with the on-call obstetrician at the closest hospital. If women develop risk factors or become high risk, care is transferred to the obstetric team at the closest hospital. For low risk women in the Netherlands, it is standard care to have independent midwives provide pregnancy, birth and postpartum care which is paid for by health insurance (which is compulsory for all citizens in the Netherlands).

Summary of service:

- Provides continuity of care.



- Women or birthing persons do not have a named midwife.
- Midwives are self-employed and paid by women's insurance companies for care provided.
- Women may birth in hospital, birth centre or home.
- Low risk women cohort of women.
- New graduates work in model

Comments: This model has demonstrated long-term sustainability, with all current midwives working in the practice for at least five- 20 years. Notably, four out of five of the midwives have children, which were all born while they worked in the practice and returned after maternity leave, highlighting the model's suitability for midwives with young families.

Antenatal care is provided through the 'Centering Pregnancy' approach, which means women meet more than one midwife from the team at each appointment, enabling women to meet all team midwives throughout their pregnancy care. It also enables women to meet and develop relationships with other women who are due in the same month.

The interviewee stated the key to the success of this model was; working with likeminded, supportive midwives, flexible ways of working and the ability to build relationships with women throughout their journey to motherhood.

The practice exclusively provides care for women classified as low-risk, with the majority of its patient population coming from a high socio-demographic background.

Rostered continuity (Forth Valley NHS, Scotland)

Interviewees: Alison McBride and Alana Harrower

Date: 30/09/2024 and 23/10/2024

100% of women at this health service receive continuity of care by a named midwife. 60% of the services midwives work in the continuity model and 40% remain in core services. Women have a primary midwife and a named back up midwife who provides antenatal, intrapartum (where possible) and postnatal care in a team of 7-9 midwives. Each midwife has a caseload of approximately 42 women per year. Each team has a senior midwife who has a significantly reduced CL (approx. 20 per year) and organises roster, professional development plans and compiles statistics for the group each month. No on call component in this model, all care is rostered.

One midwife from each team is rostered in the community or the inpatient setting. Midwives rostered to community provide antenatal care in community clinics and postnatal care at home. On community days midwives on average see 6-8 women for antenatal visits in the morning



and 5-6 postnatal visits in the afternoon. The person rostered in community for the team is responsible for reviewing all pathology and ultrasound results, this is done through their online health record (Badgernet). If they have a quiet day, they assist other community midwives with their visits or attend the inpatient areas to assist. If someone is rostered on a community day and requires unplanned leave, all non-urgent visits are rescheduled until either the primary or back up midwife is available. Each team has a named obstetrician who they can contact in business hours for collaboration

When the midwives arrive at the beginning of an inpatient shift, they present to birth suite, if one of their team women are in labour, they provide labour care, otherwise they are assigned to the postnatal ward. If one of their team women presents mid shift, they leave the ward and attend birth suite to care for their team women in labour. They can do this as they have three Maternity Care Assistants (like an Assistant in Midwifery, but with a wider scope of practice) on each shift who support the remaining midwives on the ward. Approximately 75% of women receive antenatal and postnatal, care from their primary or backup midwife. 13-20% receive intrapartum care by their primary or back up midwife.

Summary of service:

- Women have a named midwife
- Midwives paid per shift worked
- Women may birth in hospital, birth centre or home.
- All risk cohort of women.
- New graduates work in the model.

Comments: This service has undergone multiple evolutions, consistently adapting to better support staff while maintaining continuity of care for women. A key factor in its success has been its commitment to listening to staff and making adjustments that prioritise their well-being. Initially, an on-call caseload model was introduced, but staff found it unsustainable and challenging. In response, the model evolved to what it is today, which has been well-received, as evidenced by strong staff satisfaction and an overwhelming interest in recruitment (over 80 applicants recently applied for six available positions). Staff were allowed to choose which team they worked in and individual learning plans were made which ensured they felt confident to work in the continuity of care model. Frequent staff awareness sessions were conducted to promote the new model and ensure staff engagement. The first team to adopt the model served as champions, actively encouraging other midwives to join. Part-time midwives initially carried a lower caseload, but as they were scheduled for the same number of antenatal clinic days as full-time staff, their caseloads were gradually increased to match. This adjustment has proven manageable. The model operates within existing funding, and aside from initial setup costs for staff upskilling, it remains cost neutral.

The success of this model is attributed to several factors: a responsive and adaptable approach based on staff feedback, strong and supportive leadership committed to the NHS goal of



expanding MCoC, and regular evaluation. Monthly reviews ensure the model meets its objectives in continuity rates, consumer satisfaction, and clinical outcomes. One of the limitations of this model is the reduced continuity of care in the intrapartum phase, which they are trying to improve.

Team group practice (Royal Free NHS, London):

Interviewee: Amy Lynch

Date: 10/10/2024

Women are allocated a primary midwife who provides planned antenatal and postnatal care. Intrapartum care is provided by one of the team midwives who is rostered on call. Midwives are organised in teams of 8 and work in pairs. All midwives work fulltime. Each midwife has a caseload of 36 women per year. Women are supported to birth at home, freestanding birth centre or hospital. Antenatal care is provided at home or at the birth centre, postnatal visits at home. Midwives are rostered to be on call for set periods, rather than being on call 24/7 on 'working' days. These shifts include AN/PN community days (8hr day shift), 12 hr day on call and 12 hr night on call for labour and births. If on call overnight the midwife is still required to work during the day until 2pm, then go home to rest. Team midwives do not provide care for unplanned antenatal assessments. They offer antenatal classes for team women and a 'meet the midwives' session monthly to facilitate women meeting all the team midwives.

Each team has a named Obstetrician and consultant midwife who they collaborate with at a weekly team meeting.

Summary of service:

- Provides continuity of care
- Women have a named midwife.
- Midwives paid an annualised salary, with additional pay for working outside of regular rostered hours.
- Women may birth in hospital, birth centre or home.
- All risk cohort of women.

Comments: Women have a named midwife but the on call is shared between the team, midwives found this more sustainable than being on call for all of their working days. They increased the chance of women having a known midwife at their birth by providing antenatal education classes for women and a 'meet the midwives' afternoon tea monthly.



Prior to the COVID 19 pandemic this model of care was sustainable, and midwives enjoyed working in this model. After COVID a severe shortage of midwives in core services meant midwives who work in the continuity team are frequently called to work shifts in core services, which leads to the suspension of their own continuity program. In addition to this, a lack of midwives working in core services has meant midwives have to take huge caseloads to meet demand, which far surpasses the 36 per annum recommended. This prohibits the ability to provide true continuity and has led to high rates of burnout. For any continuity service to be sustainable it is essential that core services are appropriately staffed.

This continuity team operates in a low socio-demographic area, providing care exclusively to vulnerable and disadvantaged women. The team benefits from a dedicated senior midwife and an obstetric consultant, with whom they collaborate with as needed. This structured partnership has been a key strength of the model, ensuring consistent information is shared with women while promoting positive working relationships between the midwives and the named obstetrician and senior midwife. Midwives being supported to complete clinical supervision regularly was also felt to reduce burnout and increase midwives wellbeing.

Rostered Team Midwifery (St Georges, London, UK)

Interviewee: Grace Naylor

Date: 14/10/2024

Midwives work in teams of 8 to look after a caseload of 8-10 women each per month in a rostered system. Women are allocated a primary midwife for antenatal care, but intrapartum and postnatal care is provided by the whole team. Midwives work a variety of rostered shifts, including 12hr AN/PN clinic day, 12hr day shift in birth suite and 12hr night shift in birth suite. All antenatal and postnatal appointments are provided in the hospital. One midwife is rostered on a 12hr shift in birth suite each day and night to provide intrapartum care for team women, if no team women are in labour, they assist the core staff with antenatal assessments and discharging women. Midwives have set antenatal clinic days and otherwise have a rotating roster where all midwives work equal shifts across all areas. Reported to provide 100% continuity of antenatal care with primary midwife, intrapartum 60-70% of women cared for by a team midwife and postpartum continuity was not measured.

Summary of service:

- Provides continuity of carer in antenatal period only
- Women have named midwife for antenatal care only
- Midwives paid an annualised salary, with additional pay for working outside of regular rostered hours.
- Women may birth in hospital or birth centre.



- All risk cohort of women.

Comments: The interviewee regarded this model as providing the highest level of job satisfaction and best work-life balance compared to other models she had experienced, (including standard care and caseload care). This was largely attributed to the flexibility of self-rostering and the opportunity to build relationships with women during the antenatal period. Midwives structured their own schedules while adhering to fair and equitable rostering guidelines. Additionally, the use of 12-hour shifts reduced the number of days midwives spent at work. No new graduates worked in this model.

Team Midwives who were rostered in Birth suite were supported by core suite staff to look after team women, and if no team women were in labour they would do assessments or care for postnatal women which, which meant it would be easier for them handover care to look after a team women if one presented in labour mid shift.

This model offered continuity primarily during the antenatal period, with limited continuity in the intrapartum and postpartum phases. It is unclear if consumer feedback was sought from women who were cared for in this model. Despite the program being sustainable, the program is no longer operational due to a lack of funding. The initial financial support was temporary, and budget constraints ultimately led to its discontinuation.

Team group practice (Canada)

Interviewee: Alix Bacon

Date: 3/12/2024

Midwives work in a team of four to provide care for a caseload of 40 women per midwife per year. Women do not have a primary midwife; they are cared for collectively by the team. Midwives provide antenatal care in a community clinic at a General Practitioner (GP) surgery. They aim for each midwife to meet each woman twice during her pregnancy. Intrapartum care is provided at home or in the hospital birth suite. Midwives work four antenatal clinic days per month and 9x 24hr on call shifts. The on-call midwife is responsible for labour care, antenatal assessments and postnatal visits. A weekly team meeting is held to discuss women who require additional care or who are due to birth that month. At the end of each 24hr shift the on-call midwife emails the team a handover. Midwives collaborate with local area obstetricians when required.

Summary of service:

- Provides continuity of care
- Women do not have a named midwife
- Midwives paid as private practitioners from the government per woman they care for. Women do not provide payment, this is a public health system



- Women birth at home or hospital birth suite.
- All risk cohort of women.
- New graduate midwives work in model.

Comments: In this model midwives work within a team of four to provide care to a combined caseload of women, many are high risk. Women do not have a named midwife. The interviewee had worked in a caseload model previously, but felt due to family commitments and having young children that model was no longer viable for her and this model provides a predictable roster while still offering some of the same benefits as caseload care. The interviewee acknowledged the level of continuity was reduced when compared to caseload care, but women still reported high levels of satisfaction in this model. It was unclear how women's satisfaction was measured.

Team group practice (New Zealand)

Interviewee: Deborah Earl

Date: 15/09/2024

Private midwives work in a team of 6 to provide care to a caseload of 56-60 women each per year. Women do not have a named midwife and are collectively cared for by the team. Midwives work a series of rostered shifts covering antenatal clinic Monday-Friday and rostered on call shifts for 12 hrs during the day and night. The midwife on call is responsible for providing intrapartum care, unplanned assessments and postnatal visits. If the midwife rostered on call overnight is not called or they are called in for less than 6 hours they are required to assist the day call midwife with postnatal visits the next day. In this instance the night call person should be finished by 12pm. Antenatal care is provided in GP clinics, intrapartum care at freestanding birth centres or hospital birth suite and postnatal care at home for 6 weeks. Midwives can collaborate with obstetricians within the public health service through an online referral process, or by phone for urgent issues.

Summary of service:

- Provides continuity of care
- Women do not have a named midwife
- Midwives paid as private practitioners from the government per woman they care for.
- Women birth in a freestanding birth centre or hospital birth suite.
- All risk cohort of women.



Comments: This group of midwives offer team care to an ethnically diverse vulnerable and disadvantaged cohort of women. The practice has been running for over 20 years and the current midwives have worked in the practice for 1-15 years. What makes it sustainable according to the interviewee is the predictability of your working week, job satisfaction from caring for women and families that you have developed relationships with over many years and working in a supportive team. It is common in this practice that midwives care for multiple members of the same family when they are pregnant, including subsequent generations.

Clear and open communication between team members was seen as a key success of this model. A weekly meeting is held where all women who are due in the following month are discussed, as well as to organise postnatal visits and ensure workload is spread fairly. Midwives also provide an electronic handover at the end of each rostered shift to ensure the whole team was updated. Working in a supportive team where you know you can call another team member at any time for advice or support, especially for early career midwives was seen as another essential element leading to success.

A limitation of this model is that women can be cared for in labour or birth by a midwife they have not met before, but they are aware of this when they book with the team. In New Zealand women choose which midwife or team of midwives' cares for them in their pregnancy (Although choice can be limited in some areas due to midwife shortages) so this model attracts women who are comfortable with the team approach but may not be suitable for all women.

Caseload midwifery group practice (New Zealand)

Interviewee: Jamie Smith

Date: 15/10/2024

Six midwives work in pairs to care for a caseload of 40-45 women each per year. Midwives are employed by the local health service. Midwives work in an on-call capacity to provide continuity of carer to their caseload of women. They have 4 rostered days off per fortnight and their partner midwife provides cover for these days and in the case of unplanned leave. Antenatal care is provided at the freestanding birth centre; intrapartum care at home, freestanding birth centre or hospital birth suite; and postnatal care at home for 6 weeks. Collaboration when required with the obstetric team occurs through online referral system or a phone call to the on-call obstetrician for the health service if urgent.

Summary of service:

- Provides continuity of carer
- Women have a named midwife
- Midwives paid an annualised salary by the health service.
- Women birth at home, freestanding birth centre or hospital birth suite.



- Low risk cohort of women.

Comments: This group of midwives operates within an MGP caseload model, which was established 12 months ago. The team has maintained stable staffing, and there is sufficient interest to expand full-time equivalent (FTE) positions if additional funding becomes available. The model functions similarly to the local CMP and CMCS programs.

Caseload- Self-employed team (New Zealand)

Interviewee: Katya Turner

Date: 20/11/2024

Midwives work in pairs within a small group of 4 to provide continuity of carer from early pregnancy to 6 weeks postpartum to a designated caseload of women. Midwives work in an on-call capacity, with their partner midwife providing cover for days off. In this partnership each midwife has every 2nd weekend off call. Each midwife decides how many women they would like to care for over the year, but it generally varies between 6-8 per month. Collaboration is through an online referral process to the local health service; urgent referral is by phone to the on call obstetric consultant at the local hospital.

Summary of service:

- Provides continuity of carer
- Women have a named midwife
- Midwives work as private practitioners but are paid by government for services rendered
- Women birth at home, freestanding birth centre or hospital birth suite.
- All-risk cohort of women.

Comments: The interviewee identified flexibility and high job satisfaction as key factors in the success of this model. The ability to provide continuity of care to women throughout pregnancy, birth, and postpartum was particularly fulfilling, with job satisfaction increasing further when caring for the same women in subsequent pregnancies. To support well-being and prevent burnout, taking at least four consecutive weeks of leave annually was essential.

Community midwifery team (New Zealand)

Interviewee: Lyndal Honeyman

Date: 14/11/2024



Midwives worked in a team of 13 providing antenatal, intrapartum and postnatal care. Women are not given a named midwife but are allocated to the team. Three midwives each day provided antenatal care and postnatal home care to women in the community. One midwife is allocated to birth suite to provide intrapartum care during the day Monday-Friday only. One midwife each day is allocated as the team leader who covers sick calls, provides care to women requiring unplanned assessments and reviews results. One midwife would have a phone overnight to triage calls and give advice only.

Summary of service:

- Does not provide continuity of care
- Women do not have a named midwife
- Midwives paid per shift worked
- Women birth in birth suite
- All risk cohort of women

Comments: For the interviewee, the most appealing aspect of this model was the work-life balance it provided, with predominantly Monday-to-Friday, 9 AM to 5 PM hours. Additionally, the opportunity to work across both antenatal and postnatal care added variety to their role. However, this model offered little to no continuity of care

MAPS service (New Zealand)

Interviewees: Isabella Smart and Kelly McConville

Date: 10/09/2024 and 29/10/2024

Midwives work in a team to provide continuity of antenatal and postnatal care to a caseload of 8-9 women per month. Each woman has a named midwife who provides routine antenatal care and postnatal home visits until six weeks postpartum. Midwives work Monday-Friday 8:00am - 16:30 pm and one weekend per month. There is no on call component in this service and intrapartum care is not offered. Women are able to call a midwife who works from home who can answer concerns/queries during office hours and send to the hospital for review if required. Midwives do not perform unplanned assessments.

Summary of service:

- Does not provide continuity of care
- Women have a named midwife for antenatal and postnatal care
- Midwives paid an annualised salary



- Women birth in birth suite with core staff for support
- All risk cohort of women

Team group practice (USA):

Interviewee: Cecilia Jevitt

Date: 23/10/2024

Midwives work in small teams based in a birth centre, following a rostered system. Midwives work 8hr day shifts for planned antenatal and postnatal care for their individual caseloads, as well as 12-hour day and night shifts in the birth centre, where they provide intrapartum care for women under their team's care and manage unplanned assessments.

Each woman is allocated a primary midwife who delivers the majority of planned antenatal and postnatal care, while intrapartum care is shared among the entire team. This model does not include an on-call component.

Summary of service:

- Provides continuity of care
- Women or birthing persons have a named midwife
- Women birth in birth centre
- Low risk cohort of women

Comments: The interviewee reflected on her experience working in this model earlier in her career, noting its sustainability and high rates of staff retention. Midwives provided one to two postnatal visits at the birth centre, with the remainder of postnatal care managed by paediatricians. While a high level of continuity was achieved during the antenatal period, continuity significantly decreased during the intrapartum and postpartum phases.



Appendix 3.

Proposed Roster

1	2	3	4	5	6	7	8	9	10	11	12	13	14
Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
D 12	D12	D	OC	OC	OC	OC	OFF	OFF	D12	D12	D	OFF	OFF
OFF	OFF	D12	D12	D	OFF	OFF	D12	D12	D	OC	OC	OC	OC
OC	OC	OC	OFF	OFF	D12	D12	D	D	OFF	D12	D12	OFF	OFF
D	D	OFF	D12	D12	OFF	OFF	OC	OC	OC	OFF	OFF	D12	D12
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
D	D12	OFF	D12	OC	OC	OC	OFF	OFF	D12	D12	D	OFF	OFF
OFF	OFF	D	D 12	D12	OFF	OFF	D12	D	OFF	D12	OC	OC	OC
D12	D	D12	OFF	D	D12	D12	OC	OC	OC	OC	OFF	OFF	OFF
OC	OC	OC	OC	OFF	OFF	OFF	D	D12	D	OFF	D12	D12	D12

12hr day shift 7am-7:30pm for
labour care and assessments
over 36 weeks

8hr day shift (AN/PN) 08:00-
16:30

On call 7pm-7am

Day OFF



Appendix 4.

Project Plan Schedule

Phase	Key Actions	Timeframe
Phase 1: Planning	Project Planning	
1.1 Funding	Develop business case for funding	Prior to Initiation
1.2 Governance	Establish project governance- Stand up CHS steering committee (SC)	Initiation
1.3 Consultation	Report sent to CHS midwifery & medical staff, Maternity in Focus Consumer Advisory Group, ANMF and key stakeholders for input.	Initiation
	Model of service and position descriptions developed.	at 1 month
	Model of service and position descriptions sent to CHS midwifery & medical staff, Maternity in Focus Consumer Advisory Group, ANMF and key stakeholders for input.	at 2 months
1.4 Consultation closed	Consultation process closed, revisions made to model of service and position descriptions.	at 3 months
1.5 Endorsement	Model of service and position descriptions endorsed by ANMF & CHS SC.	at 3 months
Phase 2: Awareness	Develop and Rollout Awareness Campaign	
2.1 Midwifery	Awareness sessions begin with all staff	at 4 months
2.2 Medical	Update GPs and provide information regarding new model.	at 4 months
2.3 Allied Health	Allied health team updated	at 4 months



2.4 Consumer	Launch a marketing and awareness campaign to raise consumer awareness of the new service	at 4 months
Phase 3: Workforce	Workforce Planning & Recruitment Requirements Established	
3.1 Recruitment	Advert placed for recruitment	at 5 months
3.2 Interviews	Interviews conducted	at 5 months
3.3 Position offered	Positions offered to successful candidate/s	at 5 months
Phase 4: Establish the Service	Service Model Implemented and Established	
4.1 Orientation & Onboarding	2 teams of 8 midwives employed 0.8 FTE commence 1 week orientation (New graduates to have additional supernumerary time to support upskilling, pending level of experience).	at 6 months
	Develop team charter	at 6 months
	Plan roster and leave allocations	at 6 months
	CHS orientation if external candidate	at 6 months
	Ensure mandatory education is up to date for all staff	at 6 months
	Perineal repair and balloon catheter insertion training	at 9 months
	Advancing in Maternity Safety course	by 12 months
4.2 Service operationalised	Staff begin working in new service and building caseloads	at 6 months
4.3 Project closure	Project closure, care handed to Clinical Midwife Consultant/ Manager of service to continue evaluation	at 6 months
Phase 5: Evaluation	Monitoring and Evaluation	



5.1 Formative evaluation	Formative evaluation completed and reported to Steering Committee	3 months post service being operationalised
5.2 Interim evaluation	Interim evaluation completed after 6 months of service being operationalised and reported to Steering Committee	6 months post service being operationalised
5.3 Comprehensive evaluation	Comprehensive evaluation completed after 12 months of service being operationalised and reported to Steering Committee	12 months post service being operationalised
5.4 Final evaluation	Final evaluation reported to Steering Committee.	24 months post service being operationalised
Trial of service complete		
Phase 6: Endorsement	Endorsement for Future Planning	
6.1 Review of evaluation findings	The Steering Committee will review the final evaluation report to assess key findings and consider future recommendations. This review will help guide the expansion and adaptation of the service based on the evaluation outcomes.	At 24 months post service being operationalised

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DRAFT



Exploring the evidence behind different models of midwifery continuity of care in Australia and internationally: A literature review.

Abstract

Objectives :

This review aims to explore different midwifery continuity of care (MCoC) models both nationally and internationally. The review will highlight clinical outcomes, women and midwives' satisfaction of the models and cost to the health services.

Method:

The search terms "continuity" or "continuity of care" and "midwife" or "midwifery" and "caseload" or "group practice" or "MGP" or "Continuity antenatal and postnatal" or "Midwifery teams" were used in the Cochrane Database for Systematic Reviews and in the PubMed and CINAHL databases as well as searches on the Griffith University website and Canberra Health Services library website. The reference list of each article was also inspected, yielding further literature that was incorporated in the review.

Results

Midwifery Continuity of Care (MCoC) models, offer substantial benefits for women, their babies, midwives, and healthcare systems. Research consistently demonstrates that MCoC models improve maternal and neonatal outcomes, reduce medical interventions, enhance women's satisfaction with care (Sandall et al., 2024), and support midwife well-being (Dawson et al., 2018; Hewitt et al., 2024). Additionally, they are cost effective (Callander et al., 2021; Jackson et al., 2024; Wills et al., 2001; Sandall et al., 2024).

Literature surrounding MAPS model of care suggest high satisfaction among midwives and women (Cummins et al., 2022; Dharni et al., 2021), there is limited evidence regarding its clinical effectiveness compared to other MCoC models. Further research is needed to assess perinatal outcomes, cost-effectiveness, and its impact on midwifery workforce sustainability.

Midwifery group practice (MGP) caseload midwifery has the strongest evidence base, particularly for low-risk pregnancies, but emerging research indicates it also benefits women with medical and/or social risk factors (Hadebe et al., 2021; Homer et al., 2018; Khan et al., 2023; Rayment-Jones et al., 2021). While the on-call nature of caseload care provides significant relational continuity, it also presents barriers to workforce sustainability, particularly concerning midwives' work-life balance (Cummins et al., 2024; Taylor et al., 2019). In contrast, team midwifery provides elements of continuity without requiring on-call commitments and has been associated with similar improvements in maternal outcomes (Sandall et al., 2024), although direct comparisons with caseload care remain limited.

Conclusion and implications:

Robust evidence supports the benefits of caseload midwifery for women and midwives. For some midwives working in a caseload capacity is not feasible, team midwifery care is a suitable alternative option which confers benefits for women and promotes work life balance for midwives.

MAPs models of care lack research surrounding clinical outcomes. Caution should be used when employing this model as an alternative to other models of MCoC care, which have significant research to support their utilisation.

Introduction:

Midwifery continuity of care (MCoC) is defined as the provision of care by one midwife or a small group of midwives to a woman throughout pregnancy, childbirth, and the early postpartum period (Homer et al., 2019). The World Health organization (WHO) recommends this model of care for all women who live in countries where midwives are appropriately resourced and supported (World Health Organization [WHO], 2016). Extensive research highlights that MCoC models during pregnancy, childbirth, and the postpartum period yield the most favourable health outcomes for both women and babies (Sandall et al., 2024). Midwives working within these models report high job satisfaction and lower rates of burnout, contributing to the approach's sustainability (Hewitt et al., 2024). Despite evidence of the many benefits there has been difficulty upscaling MCoC models worldwide (Homer et al., 2019).

Different versions of MCoC exist globally and are continually evolving to find ways to increase uptake of the model. Most continuity models in Australia are caseload models, with a primary midwife providing, coordinating, and referring care as needed. Midwives work in a flexible and on-call arrangement, with support from back-up midwives, often organised in a Midwifery Group Practice (MGP) set-up (Homer et al., 2019). This contrasts with team midwifery, where the caseload of women is shared amongst the members of the team and they are rostered across maternity settings, with no on-call requirements (NSW Government, 2023). Another version is the Midwifery Antenatal and Postnatal Service (MAPS) which provides a named midwife for antenatal and postnatal care, but midwives are not on call and do not provide intrapartum care (NSW Government, 2023).

Different MCoC models nationally and internationally will be explored, focusing on clinical outcomes, levels of women's satisfaction with care, sustainability for midwives, and cost effectiveness. This will be used to inform and guide upscaling of MCoC in a local setting.

Discussion:

MAPS model of Care

The MAPS model of care was developed in response to surveys from the United Kingdom (UK) and Australia, which revealed that a significant number of midwives were reluctant to work in an "on call" capacity (Cummins et al., 2024; Taylor et al., 2019). The MAPS model provides women with a named midwife who offers continuity of care throughout the antenatal and postnatal periods. Labour and birth care are delivered at the woman's chosen location by midwives working within the existing standard maternity services. The model primarily focuses on outpatient services, with women receiving inpatient or unplanned care from midwives in standard Birthing Units or Maternity wards (NSW Government, 2023).

In response to government initiatives aimed at scaling up MCoC, (COAG health council, 2019; National Health Service [NHS], 2021) MAPS was introduced as an alternative model that provides some continuity of care for women while offering midwives more flexible ways of working. Although MAPS has been implemented across Australia and the UK, limited research has evaluated its effectiveness. There is currently no quantitative data on perinatal outcomes associated with this model, nor any qualitative or quantitative studies comparing MAPS care to MCoC models that include intrapartum care (Cummins et al., 2024).

A study by Dharni et al. (2021) explored qualitative findings from the implementation of the MAPS model of care in a socio-economically disadvantaged urban area in the UK. The cohort of women who received care were largely from ethnic minority groups and experienced high levels of socioeconomic disadvantage. All midwives working in the MAPS team reported high levels of job satisfaction and reduced stress versus midwives working in the standard model of care. This was largely due to the reduced case load size (60 per annum vs 100-120 in standard care) and increased flexibility and autonomy over their working days. Midwives felt they had sufficient time to support women, build trusting relationships, and provide high-quality antenatal and postnatal care. Women, in turn, expressed high levels of satisfaction, which they associated with increased reassurance and confidence in their pregnancy and birth decisions and feeling more able to disclose mental health issues. Similar findings were reflected in an Australian evaluation of MAPS services, where women reported feeling an increased sense of safety (Cummins et al., 2022) and a Swedish study by Eikemo et al., (2023) where women reported increased feelings of empowerment and confidence. While midwives generally reported greater job satisfaction, some noted experiencing stress due to the responsibility of being the primary care provider for antenatal and postnatal care (Cummins et al., 2024).

A Danish study by de Wolff et al, (2021) compared the MAPS model to standard maternity care for women with pre-existing chronic health conditions. The findings revealed that women receiving care through the MAPS model reported significantly higher levels of satisfaction with their maternity care. However, the primary outcome measured was decreased length of stay which showed no statistical difference.

In an Australian study women and midwives both referred to the MAPS model as 'the next best thing' compared with caseload midwifery (Cummins et al., 2024), which suggests they perceived case loading to be superior to MAPS. Some women also reported feeling disappointed that they had not gotten in to the caseload model. Women in a separate study felt that the MAPS model would positively impact their care, but one of the limitations of this study was none of these women had experienced a caseload model including intrapartum care before (Cummins et al, 2022).

Further research is needed to evaluate the benefits of the MAPS model for women and babies, particularly in terms of clinical outcomes and potential cost saving for the health services. Additionally, studies are required to assess the effectiveness of this model in comparison to other models of care, such as caseload MCoC models, to better understand its overall impact and value. Caution should be used when employing this model as an alternative to other models of MCoC care which, have significant research to support their utilisation.

Midwifery caseload model of care

Midwives working in a caseload model have a defined number of women per year for whom they are the primary or named midwife. The midwife is the primary point of contact for each woman and takes responsibility for overseeing her care and organising consultation and referral as necessary. The midwife provides continuity of carer throughout the antenatal, intrapartum and postnatal periods (Homer et al., 2019). The midwife works in an on-call capacity providing care 24 hour a day 7 days a week except for designated days off. Midwives are supported by a secondary buddy midwife, or a small team of midwives.

This model of care has proven to have many benefits for women and their neonates. The Cochrane Systematic Review on *Midwifery continuity of care models versus other models of care for childbearing women* highlighted women had more positive experiences during pregnancy, labour and postpartum. In terms of clinical outcomes women were less likely to experience a caesarean section, instrumental birth or episiotomy and more likely to experience a spontaneous vaginal birth (Sandal et al., 2024).

The evidence reviewed in the Cochrane report primarily focused on low-risk women. However, research also supports the benefits of caseload care for women who are vulnerable, disadvantaged, or experiencing medical risk factors. Vulnerable or disadvantaged women experience significantly worse perinatal outcomes than other cohorts of women (Faulks et al., 2023; Fernandez Turienzo et al., 2021). Studies have shown that women who experience vulnerability or disadvantage receiving caseload midwifery, are more likely to access and engage in care (Rayment Jones et al., 2023) and experience significantly improved maternal and perinatal outcomes, regardless of their obstetric risk factors (Hadebe et al., 2021; Khan et al., 2023; Rayment-Jones et al., 2021). A retrospective

analysis by Homer et al. (2018) examined clinical outcomes for a group of women in East London facing both significant social vulnerabilities and medical complexities. The study found lower rates of caesarean sections and assisted births, alongside higher rates of spontaneous vaginal birth. For neonates, it reported reduced rates of preterm birth, low birth weight, and neonatal unit admissions, as well as a neonatal mortality rate below the national average at the time. A randomised controlled trial by Tracey et al. (2013) demonstrated that caseload care resulted in equivalent clinical and perinatal outcomes for women and their neonates, confirming its safety. A more recent integrative review by Fox et al., (2023) concluded caseload care for women resulted in positive experiences for women and clinical outcomes were better or the same as standard models of care.

Midwives working in caseload models reported lower levels of burnout and improved emotional health than midwives working in standard models of care (Dixon et al., 2017). Internationally, approximately 40% of midwives report experiencing burnout (Kool et al., 2023). Research highlights Australian midwives experience some of the highest burnout levels globally (Sidhu et al., 2019). Early career midwives were more likely to report burnout and a desire to leave the profession (Harvie et al., 2019; Cull et al. 2020). Burnout negatively impacts the well-being of midwives, reduces the quality of care they deliver, and leads to midwives leaving the profession prematurely (Fenwick et al., 2018a), a critical issue in Australia amidst an ongoing midwifery workforce crisis (Homer et al., 2024).

Evidence suggests that midwives working in caseload models experience significantly lower burnout rates, improved emotional health and higher levels of job satisfaction compared to those in standard care models (Dawson et al., 2018; Dixon et al., 2017; Fenwick et al., 2018; Forster et al., 2014; Hewitt et al., 2024; Jepsen et al., 2017; Sidhu et al., 2019). An Australian study identified 5.3% of midwives working in caseload care experienced burnout compared to 23.2% working in standard care models (Fenwick et al., 2018a). In Australia, midwives providing continuity of care report lower levels of burnout, depression, and anxiety, as well as higher levels of professional identity and autonomy, compared to their peers in non-continuity models (Fenwick et al., 2018).

Several reasons caseload midwifery is protective against burnout and poor emotional health are identified in the literature. Midwives in numerous studies indicated increased professional autonomy (Dixon et al., 2017; Forster et al., 2014; Pace et al, 2022) and flexibility in working arrangements (Forster et al., 2014) in caseload models, contributed to their job satisfaction. Midwives highlighted that the ability to build meaningful relationships with women was a key factor in enhancing job satisfaction (Hewitt et al., 2024; Pace et al., 2021). Conversely, midwives in standard care settings reported lack of professional autonomy, fragmentation of care delivered and unsafe workloads as contributors to poor emotional health and burnout (Forster et al., 2014). The WHELM study (Harvie et al., 2019) surveyed midwives in Australia reasons for considering leaving the profession, over half stated the reason as feeling dissatisfied with the organisation of midwifery care or their

role as a midwife. Lack of autonomy was also frequently cited in the literature as a contributor to workplace dissatisfaction (Harvie et al, 2019).

Conversely, some research highlighted negative aspects of caseload midwifery, including its impact on family life and work-life balance due to the on-call nature of the role, which has been associated with increased burnout (Hewitt et al., 2024; Stoll & Gallagher, 2019). A UK survey examining midwives' willingness to work in MCoC models in the UK found that only 35% were open to working in a caseload model that included intrapartum care. The most frequently cited barrier was the challenge of managing caring responsibilities outside of work, such as looking after children (Taylor et al., 2019). Additionally, some midwives felt unprepared to work across the full scope of practice and were concerned about how such models would affect their work-life balance (Harris et al., 2020; Taylor et al., 2019).

The increased salary costs for midwives in caseload models are often cited as a barrier to expanding MGP caseload care. However, research has demonstrated its cost-effectiveness. A study by White et al. (2014) found that for low-risk, first-time mothers, MGP care significantly reduced public hospital costs compared to standard maternity care or private obstetric care in a public hospital. These savings were largely attributed to fewer interventions during labour and birth. Similarly, an economic analysis by Callander et al. (2020) showed that MGP caseload care was more cost-effective than routine induction of labour at 39 weeks for first-time mothers, primarily due to a greater reduction in caesarean sections. Further supporting this, a Cochrane Systematic Review (Sandall et al., 2024) highlighted cost savings in antenatal and intrapartum care for midwifery continuity models, including MGP caseload care and midwifery team care. More recently, Jackson et al. (2024) found that while MGP caseload care was cost-neutral for the public hospital system, it resulted in cost savings for public funders. However, both this study and previous research focused exclusively on low-risk women, limiting their applicability to the broader population, including those with medical risk factors.

Donnellan-Fernandez et al. (2018) reviewed nine studies on the costs of MGP caseload care for high- or all-risk women but found insufficient evidence to draw definitive conclusions. In contrast, Callander et al. (2021) analysed costs for an all-risk cohort and identified substantial cost savings in the MGP caseload group compared to standard public hospital maternity care. While this suggests that MGP care may offer financial benefits beyond low-risk pregnancies, the study's small sample size is a limitation.

Team midwifery care

In team midwifery care (Often referred to as rostered team midwifery) midwives work in a small team (maximum of 8 midwives), operating within a traditional rostered style of work (Donnelly et al., 2016; Sandall et al., 2024). The team shares a caseload of women each month, providing 24-hour care through rostered shifts, with no on-call component. Continuity of care, in the absence of continuity of carer, is achieved through the development of a shared philosophy and cohesive ways of working and sharing of pertinent clinical information (Department of Health, 2020).

Ten out of 17 trials in the systematic Cochrane review *Midwife continuity of care models versus other models of care for childbearing women* (Sandall et al., 2024) were focused on outcomes relating to team midwifery. Sub-analysis of outcomes suggests that there were not significant differences across the two models of MCoC and therefore team midwifery provides efficacy in delivering clinical improvements in care (Sandall et al., 2024). The Cochrane review highlighted that women receiving midwifery continuity of care (Team midwifery and case loading) were less likely to have a caesarean section, assisted vaginal birth, episiotomy and more likely to have a spontaneous vaginal birth. Women were also more likely to report their care during pregnancy, labour and birth and postpartum as positive (Sandall et al., 2024). Increased satisfaction was noted when women were cared for with a team model (Biro et al, 2003; Homer et al., 2002; Rowley et al., 1995; Waldenstrom et al, 2000) and a reduction in medical procedures in labour and a shorter length of stay (Biro et al, 2000). In one study team care was associated with fewer maternal and neonatal adverse outcomes than standard care (Rowley et al., 1995).

Midwives in the Netherlands report lower rates of burnout compared to those in other countries. Notably, most community midwifery practices operate within a continuity team model, suggesting this model may help to prevent burnout (Kool et al., 2023). The *Midwifery Futures* report also demonstrated midwives working in MGP or team midwifery care were less likely to express an intention to leave the professions, indicating these models are more sustainable than standard care models for midwives (Homer et al., 2024).

A study of women in the Netherlands, who primarily received team-based midwifery care, revealed a desire for greater continuity of carer than what was provided within the team model (Baas et al., 2015). However, the study did not report the size of the teams. A separate study in the Netherlands compared team midwifery care to case loading and found women had lower rates of caesarean section, induction of labour and episiotomy in the case loading model when compared to a matched cohort of women in midwifery led team care (Offerhaus et al., 2020).

As it pertains to team midwifery care, rather than MGP, there is evidence that continuity of care rather than continuity of carer contributes to women's positive experiences (Homer et al, 2019; Sandall et al., 2024). Research supports the ability for women to develop relationships with their midwives is what is most important to them and leads to positive experiences (Perriman et al., 2018). The benefits of this model for midwives include having some of the positive aspects of relationship-based care and being able to work across the full scope of practice. Research suggests being on call is a major barrier to some midwives working in continuity of care models, team midwifery care offers an alternative option (Cummins et al., 2024; Taylor et al., 2019).

Team midwifery care is also cost effective (Sandall et al, 2024), and generally does not require additional funding to implement or sustain. Team midwifery led to cost savings for

the health service when compared with standard models of care (Wills et al., 2001; Rowley et al., 1995).

This review has highlighted a lack of recent evidence surrounding team midwifery care in the Australian context. This is likely due to the popularity of MGP caseload care, which is the predominant form of MCoC operating in Australia. Research comparing team midwifery care to caseload care in the Australian context would prove valuable.

Conclusion: To inform the future scaling of MCoC, further research is essential, particularly in evaluating alternative models such as MAPS and team midwifery in diverse settings. Comparative studies on workforce sustainability, clinical outcomes, and cost-effectiveness across all MCoC models will be crucial in ensuring that maternity care systems meet the needs of both women and midwives while optimising resource allocation.

Given the midwifery workforce crisis, it is imperative that models promoting both continuity of care and midwife well-being are prioritised in policy and practice. Team midwifery care may be a suitable alternative option which confers benefits for women and promotes work life balance for midwives.

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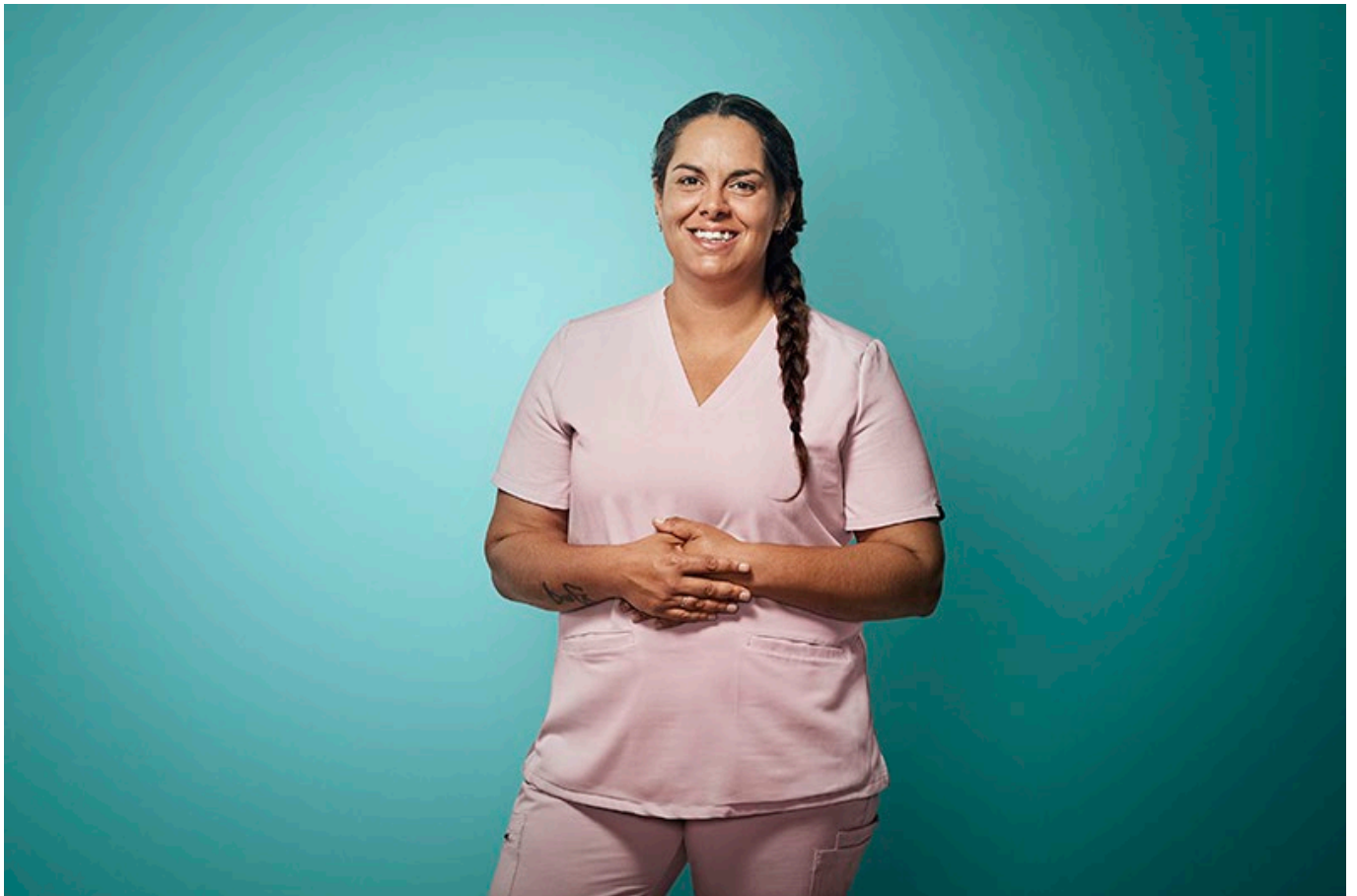
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Service Evaluation Framework: Community Midwifery Team

February 2025



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Introduction

A new innovative midwifery continuity of care (MCoC) model is to be implemented across Canberra Health Services (CHS). This new model aims to offer midwife-led or coordinated continuity of care during pregnancy, intrapartum and postnatal period for an all-risk cohort of women and birthing people.

Midwifery continuity of care (MCoC) models consistently demonstrate improved health outcomes and higher levels of satisfaction for women when compared with standard models of care (Sandall et al., 2024). MCoC models support a woman and person-centred approach to care, promoting informed decision making and self-determination. The models are cost effective (Baird et al., 2024) and midwives working within these models report higher job satisfaction and lower rates of burnout, contributing to the approach's sustainability (Hewitt et al., 2024).

Global research emphasises that vulnerable women should be prioritised for CoC due to its numerous benefits, including improved healthcare outcomes and women's increased satisfaction with their care (Frederiksen et al., 2023; Homer et al., 2017; Priday & McAra-Couper, 2016; Rayment-Jones et al., 2021).

The ACT Government, through the Maternity in Focus initiative has made a commitment to improve access to MCoC to enable over 50% of women to have access by 2028 and review the feasibility of 75% by 2032 (ACT Health, 2022). Specifically improving access for Aboriginal and Torres Strait Islander peoples, identified vulnerable populations of women and women with complex medical needs.

This model of care has been developed to achieve Goal 8 of the Maternity in Focus: First Action Plan 2022-2025 Continuity of Care: Expand midwifery-led and midwifery coordinated continuity of care models to improve access, increase equity and improve outcomes.

In alignment with the Maternity in Focus initiative, the objectives of this new model of care are to:

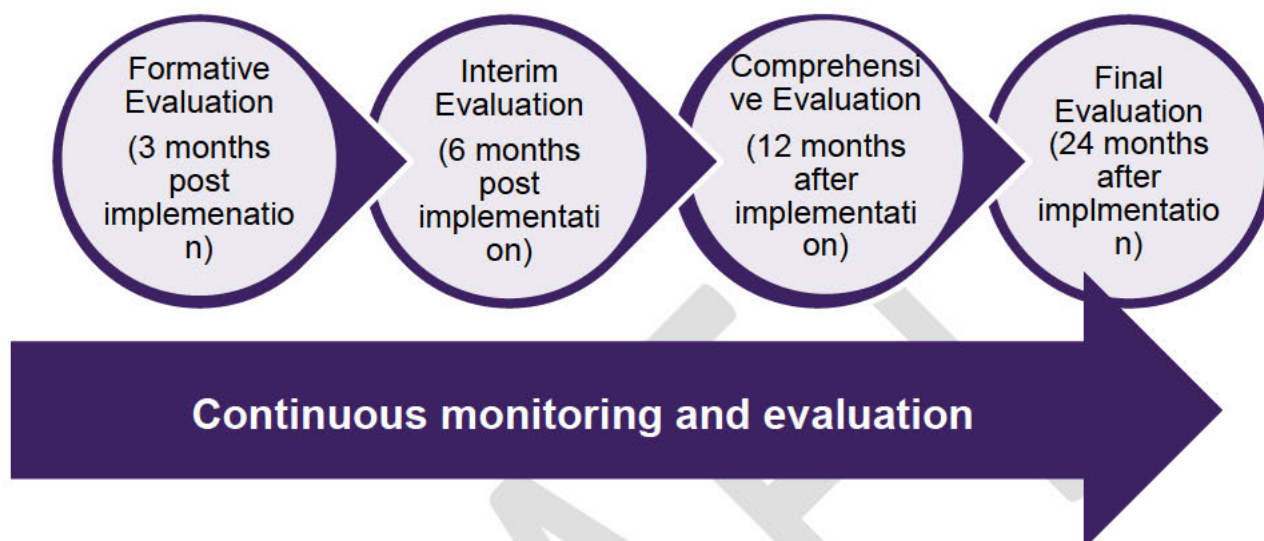
- Increase access to continuity of midwifery care, especially for identified priority groups.
- Improve women and birthing peoples experience of their maternity care.
- Improve health outcomes for women, birthing people and their newborns.
- Create an environment which enhances staff wellbeing and satisfaction, increasing sustainability of the workforce.

Ethical considerations

- Data is collected and recorded accurately.
- Data is appropriately de-identified to protect confidentiality.
- Informed consent is received from all staff and consumers providing feedback prior to collection.
- Consumer feedback is gathered in a format that is accessible and inclusive, enabling all women and birthing individuals to participate.



Timeline for Evaluation



Who will be involved in the evaluation?

- Project officer (if any).
- Midwifery Manager (CMM) of new model.
- Consumers-Women and families who utilise the new model of care.
- Staff working in the model.

Reporting and Dissemination

1. **Formative Evaluation Dissemination:** Share findings promptly with the project working group for review and decision-making. Use the insights to adjust processes, refine strategies, and address emerging issues in real-time.
2. **Interim Evaluation Dissemination:** Prepare a written report summarising key findings, trends, and recommendations. Distribute the report to key stakeholders to inform next steps and ensure alignment with objectives.
3. **Comprehensive Evaluation Dissemination:** Compile a detailed written report covering all aspects of the project evaluation. Share the report with stakeholders. Highlight successes, challenges, and actionable recommendations for the future.
4. **Final Evaluation Dissemination:** Compile a detailed written report covering all aspects of the project evaluation. Share the report with stakeholders. Highlight overall success or failure of the trial.



Formative Evaluation

A formative evaluation will take place three months after implementation and be conducted by the project officer.

Objective

Assess the fidelity, feasibility and quality of the implementation. Determine if the model has been implemented as designed. Identify barriers and enablers encountered in the implementation phase. Address emerging challenges and improve service delivery early in the process.

Key performance Indicators (KPIs)

1. Number of women being cared for in the service.
2. Identify barriers or enablers encountered in the implementation process.

Measuring KPIs

1. Audit of number of women cared for in the service to date via the Digital Health Record (DHR).
2. Identify any barriers or enablers encountered during the implementation process through interviews with stakeholders, to better understand factors that may hinder or support the successful adoption of the new model.

Anticipated outcomes

1. The service is designed to care for an anticipated caseload of 36 women per annum per 1.0 full-time equivalent (FTE). It is acknowledged that during the initial phase, caseload numbers may be lower to accommodate capacity-building efforts and ensure the model's successful implementation.
2. Barriers and enablers regarding implementation identified by stakeholders, ways to improve and remedy issues sought.

Interim Evaluation

An interim evaluation will be conducted at six months post implementation by the CMM of the model.

Objective

Review clinical outcomes, level of continuity of care being delivered and staff and consumer satisfaction.



Clinical Indicators (CIs)

Women's Healthcare Australasia (WHA) clinical indicators	
Maternal	Neonatal
Caesarean section rate	Apgar score of 6 or less at 5 minutes post birth
Vaginal birth after caesarean (VBAC)	Special care nursery (SCN) or neonatal intensive care unit (NICU) admission (Without congenital anomaly/birth defect)
Unassisted vaginal birth	Stillbirth rate
Instrumental vaginal birth	Low birth weight
Induction of labour	
Epidural for pain relief	
Episiotomy	
3 rd and 4 th degree perineal trauma	
Post partum haemorrhage (PPH) • >1000mls <1500mls • > 1500mls	
BFHI Data	
Immediate uninterrupted skin/skin at birth for 60 min	Type of feeding at DC from service
Type of feeding at DC from hospital	

Measuring CIs

1. Audit of clinical outcomes (as listed above) through DHR reporting.
2. Utilise WHA clinical indicators to benchmark performance against similar services both locally and nationally.

KPIs

1. Number of women cared for by service.
2. Level of continuity of care delivered.
3. Consumer satisfaction.
4. Staff satisfaction.
5. Work patterns.

Measuring KPIs

1. Identify total number of women cared for by service through DHR reporting.
2. Measure level of continuity of antenatal care, intrapartum care and outpatient postnatal care through DHR audit of clinical records (This refers to routine antenatal and postnatal outpatient care and excludes episodes of unplanned care).
3. Review of consumer satisfaction through the Maternity in Focus-ACT Maternity survey.
4. Staff satisfaction will be measured by the McCloskey-Mueller Satisfaction Scale (Lee et al., 2016). Burnout levels by the Copenhagen Burnout Inventory (CBI) (Kristensen et al., 2005). Results to be compared with pre implementation survey results.



5. Staff on call hours recorded for each pay period to monitor afterhours activity.

Anticipated Outcomes

1. Clinical indicators fall below WHA benchmarking levels.
2. FTE dependant, the model will care for 36 women per 1.0 FTE each month.
3. 100% of scheduled antenatal and postnatal outpatient care provided for women by a team midwife. 100% of women receive care during labour and birth by a team midwife.
4. Consumer satisfaction levels exceed standard care models.
5. Staff satisfaction increased and burnout levels decreased when compared to pre implementation survey results.

Comprehensive Evaluation

The comprehensive evaluation will build upon insights gathered from the formative and interim evaluations and will be conducted twelve months after implementation. A written report will be prepared and finalised within three months of the service reaching twelve months of operation.

Objective

Outline challenges and overall performance during the first year, including clinical outcomes and consumer and staff experiences. Use the findings to inform ways to scale up, expand and improve the service.

KPIs

1. Number of women cared for by service.
2. Number of women cared for from identified priority groups.
3. Level of continuity of care delivered.
4. Consumer satisfaction.
5. Staff satisfaction.
6. Work patterns.

Measuring KPIs

1. Identify total number of women cared for by service through DHR reporting.
2. Perform DHR audit of clinical records to identify number of women cared for from identified priority groups.
3. Measure level of continuity of scheduled antenatal care, intrapartum care and outpatient postnatal care through DHR audit of clinical records (This refers to routine antenatal and postnatal outpatient care and excludes episodes of unplanned care).
4. Review of consumer satisfaction through the Maternity in Focus-ACT Maternity survey.
5. Staff satisfaction will be measured by the McCloskey-Mueller Satisfaction Scale (Lee et al., 2016). Burnout levels by the CBI (Kristensen et al., 2005). Results will be compared with pre implementation and interim evaluation findings.
6. Staff on call hours recorded for each pay period to monitor afterhours activity.



Clinical Indicators (CIs):

Women's Healthcare Australasia (WHA) clinical indicators	
Maternal	Neonatal
Caesarean section rate	Apgar score of 6 or less at 5 minutes post birth
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Unassisted vaginal birth	Stillbirth rate
Instrumental vaginal birth	Low birth weight
Induction of labour	
Epidural for pain relief	
Episiotomy	
3 rd and 4 th degree perineal trauma	
Post partum haemorrhage (PPH) • >1000mls <1500mls • > 1500mls	
BFHI Data	
Immediate uninterrupted skin/skin at birth for 60 min.	Exclusively breastfeeding at DC from hospital
Exclusively breastfeeding at DC from service	

Measuring CIs

1. Audit of clinical outcomes (as listed) through DHR reporting.
2. Use WHA clinical indicators to benchmark against similar services locally and nationally.

Anticipated Outcomes

1. Clinical indicators fall below WHA benchmarking levels for comparable models of care.
2. FTE dependant, the model will care for 36 women per 1.0 FTE each month.
3. Women from identified priority groups represent a minimum of 50% of women cared for in the service.
4. 100% of scheduled antenatal and postnatal outpatient care provided by team midwife.
100% of intrapartum care provided by a team midwife.
5. Consumer satisfaction is higher when compared with standard care models.
6. Staff satisfaction levels have increased, and burnout levels are lower when compared with pre implementation and formative evaluation survey results.

Final Evaluation

The final evaluation will be completed at 24 months post implementation of the service. A written report will be prepared and finalised within three months of the service reaching 24 months of operation.



Objective

Outline challenges and overall performance during the trial, including clinical outcomes and consumer and staff experiences. Positive findings may support the expansion, scaling up, and establishment of the service as a permanent option for women in the ACT. Conversely, if the findings indicate significant challenges or negative outcomes, they may inform decisions regarding the service's dissolution.

Key performance indicators (KPIs)

1. Number of women cared for by service.
2. Number of women cared for from identified priority groups.
3. Level of continuity of care delivered.
4. Consumer satisfaction.
5. Staff satisfaction.
6. Work patterns

Measuring KPIs

1. Identify total number of women cared for by service through DHR reporting.
2. Perform DHR audit of clinical records to identify number of women cared for from identified priority groups.
3. Measure level of continuity of scheduled antenatal care, intrapartum care and outpatient postnatal care through DHR audit of clinical records (This refers to routine antenatal and postnatal outpatient care and excludes episodes of unplanned care).
4. Review of consumer satisfaction through the *Maternity in Focus-ACT Maternity survey*.
5. Staff satisfaction will be measured by the McCloskey-Mueller Satisfaction Scale (Lee et al., 2016). Burnout levels by the CBI (Kristensen et al., 2005). Results will be compared with pre implementation and interim evaluation findings.
6. Staff on call hours recorded for each pay period to monitor afterhours activity.

Clinical Indicators (CIs)

Women's Healthcare Australasia (WHA) clinical indicators	
Maternal	Neonatal
Caesarean section rate	Apgar score of 6 or less at 5 minutes post birth
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Instrumental vaginal birth	Low birth weight
Induction of labour	
Epidural for pain relief	
Episiotomy	
3 rd and 4 th degree perineal trauma	
Post partum haemorrhage (PPH)	



• >1000mls <1500mls • > 1500mls	
BFHI Data	
Immediate uninterrupted skin/skin at birth for 60 min.	Exclusively breastfeeding at DC from hospital
Exclusively breastfeeding at DC from service	

Measuring CIs

1. Audit of clinical outcomes (as listed) through DHR reporting.
2. Use WHA clinical indicators to benchmark against similar services locally and nationally.

Anticipated Outcomes

1. Clinical indicators fall below WHA benchmarking levels for comparable models of care.
2. FTE dependant, the model will care for 36 women per 1.0 FTE each month.
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100% of intrapartum care provided by a team midwife.
5. Consumer satisfaction is higher when compared with standard care models.
6. Staff satisfaction levels have increased, and burnout levels are lower when compared with pre implementation and formative evaluation survey results.

Conclusion

This Service Evaluation Framework supports the implementation of a new model of midwifery continuity of care. The evaluation occurs in three phases: formative (3 months), interim (6 months), comprehensive (12 months) and a final evaluation (24 months). The evaluation will highlight if the new model is meeting its objectives through reviewing clinical data, measuring women's satisfaction with their maternity care and staff satisfaction working within the model. Findings from the evaluation will inform ongoing improvements to support the provision of high-quality woman centred maternity care, which meets the needs of women and maternity care providers. Positive findings would support the upscaling of the model, ultimately leading to the achievement of the Maternity in Focus goal of 50% of women having access to MCoC by 2028.



DRAFT

