A new way of being: an autoethnographic account of an academic journey exploring continuity of midwifery care

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Katherine M H Gregory

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Copyright statement

Abstract

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Author: Katherine M H Gregory

This autoethnographic thesis is a deep reflection on my journey through a clinical academic training pathway in which the experiences of midwives who work in a continuity of care model were explored. It is a story of adaptation and survival, and reflects a postgraduate research journey in which many challenges have been overcome.

Within this postgraduate research programme, I designed two qualitative studies which aimed to generate enhanced knowledge about the implementation of continuity of care models in NHS settings. A study employing Participatory Action Research aimed to engage with my colleagues in a continuity of care team, fostering an iterative cycle of engagement, learning and improvement. In response to changes in the clinical area, a redesigned study based on an Appreciative Inquiry methodology considered how midwives who are employed on a part-time basis can be facilitated to provide continuity of care. Developments at local and national levels meant that these research studies were not feasible to run within the confines of the postgraduate research pathway.

My own experience as a midwife providing of continuity of care, as a mother receiving maternity care through two pregnancies, and as a clinical academic, provided rich understanding of the context of the research. These multiple identities were at times in tension with each other and this supported critical reflection on the complexities of providing maternity care which can meets the diverse needs of women and midwives, and the possibilities for organisational development and implementation of new models of care within the NHS healthcare system. A pragmatic recommendation to implement a part-continuity model is drawn, but the limitations of this are recognised from a personal and professional perspective.

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Acknowledgement

I would like to extend sincere thanks to my supervisory team. My lead supervisor who has guided me from start to finish- Professor Lee-Ann Fenge, whose consistent support and expert advice has ensured I reached this point. Dr Laura Iannuzzi, Dr Luisa Cescutti- Butler and Dr Stella Rawnson- their experience and knowledge has been invaluable during this process. My gratitude extends to Bournemouth University and my NHS match-funding organisation for funding the opportunity to get involved in academic research.

I would like to thank the amazing comrades I have met during this journey. Charlotte, Vanessa and Jess- their support through the toughest times has been what has got me through, I am so pleased to have met them and I look forward to watching their journeys unfold.

To my husband, who has walked this path alongside me, and my amazing family and friends who have encouraged and motivated me. I am so thankful for you. My daughter, Lyra, I hope that you will go on to follow your dreams, whatever they may be, and, like me, learn to adapt and rise when you are faced with challenges. Finally, to my darling Daddy. I wish you could have proofread this, just like you read everything else I have written without a single complaint. Your total belief in my ability to do anything is probably what encouraged me to even consider this process and I will forever carry that with me.

1.0 Introduction

This is a representation of an academic and personal journey of adaptation, resilience, and survival. The original map for this journey was relatively straightforward, a four-year Clinical Academic Doctoral (CAD) training programme with predictable hurdles such as Probationary and Major academic review and closing with a Viva Voce examination.

Early on in this journey, the world around me changed on a global scale (the Covid-19 pandemic) and personally (I became a mother for the first time). I redrew my map and made my own sense of the new landscape surrounding me. I am a woman changed by this experience, empowered by an active choice to reject the route which was expected.

At the start of this journey, an autoethnographic methodology would have been an inappropriate choice: this thesis would have been a more traditional report on the research study which I designed. Each time I rose from a challenge on my research path, it led to autoethnography being an ideal methodology. This autoethnographic approach provided me with the framework to interrogate and reflect on my own experience and examine how this paralleled with aspects of the midwifery profession. By making this theoretical lens explicit, my reflective account is located within an academic research method and is legitimised (Jones et al. 2016). As within my experience as a midwife, I am subversively altering the expected norms within my field (Jones et al. 2016).

1.1 To Autoethnography

Although I formally came to the methodology of autoethnography (Jones et al. 2016) relatively late in my academic journey, it was clear that this was a process and method which I had been following throughout my academic journey. It became the glue which held the pages of this thesis together, a lens to clarify my story. Autoethnography legitimised the existing inclusion of deep reflection on personal and professional experiences I had experienced on the path of my postgraduate study and

encouraged richer sharing and deeper analysis and consideration of the wider factors of influence within this story.

Reflexivity is intrinsic to autoethnography (Berry 2016), and this has been central to my role as a researcher throughout this process. The qualitative methodologies which I had previously explored placed a value on reflexivity and recognised that the researcher themself is an influential tool of the research (Borg et al. 2012; Creswell 2018). Throughout the academic process, I have been continuously inquiring into my own experience and critically reflecting on this informally without intentionally 'doing' autoethnography. I draw from my personal reflective journal, notes from academic supervisory sessions, reflections from personal counselling sessions and my personal memories to elicit deeper insight into the experience and parallel this with the journey of midwifery. I sought to explore how the journey has personally and professionally affected my identity, values, and dreams.

Autoethnography is a method which combines the study of (*graphy)* the self *(auto)* in relation to cultural or societal influences (*ethno*) (Chang 2016b). Autoethnography “shares the storytelling feature with other genres of self-narrative but transcends mere narration of self to engage in cultural analysis and interpretation” (Chang 2016a, p.43). The focus on enmeshing the personal story of the researcher with the wider cultural context is important in autoethnographic study (Creswell (2013), the ‘self’ in autoethnography considered “porous” (Tolich 2010, p.1608). The methodology recognises that an individual’s experience and understanding of reality is influenced by the conditions in which they are embedded. Autoethnography may present an emotive narrative similar to an autobiography but exhibiting complex self and social awareness and demonstrating a critical understanding of the surrounding cultural phenomena (Jones et al. 2016).

This autoethnography presents my journey through academia and midwifery, interrogating the concept of identity as a midwife, the desire

and ability to work in continuity of care and what is means to be a working mother. I consider how my experiences have shaped and altered my values, hopes and needs. This is reflected through the consideration of wider literature around this, formally in the form of a literature review and more informally such as consideration of the history of the midwifery profession and examination of literature surrounding intergenerational differences within the world of work.

Autoethnography as a methodology has numerous purposes. The research can “write to right” (Bolen 2012, p.208), working with their insider knowledge to navigate difficult experiences (Lee et al. 2020). By openly writing about topics which may be hushed or taboo, autoethnography can reclaim choice, and disrupt traditional ways of being. Autoethnographic research representing a human story is accessible and representative unlike many traditional forms of research (Jones et al. 2016).

These purposes resonated with my own sense of reclaiming my story and rewriting the identities of failing midwife and PhD student. A final aspect of autoethnography which I have embraced is "intentional vulnerability" (Jones et al. 2016, p.24). Honesty about the events in my life contained within this thesis include some global issues such as the pandemic and other more personal deeply intimate events. This is to engage the reader in a response, allowing them to critique both my own experiences and decisions in the context of the culture in which they were made, and spark reflection on their own pertinent experiences (Jones et al. 2016).
Ellis (2016, p.10) eloquently describes autoethnography as a survivor story, “a new way of being”. This resonated with me and inspired the title of my thesis. I recognised that “a new way of being” perfectly encapsulated so many of the experiences navigated in this thesis: as a midwife and an academic, I have discovered new ways of being through this experience. Personally, I have discovered a way of being in the world despite role changes within my personal life. This also perfectly describes the transition for midwives joining a continuity of care model: they must

find a new way of being, no longer working shifts and saying goodbye when they go home, but blurring the lines between work and home life, acting as a navigator of services for the women in their care.

"For most of us, autoethnography is not simply a way of knowing about the world; it has become a way of being in the world, one that requires living consciously, emotionally, and reflexively. It asks that we not only examine our lives but also consider how and why we think, act, and feel as we do. Autoethnography requires that we observe ourselves observing, that we interrogate what we think and believe, and that we challenge our own assumptions, asking over and over if we have penetrated as many layers of our own defenses, fears, and insecurities as our project requires. It asks that we rethink and revise our lives, making conscious decisions about who and what we want to be. And in the process, it seeks a story that is hopeful, where authors ultimately write themselves as survivors of the story they are living." (Ellis 2016, p.10)

1.2 My Research Journey

The following chapters demonstrate my knowledge of the research subject and of research methodologies. This thesis will justify the presentation of a Masters of Research (MRes) award. However, this thesis will only go part way to demonstrating the depth of self-knowledge, tenacity, and adaptability I have gained.

This thesis demonstrates my systematic understanding of the field of continuity of care, maternity service reform, wider societal influences on the midwifery profession and societal views of women in the workforce. I present the development of my research through consideration of the methodological approaches and ethical considerations I explored and critically reflect on their appropriacy. In the chapter following, I detail my journey through the Researcher Development Programme at Bournemouth University.

My postgraduate research journey began in September 2019. I was attracted to research because it represented an opportunity to affect change in maternity services and to generate new knowledge about how care should be provided. My time spent as a clinical academic midwife provided space to deeply explore the philosophies of knowledge creation, critically analyse concepts, theories, and real-world situations and to develop and plan two research studies. I was accepted onto a four-year Clinical Academic Doctoral (CAD) studentship programme at Bournemouth University. I overcame many challenges during my postgraduate research experience including a global pandemic, changes to the maternity service in which I was based which necessitated redesign of the research, and personal changes (bereavement and maternity). In May 2022, I took the empowering decision to change my university registration from PhD to MRes. This has allowed me to academically demonstrate the growth in my knowledge of ontological and epistemological theory, research design and qualitative methodologies. I have explored ethical considerations in research, developing a broad knowledge of organisational development concepts, change and evaluation theories and knowledge related to the field of continuity of carer.

1.3 Initial research proposal and adapting to Covid-19

When I commenced the studentship, an outline research proposal was already planned. The research proposal explored the experiences of midwives working in an established continuity of midwifery care team using a Participatory Action Research (PAR) methodology (McIntyre 2008). The subject of continuity of care was of great interest to me as I had personal experience of working in continuity of care models. As an undergraduate midwifery student, I had enjoyed an elective placement with an innovative case loading team in the North of England “One to One Midwives”. I used this as inspiration for my undergraduate dissertation which explored the experiences of midwives who worked in continuity of care models. I worked in a small community midwifery team in a deprived

area of Bristol and saw how these women benefitted from continuity of care in the antenatal and postnatal period. Later in my career, I experienced the highs and lows of balancing caseloading practice and managing life on call in a homebirth team. This combined experience within midwifery continuity of care showed me the deep fulfilment which could be experienced through the development of a strong therapeutic relationship with a mother and her family; and autonomy to provide individualised care as a midwife. I have also experienced the professional challenges of working in a model which was incongruous with the contemporary standard care model, the personal challenges of unpredictable working hours and the effect this could have on family, friends and ultimately on my own wellbeing.

There has been a focus on midwifery continuity of care models in the United Kingdom (UK) since the publication of Changing Childbirth in 1993 (Expert Matenity Group). The publication of the strategic plan, Better Births (NHS England) in 2016 marked a renewed emphasis on delivering midwifery continuity of care. I wanted to be able draw on my own experiences to support the development of continuity of care models which were beneficial to women and sustainable for midwives.

As part of my full-time CAD programme, I was able to work clinically as a midwife within a continuity of care team for 40% of the time. From the research proposal, I developed a Participatory Action Research study (‘Midwives’ EXperience of Continuity Study’ - The MEXoC Study) which engaged my team as co-researchers (McIntyre 2008). Together, we planned to inquire into our experience of continuity of care and collectively take action to improve it.

During the development of the MEXoC study, the Covid-19 pandemic began. In March 2020, at the start of the week in which the UK went into lockdown (Cabinet Office 2020), I attended a homebirth of a women for whom I had provided midwifery care in the third trimester of her pregnancy. The mother spent the afternoon in an intense experience of

labour. Her toddler daughter and partner wandered in and out of the room she was in. The first-year student midwife and I were relaxed, in the flow state of providing midwifery support in a straightforward physiological labour which was progressing as a textbook would dictate. The birth of this baby was a high for all in the room, parents elated, midwives satisfied, and a student midwife overjoyed at witnessing her first physiological birth. We were not to know that this was to be the last ‘normal’ interaction we would have during the next few years.

A day later, the UK government issued a ‘stay at home’ order and the first of a succession of lockdowns were announced (Cabinet Office 2020). Overnight, daily life in our homes, at the university and in the hospital became unrecognisable. The mother who gave birth the day before would not see maternity staff again without a mask covering their faces. I would not sit upon her sofa, discovering how she was adapting to life with two children, how she was recovering and assessing the health of her newborn. This family, like every other family outside of one’s own immediate family, became a threat to staff, and maternity staff were a danger to this family. An invisible and unknown danger was around us, and nobody understood yet what this meant.

Ways of providing maternity care which had been entrenched for decades were no longer appropriate (Jardine et al. 2021). The central tenant of midwifery care of being ‘with woman’ (Bradfield et al. 2019) was forced to adapt to the concept that human interaction could be a real threat to human health (Brigante et al. 2022). Midwives and women interacted primarily through screens and phone calls (Jardine et al. 2021). If face to face contact was essential, it happened as briefly as possible, through masks, gowns and gloves which disguised the identity of the wearer (Bailey and Nightingale 2020).

Whilst my colleagues were grappling with protective equipment and new communication technologies, I was tasked with phoning hundreds of women who planned to attend outpatient appointments, screening them

for any signs of this new virus and informing them of the changes to maternity services. In the first trimester of pregnancy myself, I tried to offer support and understanding to their disappointment, upset and fear despite having limited guidance available on Covid-19 and pregnancy (Jardine et al. 2021). The pandemic and my pregnancy continued, and I moved to a new role as a midwife on the telephone triage service. I staffed the single phone line which women could call to speak to maternity services. Amongst the appointment time changes and transfers to other departments, I spoke to hundreds of women in a similar position to myself, with nobody to turn to about their concerns, worries and fears. I requested ambulances for women with serious respiratory symptoms associated with this virus, supported women who were bleeding in early pregnancy alone at home, provided guidance to women in labour who were afraid of leaving their home to enter a 'dangerous' hospital. Alongside this, I advocated for mothers who had concerns about the wellbeing of their newborn to be assessed in person by a health care professional.

Like many health care workers who provided care through the pandemic, I adapted to working in a new role, focusing on the job in hand and pushing aside my emotional responses to the traumatic stories I was faced with (Eagen-Torkko et al. 2021; Smith 2021; Couper et al. 2022). I was one of the lucky ones, kept as safe as could be from the virus by the isolation of my box-room cupboard with a closed office door, no wounds on my face from a respirator mask.

My academic role continued despite the pandemic, but I moved to working from home in a make-shift office. I adapted the research design to facilitate the undertaking of the study during a pandemic, for instance utilising online communication technology to undertake focus groups although I struggled to find adequate literature to support the integrity of these altered data collection methods (Eigege et al. 2022). I prepared a study protocol and relevant documents in preparation to apply for ethical approval from the university and Health Research Authority on my return from maternity leave.

1.4 Midwife to mother

My own maternity care experiences reinforced my conviction in the value of midwifery continuity of care. The ongoing pressures on maternity care due to the pandemic led me to engage the services of my local independent midwives in my early third trimester. Independent midwives are self-employed midwives who offer midwifery care on a private basis. They generally offer high levels of individualised continuity of care due to the personal nature of the working relationship (Fitzsimmons 2022). My professional knowledge about navigating through the maternity care system empowered me to make this choice to ensure I could build a trusting relationship with a caregiver with whom I shared a philosophy of care (Church 2014; Coulton Stoliar et al. 2022). For many midwives, this sense of control is imperative to being able to switch off the 'midwife brain' and let go into the transition to motherhood (Redwood 2008; Coulton Stoliar et al. 2022), and my experiences echo the literature surrounding midwives own birth choices.

My husband and I developed a trusting relationship with our midwives, built through regular appointments in our home where, in addition to monitoring the health and wellbeing of my pregnancy, they came to know us and our hopes and fears around birth and parenting. Their presence in labour was a great comfort to me and I felt able to relax into the birthing process because I trusted them. Following the euphoric birth of my daughter, they ensured that my new family and I were comfortable before slipping away, leaving us with the reassurance that their advice was just a text message away. In the weeks after the birth of my daughter, they sat with our family and held space for us to share our emotions, elation, and challenges as we adjusted to our new roles. Often, things did not need explaining- our midwives just knew.

I reflected on my professional experiences of providing midwifery care and paralleled them with the gold-standard care which I had received. Whilst there are limitations to the care offered in an NHS setting compared to a

private setting, so many of my personal experiences of trust and understanding were connected to the therapeutic relationship which was formed through continuity of care. I had seen glimpses of this effect when working as a homebirth midwife in a small continuity team, so my own experience served to strengthen my understanding of the value of this for all women.

On my return from maternity leave in July 2021, the restrictions placed upon society because of the pandemic had eased to allow social interaction outside of the home (Institute for Government 2021). Catching the virus was no longer the terrifying prospect it had been at the start of the pandemic, but midwives continued to wear face masks and to regularly test for virus. Within the maternity unit in which I worked, the leadership team had changed, and the continuity of care team had been disbanded. With my co-researchers no longer available, it was clear that the MEXoC study was no longer feasible within the context of a match-funded PhD.

I was surprised at the relief I felt at no longer having the option of returning to continuity of care. I had concerns about how I would perform as a continuity of care midwife whilst mothering my seven-month-old breastfed infant. The unpredictable nature of the work could have presented issues with sourcing ad-hoc childcare or finding adequate time and space to express breastmilk when I was away from my daughter. Concerns specifically around the difficulties of managing caring responsibilities whilst working in continuity of care models are shared by many midwives (Taylor et al. 2019).

I returned to work long shifts as a midwife on a labour ward. Like many mothers (Costantini et al. 2022), I compressed my contracted hours to five long shifts a month. This allowed me to spend more time at home as a parent rather than working in the hospital two days a week and undertaking academic work on the following three. The return to work after maternity leave is often challenging for mothers who must adjust to managing their role as a mother, with performing as an employed worker

(Costantini et al. 2022). Mothers who work in healthcare have specific challenges for example working long shifts or requiring time within the day to express breastmilk (Hearfield et al. 2022). Echoing the experiences of many mothers in the literature, I felt guilt at leaving my child and felt overwhelmed at balancing my new responsibilities (Parcsi and Curtin 2013; Costantini et al. 2022). I examined my altered priorities and considered if my 'career' had simply become 'work' as reported by many women (Parcsi and Curtin 2013, p.256).

At this point, I considered leaving my clinical academic programme. A significant redesign of the research was required which meant a set-back in my academic progress. Clinically, I felt alienated from my colleagues, no longer part of a team of motivated and supportive midwives who held a shared philosophy of care. I felt devalued and misunderstood by the new management team who insisted I return to clinical midwifery work on mixed day and night shifts, despite my young baby and clinical academic role covering three academic days weekly. I felt that my dual role as a clinical academic was not recognised or valued by the clinical team. Trusson et al.'s (2019) research into the experience of non-medical clinical academics highlights that the challenges I experienced in integrating clinical and academic work are not unique. Despite a renewed focus on improving the quality of healthcare by engaging nurses and midwives in research careers (Health Education England 2014; The Royal College of Midwives 2021), there is a "serious lack of organisational and professional value placed on the knowledge and skills achieved by some clinical academics" (Trusson et al. 2019, p.5).

Despite my concerns, I decided to continue with the programme. My own personal and professional experiences of continuity served as motivation to continue my academic pathway. I planned to develop research which would generate essential knowledge to support the implementation of midwifery continuity of care services, and my new insights as a mother allowed me to approach this with a new perspective.

1.5 Redesign and the birth of the COMPart study

The opportunity to redesign the research study allowed me to adjust the focus of the research. My initial literature review of the experiences of midwives providing continuity of care supported me to identify a gap in the literature. There was a real-world challenge in the provision of continuity of midwifery care services around enabling part-time midwives to work in this model.

As a match-funded research programme, I was mindful that my research should be of value to the funding organisation, so I engaged in discussion with the local management team, who reported that a large proportion of their workforce were employed on a part-time basis and that this was a challenge for workforce planning.

The study redesign involved updating the literature review and further background reading. I had to research appropriate methodological approaches, write a full protocol, interview guide, data management plan, participant recruitment adverts, participant information sheets and consent, and prepare BU and Health Research Authority ethical approval applications. The Continuity of Midwifery Part-Time (COMPart) study was planned to be an Appreciative Inquiry (Ludema et al. 2006) into the experiences of midwives who had worked part-time in continuity of care settings.

1.5.1 Aims and objectives

The aims and objectives of the COMPart study were:

Aim: To explore how midwives employed on a part-time basis can provide midwifery continuity of care services within the NHS.

Objectives:

1) To explore the experiences of part-time midwives working in continuity of care settings and develop insights into practices which support them;

2) To explore insights into personal and organisational strategies from midwifery managers which support midwives in continuity of care settings;

3) To explore how an appreciative inquiry approach may facilitate midwives to move towards a co-designed model of continuity of care.

Table 1: Aims and Objectives of COMPart study

To achieve these objectives, two phases of research were planned. In Phase One, 10 midwives with experience of part-time continuity of care in the UK would be recruited for semi-structured online video interviews. The interview guide supported the appreciative nature of this to understand the positives of the experiences reported by participants and what strategies they felt had sustained their practice. The interviews would be transcribed and thematically analysed (Braun and Clarke 2006).

Phase two of the study would recruit midwives and midwifery managers from the match-funding NHS maternity service to attend focus groups in which participants could explore how themes developed in analysis of phase one could be used to support the local setting in understanding the opportunities for part-time workers within a continuity model. Separate focus groups for participants from the midwifery leadership team and midwifery staff would support participants to express their views freely.

These focus groups would be recorded, transcribed and thematically analysed (Braun and Clarke 2006).

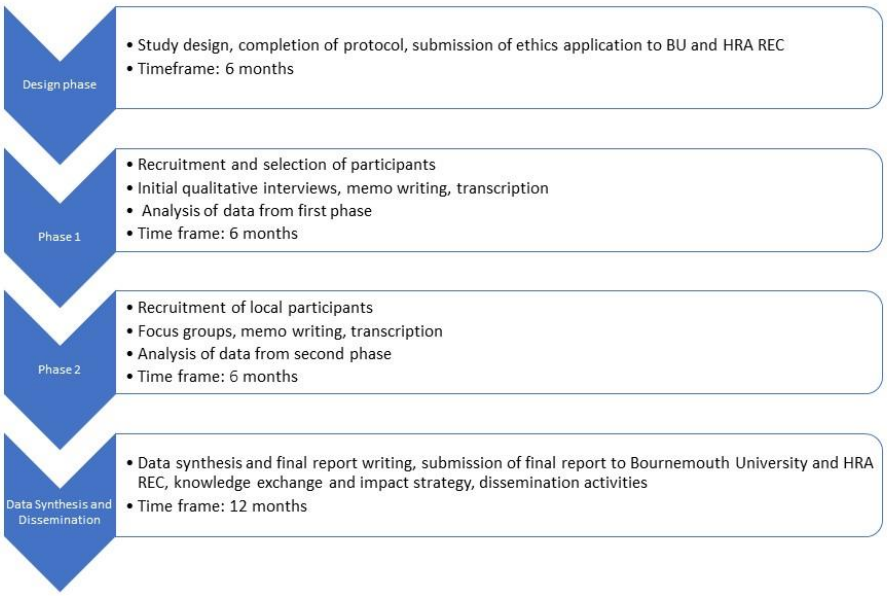


Fig. 1 Proposed COMPart Study Timeline

I planned a suitable study timeline to ensure that my research would fit within my academic timeline (see Fig. 1 above). My research plans were successfully defended at the Major Review Viva Voce academic examination. I prepared to submit my application for ethical approval and open the research study.

1.6 The next challenge: navigating loss

In March 2022, the Final Report of the Ockenden Maternity Review was published (Ockenden 2022). This report detailed the failures of an NHS Trust in caring for women and babies in their care and detailed essential actions to be immediately implemented nationwide. One of these actions was that the implementation of continuity of care services should be immediately suspended unless an NHS Trust could demonstrate minimum levels of safe staffing on all shifts (Ockenden 2022, p.149).

Whilst Phase One of the research study could continue, Phase Two of the COMPart study would involve focus groups of local midwifery staff and aimed to initiate a co-creation project to develop the continuity of care services in the local area. Following discussion with the Director of Midwifery in the funding organisation, it became clear that it would no longer be possible to run Phase Two in the altered clinical environment following the Ockenden report.

At this point, I considered the ongoing options with the research I had planned. I consulted with my academic supervisory team and my Major Review examiners to understand how Phase One of the research could be adapted to meet the requirements of a PhD level study and I explored alternative options. Since any changes would be a significant revision to the research, a second Major Review may have been required. There was some possibility of adapting the research design to meet the requirements of a doctoral award, but my personal life was becoming more complicated.

Around this time, shortly before my daughter's first birthday, my beloved father died. His lung cancer diagnosis had been delayed significantly by the pandemic. I took leave from my clinical and academic work to nurse him at his home in his final few weeks of life, stepping in where the overstretched healthcare system was unable to meet his needs. In his death, I recognised the importance of continuity of care in other areas of healthcare. A 2012 Cochrane review of continuity of care in cancer patients notes that poor continuity of cancer care is one of the "main problems in cancer care" (Aubin et al. 2012, p.6) and "may lead to fragmented and uncoordinated care, and results in an increased likelihood of not receiving recommended preventive services or recommended care" (Aubin et al. 2012, p.1). My father's palliative care was very different to the physiologically normal process of pregnancy and birth but similarly to a newly pregnant mother, the absence of a contact person to support with the navigation this unfamiliar healthcare pathway and life transition was difficult. The National Institute for Health and Care Excellence (NICE) note that this directly affects the satisfaction of patients receiving end of life

care and their families (National Institute for Health and Care Excellence 2019).

In the clinical midwifery element of my CAD programme, I continued to feel undervalued and recognised an increasing sense of distress at the gap between the fantastic care I had received as a mother, and the care I was able to give in the fragmented care system in which I was employed. I felt a growing sense of injustice at the way in which my return to work after maternity leave had been managed and felt too emotionally fragile to return to working in a way which I felt was unsupportive for midwives and the women they cared for. My experience as an experienced midwife, feeling unable to perform in the role I loved due to pressures within the maternity care system reflects a wider issue affecting the retention of midwifery staff (The Royal College of Midwives 2016b; Harvie et al. 2019; Smith 2021).

An opportunity to work in delivering clinical research within an NIHR Local Clinical Research Network became available to me and I took the empowered decision to leave the full-time CAD programme and change my registration from PhD to part-time MRes. This was not without trepidation and grief. My new role was my first outside of direct midwifery care and the decision to take a break from midwifery was a difficult one. Midwifery is part of my identity and gives me purpose, a feeling shared across the profession (Hunter and Warren 2013). Stepping away from clinically caring for women, something I felt so passionate about, was heart-breaking. However, it also created space to explore the opportunities aligned with the skills I had developed in midwifery research.

Stepping away also meant actively choosing to ‘fail’ my PhD. PhD attrition rates are difficult to obtain (Firth 2022) but rates reported in the literature vary between 25% (Maher et al. 2017) to 57% (Hunter and Devine 2016). Despite these relatively high rates, scarce literature or guidance exists on this. I continue to grapple with how best to represent my time as a PhD candidate, and my submission of this MRes thesis is a part of rewriting my

own story of failure into a success (Firth 2022). Most who leave PhD programmes do not leave due to academic failure (Maher et al. 2017) but more a realisation that post-doctoral career options are not appealing or not worth the sacrifices required to obtain a PhD. Personal reasons such as relationship changes and parenthood play a strong part in candidates' decisions to leave (Lovitts 2002; Crawford et al. 2021; Kis et al. 2022). No candidate who left did so for a singular reason (Lovitts 2002), and I recognise the complex interplay between factors pushing students to leave and keeping them in academia in my own experience.

This thesis is the culmination of four years of hard-work, passion, and commitment to improving maternity services. I have learned a great deal about research methods, and I have planned two qualitative research studies. The journey has not been a smooth one, but I have developed tenacity and adapted to overcome a variety of unexpected challenges. Developing my critical analysis skills has supported me to develop new perspectives on life, maternity services and feminism, whilst supporting me to reflexively consider who I am as a midwife, researcher, mother, daughter and woman.

1.7 Route maps through my journey

The following pages contain two route maps (Fig 2 and 3), the first depicting the expected route through my CAD Programme and the second depicting the journey I have taken. I chose to use a creative pictorial representation of my journey to help me to distil and make sense of the path which I have taken (Buckley and Nerantzi 2020).

The use of emojis (small pictures used to communicate, emphasise or guide the reader to the intending meaning of a statement) is increasingly common place in computer-aided communication such as text and email (Gesselman et al. 2019). I use emojis as a form of everyday language in my personal life and this assists my communication by ensuring I am able to express nuance in my written social communications. Whilst I would not consider myself to be artistic in the traditional forms of drawing or painting,

I felt comfortable using my newly developed emoji language to assist my exploration and expression of my journey.

The first map is the path I anticipated that my four-year Clinical Academic Doctoral programme would take. It is somewhat ordered and structured, with clear steps taken in a sequential process. The gates represented in green are the anticipated barriers to progression, and annual reviews of my academic progress. There are three prizes or wins represented by sunburst shapes, the largest of which is the final Viva Voce exam which would be the culmination of the thesis. The ongoing clinical element of my programme is represented at each level by a pink heart, demonstrating my ongoing love and passion for midwifery.

The second route map represents how my path really looked. The neat order and linear progression of the first route map contrasts with the messiness of the actual route taken. This emphasises the unpredictability and chaos of real life. The events which I have chosen to represent were selected following analysis of data such as my journal and supervision documentation which allowed me to reflect on their significance at the time. Many of these events align with “Life Change Unit” events identified in the Holmes-Rahe stress inventory (1967) as some of the most significant life events which can occur to a person. This scale, used to predict the relationship between stress and future illness, is considered a well validated tool within psychology, particularly for a western cultural setting like my own (Noone 2017). The use of this tool highlighted my own resilience and strength, following what was a high-level period of stressful life events, especially with the addition of an unpredictable and lifechanging pandemic.

In the first level of the image, representing year one of the program, the path is comparable to the expected path, with clear progress points taken. The successful completion of my Probationary Review is represented by a bright yellow sunburst. A positive representation of clinical midwifery is present as I continued to provide care as part of a continuity of care team

which supported me to work authentically to my values as a midwife. I chose to represent my return to clinical midwifery and the challenges which I experienced through a broken-hearted symbol. This is to emphasise the depth of emotion I had surrounding what felt at the time like the loss of my greatest passion and life work.

Towards the end of the first year, the first unexpected hurdle is represented by a large red exclamation mark. The strong red colour is somewhat asynchronous from the existing colour theme and purposefully stands out. An exclamation mark is used in language as a “distinctive indication of major significance, interest or contrast” (Merriam-Webster 2023) and therefore I felt it embodied the significance and surprise of simultaneously becoming pregnant and the emergent Covid-19 pandemic. Further repetitions of this show moments of crisis within the journey such as the study redesign. Question marks symbolise moments following these crisis moments where I questioned my path and engaged in deep reflection about my purpose and future within academia.

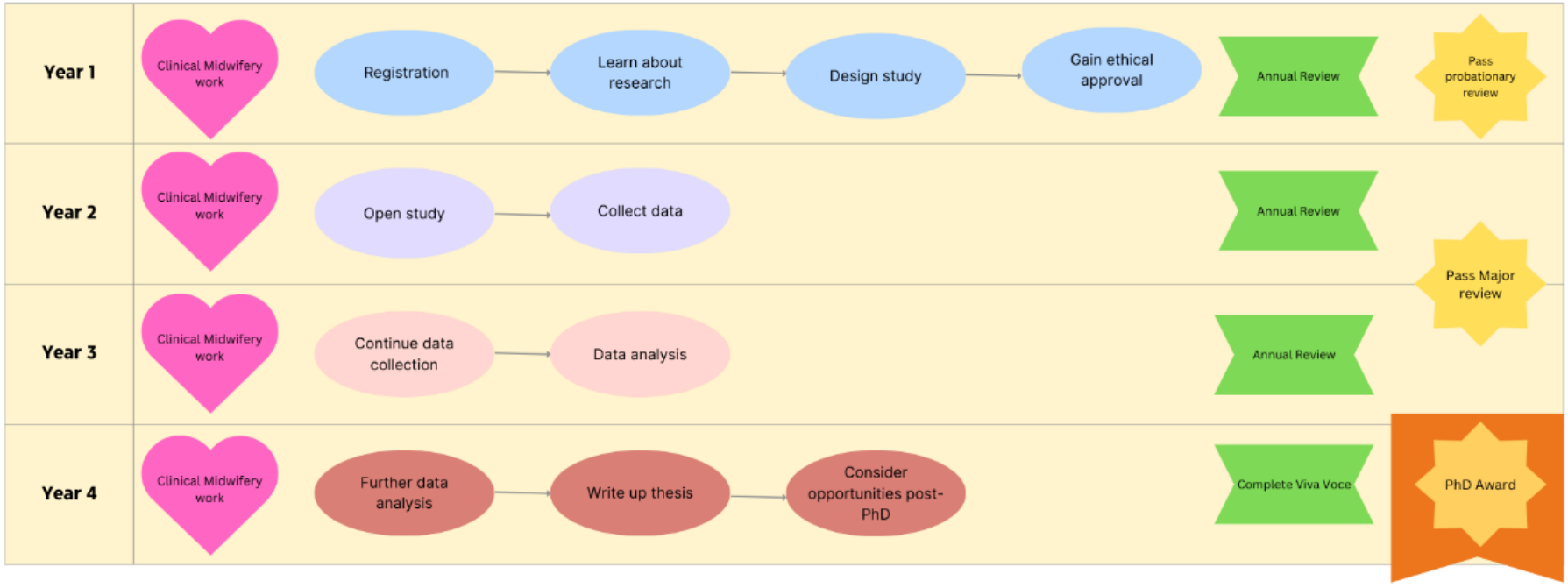
Emoji germs symbolic of the corona virus are initially strong in colour and numerous, which gradually fade and become sparser on the page as the pandemic had less of an effect on daily life. Heart shaped arrows labelled ‘mothering’ appear on my return from maternity leave, ever present throughout the remainder of the map. This shows the significance of this change in my life which creates an additional layer of complexity in the scene and in my life.

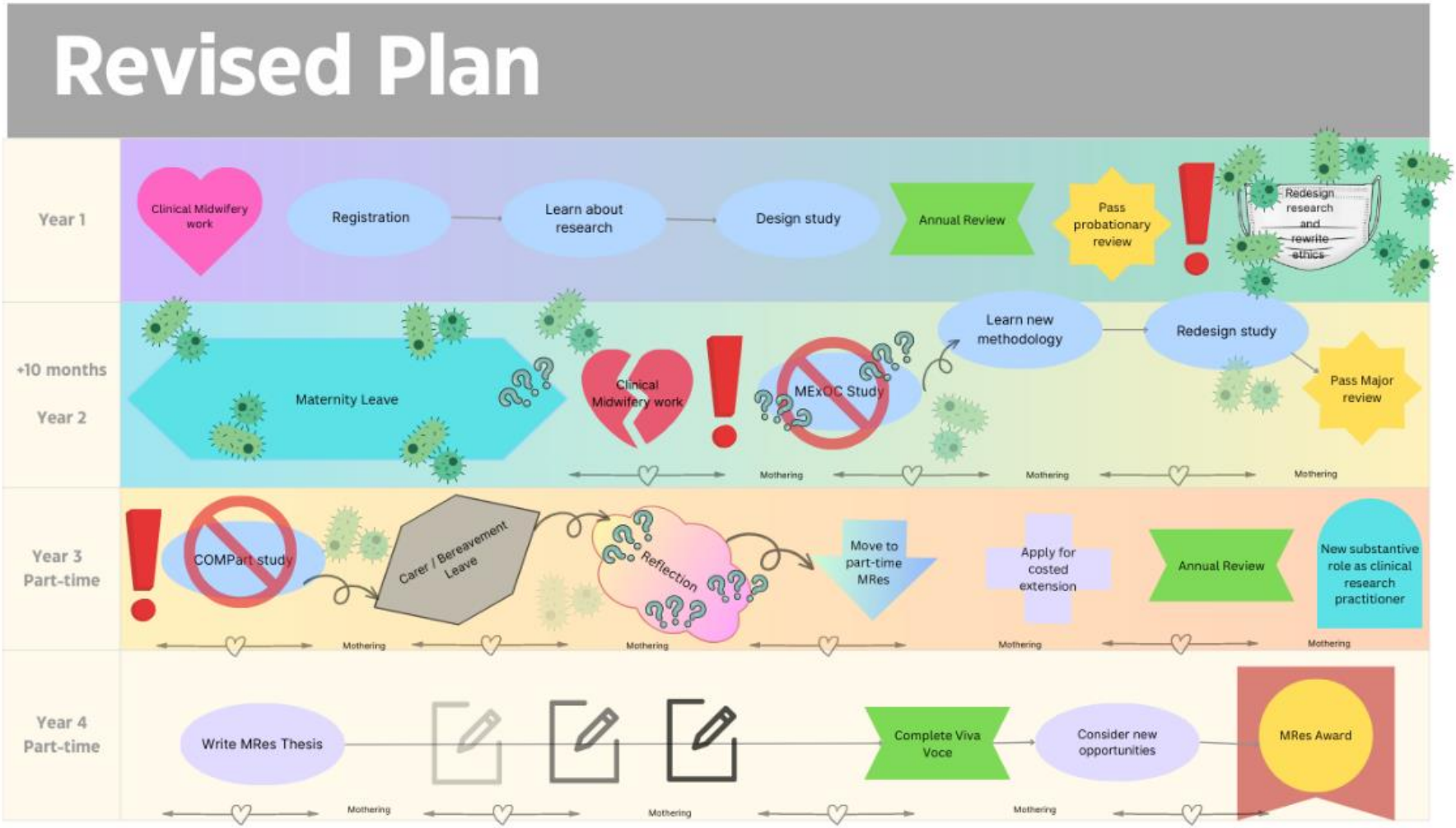
Arrows which initially were straight steps onto the next progression point become curly and lead to stepping stones in unexpected places and in unpredictable, messy orientations.

A blue door represents the opportunity which I took to move into a new research role. The strong colour is bold but neutral, symbolising a bold decision and a new start. The final layer of the map is more settled with a clear direction and emergent thesis represented by a pen and paper with increasing clarity and emphasis as the end is in sight. Towards the end of

the journey, a step highlighting new opportunities represents my desire to grow from this experience, to represent this story in a positive way where I have gained great insight into myself, academia, and midwifery. The final award is no longer a sunburst as the other successful moments were represented on the journey. The smooth, round yellow circle not what was expected at the start of the journey, but represents a full stop, a successful end point on a journey which could not have been predicted.

Original CAD Plan




Revised Plan
Year 1
Clinical Midwifery work
Registration
Learn about research
Design study
Annual Review
Pass probationary review
Redesign research and rewrite ethics
+10 months
Year 2
Maternity Leave
Clinical Midwifery work
MExOC Study
Learn new methodology
Redesign study
Pass Major review
Mothering
Year 3
Part-time
COMPart study
Carer / Bereavement Leave
Reflection
Move to part-time MRes
Apply for costed extension
Annual Review
New substantive role as clinical research practitioner
Year 4
Part-time
Write MRes Thesis
Complete Viva Voce
Consider new opportunities
MRes Award

2.0 Literature Review

This chapter will detail my exploration of existing literature. A crucial stage of any research involves gaining a detailed and systematic understanding of the existing literature in the field (Aveyard et al. 2016). This ensures that the researcher has a solid background knowledge of and highlights gaps, inconsistencies and limitations to the existing knowledge base (Aveyard et al. 2016). A literature review is also recognised as a piece of research in its own right (Aveyard et al. 2016; Boland et al. 2017).

2.1 Engaging with existing literature

I engaged with a wide variety of literature topics spanning methodological and philosophical approaches, which underpinned my theoretical knowledge; sociological and psychological texts; and topic specific literature on midwifery and continuity of care.

Early in the research journey, an exploratory literature review of midwives' experiences of providing continuity of midwifery care enabled me to identify areas in the knowledge which required further research and justified the development of my research study (Aveyard et al. 2016). When I commenced my research programme, a systematic review of the same topic was registered on PROSPERO, a database of systematic review protocols. I recognised that there was limited value in replicating this systematic review but maintained a systematic approach to literature searching to ensure that all relevant literature was identified to inform the development of my research. I critically engaged with the literature to consider the strengths and weaknesses of each approach and how this may affect the quality of the research, recording this on a database to log my reading. I did not apply formal qualitative appraisal tools to the literature. These tools may provide an assessment guide for novice researchers but can be restrictive and grounded in a more positivist stance (Williams et al. 2020). This was appropriate because the aim of the literature review was to provide a comprehensive basis of knowledge on the topic from which to develop an original piece of research, so I reflected

on the relevance and transferability of findings to the context of my own literature review.

The publication of full systematic review by Pace et al. (2021) served to validate my own understanding and critique of the literature and encouraged my own critical reflection. The review by Pace (2021) chose to include research papers which examined the experiences of British independent midwives. Whilst the experiences of this group are valuable in terms of their experiences of working in continuity of care, I had chosen not to include this group as the participants in my planned research within the NHS would have faced very different structural and organisational challenges. Later in my research journey, I reflected that the inclusion of international research where midwives provide care in differing healthcare systems within my own literature review, may have had similar limitations to transferability to inform the development of NHS practices as the inclusion of British independent midwives. Nevertheless, the reported themes of the participant experiences in Pace's systematic review (2021) were similar to those identified by my own literature review and this added rigour and credibility to my conclusions.

2.2 Initial literature search method:

I developed a clear research question to clarify the what I sought in my literature search (Aveyard et al. 2016). Using the PICO acronym, I broke my topic into key concepts to formulate a clear question. The PICO acronym has been demonstrated to provide a comprehensive search tool in qualitative research (Methley et al. 2014).

P Population	Midwives
I Interest	Midwife experiences
C Context	Continuity of care models
O Outcome	Attributes of sustainable continuity of care

Table 2 PICO Acronym

In order to ensure the full scope of literature was identified, I considered the most appropriate search methods. Six electronic databases were selected because they were most likely to contain research which would answer the research question. These were The Cochrane Library, MIDIRS, Intermid, Pubmed, CINAHL, and British Library EThOS. Further hand searching of reference lists was employed to ensure that relevant literature was not missed. Online literature searching was repeated periodically to ensure emerging relevant literature was identified and I signed up for email alerts for my search terms on the databases. I also found that social media, particularly Twitter, was a rich place to identify relevant newly published literature in this rapidly developing field. Additional online searches using online search engines, my own professional knowledge of the field and that of my professional network, identified non-academic sources such as government reports, reports from non-governmental organisations such as World Health Organisation, publications from professional bodies such as the Royal College of Midwives, and grey-literature in the form of blogs, websites and non-academic articles. Whilst non-academic work can be seen to offer limited

value due to lack of peer-review, it remains an illuminating source of background information in a field which is contemporaneous and developing at a fast rate (Kousha et al. 2022).

I drew on my own knowledge of the subject to consider initial search terms and alternative words for these. I trialled various search terms in electronic database searches but found some had limited relevance in retrieving relevant results or were too restrictive. I utilised Boolean operators and truncation to specify the relevance of results. The search terms used were “continuity of care*” AND midwi*, “caseload*” AND midwi*, “relational care*” OR “relational continuity” and midwi* and “group practice” AND midwi*.

I considered inclusion/exclusion criteria for the initial literature search. I chose to include studies from 1992 onwards because prior to this the socio-political culture of maternity care was very different in the UK. In 1993, The report known as ‘Changing Childbirth’ was published which first pushed the agenda of continuity of care and women’s choice (Expert Matenity Group 1993; McIntosh and Hunter 2014). The world, society and maternity care has developed significantly since 1993 and the experiences of midwives in such different environments may have limited transferability to the present-day world of increased technology and cultural shifts in expectations of work and gender. Additional criteria were that publications should be in English, and the geographical location must have a similarly developed healthcare system to the UK. To do this I reviewed published research by leaders in the field and was guided by their insight (Sandall et al. 2016; Homer et al. 2019). I identified literature from the following countries which had comparable healthcare systems and where midwives were recognised as an autonomous professional group: Australia, New Zealand, Denmark and Canada.

3.0 Background context of midwifery continuity of care

This chapter provides a background and context to continuity of care within midwifery, including the drivers behind the implementation of this model and the potential benefits to childbearing women. My journey from a doctoral pathway presented a wide immersion into the literature and as such, this is reflected in the structure of this chapter. A concise review of published literature in section 3.5 will explore the experiences of midwives who work in continuity of care models.

3.1 Defining continuity of care

At this point it is important to reach a definition of what continuity of care refers to. McCourt et al. (2006) develop Saultz's (2003) seminal model of continuity in the context of maternity care. This table is included below. By defining continuity as a hierarchical concept where each level of continuity is dependent on the existence of the level preceding it, the complex systematic and organisational structures underpinning the existence of continuity can be understood.

Level of Continuity	Description
Informational	An organised collection of medical and social information about each woman is readily available to any health care professional caring for her. A systematic process also allows accessing and communicating about this information among those involved in the care.
Longitudinal	In addition to informational continuity each woman has a 'place' where she receives most care, which allows the care to occur in an accessible and familiar environment from an organised team of providers. This team assumes responsibility for coordinating the quality of care including preventive services.
Interpersonal	In addition to longitudinal continuity, an ongoing relationship exists between each woman and midwife. The woman knows the midwife by name and has come to trust the midwife on a personal basis. The woman uses this personal midwife for basic midwifery care and depends on the midwife to assume personal responsibility for her overall care. When the personal midwife is not available, cover arrangements assure that longitudinal continuity occurs.

Table 3: Hierarchical definition of continuity of maternity care, from (McCourt et al., (2006) adapted from Saultz, (2003), p.141)

The terms 'continuity of care' and 'continuity of carer' are often used interchangeably; however they refer to two different concepts (Forster et al. 2011). The term 'continuity of care' describes a shared philosophy or approach to care between care providers. This may mean that differing care providers follow the same guidelines or treatment protocols but does not describe any continued relationship between the care provider and woman. In contrast, 'continuity of carer' refers to relational continuity where maternity care is provided by a midwife who is known to the woman (Pace et al. 2021). Whilst the terms are used interchangeably in published literature, it is clear that the current emphasis on continuity of midwifery care refers to improving relational continuity (NHS England 2016). The

definition of continuity of care in this thesis will refer to the agreed international definition:

"A [continuity] model provides women with care from the same midwife or small team of midwives during pregnancy, birth, and the postnatal period with appropriate involvement of the multidisciplinary team when needed" (International Confederation of Midwives 2021, p.1).

This implies continuity occurs in a system which has successful informational and longitudinal continuity in order to achieve continuity of carer.

3.2 Evidence for continuity of care

A Cochrane review comparing midwifery led continuity of care models versus standard care included over 17,000 women in 15 randomised trials and identified that continuity of care was associated with a range of improved clinical outcomes (Sandall et al. 2016). Women with straightforward pregnancies and women with complex pregnancies were less likely to have a premature baby and their babies had a reduced risk of death (including miscarriage, stillbirth, and neonatal death) (Sandall et al. 2016). Women who received continuity of care were more likely to have a spontaneous vaginal birth uncomplicated by use of an epidural, episiotomy, artificial rupture of membranes or instrumental birth such as use of forceps (Sandall et al. 2016). For women at greater risk of poor health outcomes, such as women from minority ethnic groups or who are considered vulnerable (for example though a history of poor mental health), these improved outcomes are even further marked (NHS England 2017). An updated integrative review focusing on women classified as high risk reaffirmed these findings in this group and noted a reduced elective caesarean rate among those who received continuity of care (Fox et al. 2022). Walters et al. (2019) identified a reduced risk of postnatal depression and increased rates of breastfeeding in women who received continuity of care.

Research on these clinical outcomes is important, because interventions such as epidural and caesarean section are associated with uncommon but real risks to the health of the mother and baby (Shaw et al. 2016; Sandall et al. 2018). These interventions can be lifesaving and for some individuals are associated with positive experiences, however they can also pose iatrogenic harm to mother and baby which must be carefully balanced. Furthermore, long-term effects of common birth interventions on a population level may not yet be recognised: emergent knowledge on phenomena such as antibiotic resistance and the human microbiome is developing fast and may become an important factor in decision making (Sandall et al. 2018).

Whilst the mechanisms of the improved clinical outcomes associated with receiving continuity of care are not entirely understood, it is recognised that this is likely associated with relational continuity (International Confederation of Midwives 2021). Women cared for in a relational model of care report that they value the strong relationship with their midwife and increased feelings of trust and empowerment (Perriman et al. 2018). Provision of maternity care which supports trusting relationships between a woman and her care providers has been shown to provide enhanced levels of maternal satisfaction with their maternity care experience (Waldenström et al. 2000; Biró et al. 2003; Forster et al. 2016). There is strong demand from pregnant women to be cared for by a known maternity provider (McLachlan et al. 2019). A woman's experiences during her childbearing journey can have a profound and long-lasting effect on their own wellbeing and that of their children (Redshaw et al. 2019).

Continuity of midwifery care has been found to cost less than other models of care (Sandall et al. 2016). A study by Toohill et al. (2012) compared the outcomes and costs of care in an Australian Midwifery Group Practice offering continuity of care versus standard care for women at low risk of pregnancy complications. It was clearly demonstrated that the costs associated with receiving continuity of care were lower than standard care, despite receiving postnatal care for six weeks after the birth compared to a

standard one week. The measurement of financial costs of caring is not straightforward, with many factors bearing an influence on the treatment cost throughout one maternity period. Donnellan-Fernandez et al. (2018) highlight the inconsistencies in measuring cost-effectiveness and evaluating care costs for women with complex pregnancies, who may require more expensive or multifactorial treatments than a woman with a straightforward pregnancy. An Australian study which included mixed-risk participants forecast that continuity of midwifery care cost around 22% less than other models of care (Callander et al. 2021).

The cost savings associated with continuity of care can be generated from reduced intervention rates. Toohill et al (2012) noted that the most significant savings were found in intrapartum costs, where women receiving continuity of care experienced fewer inductions and had a reduced uptake of pharmaceutical pain relief. Continuity of care was found to be associated with earlier discharge home, resulting in reduced ward bed occupancy charges. Babies born to women receiving standard care were more likely to be admitted into special care, which is a high-cost specialist area (Toohill et al. 2012).

Continuity of care is associated with increased uptake and duration of breastfeeding (Walters et al. 2019). Although not directly reported in studies of cost-effectiveness of continuity of care, this can result in substantial cost reduction for a health service as babies are less likely to require medical care in infancy for problems such as ear infections or diarrhoea; and in later life due to a reduced risk of diabetes and obesity (Walters et al. 2019). Increased breastfeeding also results in a reduced risk of some long term health conditions for a mother, which may offer longer-term cost savings (Walters et al. 2019)

Whilst measuring the multifactorial influences on cost effectiveness of continuity of care is complex, it can be concluded that offering all women continuity of care would result in substantial savings when compared to

the other models offered, whilst providing better outcomes and at least equivalent satisfaction (Sandall et al. 2016).

International guidelines recommend that midwifery led maternity care which support a woman to develop a relationship with a known midwife or small group of midwives should be offered to all women (World Health Organization 2016). Other well-resourced countries such as New Zealand and Australia have well developed systems of maternity care which offer varying degrees of midwifery continuity of carer (Tyler et al. 2019). In the UK, continuity of care has been a focus of maternity policy since the 1990s. The report 'Changing Childbirth' released in 1993 supported the development of continuity of care schemes within the NHS (Expert Matenity Group 1993). More recently in 2016 the 'Better Births' report (NHS England 2016) explicitly recommended that continuity of maternity care was implemented across England. Prior to the release of the Better Births report, few women were receiving full continuity of care throughout the childbirth continuum (Sandall et al. 2019). Women who receive standard NHS maternity care women may meet a number of midwives in their antenatal and postnatal care and are very unlikely to have previously met the midwife who cares for them in labour (Sandall et al. 2019). Most NHS maternity care providers require significant organisational alterations to service structures in order to successfully offer this model to a greater proportion of pregnant women (McInnes et al. 2018).

3.3 Models of continuity

Maternity services which aim to offer relational continuity of care are built around the needs of the woman (Pace et al. 2021) and are congruent with the fundamental philosophy of midwifery (Page and McCandlish 2006). This is a juxtaposition to the industrialised world in which we live, where time can be split clearly into chunks of work or leisure. In an industrialised healthcare system, workload can be planned by employing staff to be present on shift at set times. Efficiency and cost efficacy can be clearly measured against set parameters. Maternity care can be reduced to

discreet modules, provided by differing staff in locations which are most efficient for the care provider (Page and McCandlish 2006). The organisational structures in which such care is provided (such as shift handover times) establish a border between the personal and the professional life of the midwife (Pace et al. 2021).

In order to provide relational continuity of midwifery care, the care must be arranged around the needs of the woman (Pace et al. 2021). The organisation of most models of continuity of midwifery care requires that a midwife is available to care for the women at times which can be unpredictable such as the onset of labour. In order to achieve this, midwives may blur the boundary between their home and work life, being on call for the women they care for (NHS England 2017).

There are many ways of structuring maternity care which can offer relational continuity of midwifery care. In countries such as New Zealand, where midwives are able to design the care model they offer to meet their own needs and those of the women they care for, wide variations in working practices and structures can be observed (Donald 2012). Midwifery care may be provided by an individual midwife who is available at all times for the women. Some midwives may ringfence time where they are not available for unscheduled care by carefully planning the expected birth dates of the women they care for. Midwives may develop partnerships with one another, larger group practices where care is shared and time off more structured.

Midwifery care in the NHS is provided as part of an industrialised healthcare system incorporating maternity care. Limitations to funding and constraining policies regarding employment practices, annual leave and financial reimbursement may restrict flexibility and innovation in maternity care provision. Following the national policy advocating the implementation of a system which offered continuity of care, a guidance document recommended organisational structures which could be introduced (NHS England 2017). Whilst this was not entirely directive, the

limitations of being part of a wider organisational system meant that few alternatives were implemented. The models listed in this guidance document are ‘team continuity’ (whereby a woman develops a relationship with a small group of midwives who share responsibility for her care) and ‘full caseloading’ (where a woman is assigned a named midwife who provides the majority of her care, sometimes with back-up from a buddy midwife) (Homer et al. 2019).

Both of these models have been demonstrated to offer improved satisfaction and clinical outcomes (Sandall et al. 2016) and are based upon the tenets of relational continuity whereby the woman develops a therapeutic relationship with the person (or small team of people) who care for her during the perinatal period. Other dimensions of continuity may also be provided in these models: midwives from the same team will work from the same guidelines and thus provide an enhanced level informational continuity. Women have a more seamless experience of care from differing specialities or services coordinated by a named midwife, experiencing enhanced management (longitudinal) continuity (Cheyne et al. 2019).

In a full caseloading model, a midwife takes full responsibility for the maternity care of a caseload of women (NHS England 2017; Homer et al. 2019). A midwife organises their working pattern to suit the needs of the caseload and is available to provide unscheduled care such as intrapartum care at all times. The midwife is personally responsible for rescheduling any appointments, should they be missed, due to unscheduled care. The midwife may have inconsistent protected time when they are not available for work. Caseloading midwives may arrange their work to support a longer period of time off, for example three months of availability followed by a month of annual leave. This model offers great autonomy and flexibility to the midwife and a high level of continuity of care to the woman but has limited appeal to the midwifery population due to the profound impact of full-time professional availability on the midwives personal life (NHS England 2017; Homer et al. 2019).

In a team continuity model, a group of four to eight midwives share responsibility for a caseload of women (NHS England 2017). Each woman has a named lead midwife with whom they build a relationship, but they may also receive maternity care from any of the other team members. The team share the on-call availability for unscheduled care such as labour care and cover one another for annual leave and sickness. In this model the midwives are able to predict their protected time off through use of a rota system but retain an element of flexibility and autonomy in managing their own diary to provide scheduled care to their caseload. This may offer an increased appeal to the midwifery staff but may result in a reduced level of continuity of care compared to full caseloading. (NHS England 2017). Ensuring that women have built a relationship with a larger team of midwives can be a challenge and sometimes midwives may provide care for women they have not previously met.

Whilst the early guidance on implementing continuity of midwifery care (NHS England 2017) offers caseload care as an option, later guidance only recommends continuity is provided via a team of midwives of no fewer than six and no more than eight midwives (NHS England 2021). This concept of relational continuity where instead of a deep interpersonal ‘knowing’ between midwife and mother, a woman develops superficial relationships with multiple midwives on the team, can be considered contentious (Page and McCandlish 2006). The Cochrane review on continuity of midwifery care states that there is continued debate over the models of continuity offered (Sandall et al. 2016). Freeman (2006) considers that only caseloading models (most care provided by a named midwife) are philosophically aligned with the fundamental principles of women-centred midwifery care. Huber and Sandall (2009) considered that this form of relational continuity was most beneficial for women because it reduced the chance of receiving conflicting advice, and increased feelings of trust and calm which they posited was the mechanism behind the improved outcomes. Nonetheless, team-based continuity of midwifery care has been demonstrated to have comparable clinical outcomes to caseload

midwifery (Sandall et al. 2016) and could be less challenging to implement in the NHS as it is more similar to the standard, fragmented care system.

3.4 Contemporary NHS midwifery practice and barriers to change

Standard NHS midwifery care offers regular care with midwives from early pregnancy throughout the childbearing period. This is often provided in a community setting outside of hospital such as GP surgeries and children's centres by autonomous midwives in partnership with obstetric colleagues and other medical specialists. Mothers may have additional appointments for ultrasound scans or medical reviews with other members of the maternity care team. Midwives provide intrapartum care in a variety of settings including a woman's home, birth centres and obstetric labour wards. Mothers and babies who have any medical complexities or who are requiring support can be cared for by midwives on inpatient wards. Further postnatal care of the mother and baby is provided for 10 days to six weeks after the birth and often occurs in the women's home or in outpatient clinics. Midwives work as part of an interdisciplinary team of doctors, radiographers, physiotherapists and maternity support workers / maternity care assistants (Homer et al. 2019).

At present, the majority of NHS midwives work in a shift pattern structure within a community or hospital setting (NHS England 2017). Midwives working in the community generally provide antenatal and postnatal care within core hours and may provide a level of antenatal and postnatal continuity although this rarely covers intrapartum care (Taylor et al. 2019). In the hospital setting, most midwives work shifts providing acute care to women such as labour care. This rarely offers continuity of care to women because it is unlikely that a midwife she has met before is rostered onto a shift when she requires unplanned care such as when she is in labour (NHS England 2017).

Furthermore, many nursing and midwifery staff do not work full time, which may further reduce the chance of continuity in this setting. The most recently published NHS midwifery workforce statistics showed that part-

time midwives made up 57% of the midwifery workforce (Department of Health 2010) and an increasing trend of part-time working was recognised in a 2019 report (Health Education England 2019a). In 2014, 27% of midwives who responded to an RCM survey were employed to work fewer than 30 hours per week and many respondents reported that they struggled to achieve the flexibility regarding shifts which they required. This may lead to midwives working bank or agency shifts which could further reduce continuity as midwives may work shifts in different areas or NHS Trusts (The Royal College of Midwives 2016a).

The 2018 NHS England Staff Survey highlighted that midwives report among the highest levels of stress of any health care profession (The Royal College of Midwives 2019). A 2018 online survey of 2000 midwives working in a variety of settings in the UK revealed significant levels of emotional distress among the participants, with 83% of respondents suffering from personal burnout and 67% experiencing work related burnout (Hunter et al. 2017). Participants were substantially more likely than the general population to score highly for stress, depression and anxiety. In the same study, 66% of the midwives surveyed had seriously considered leaving midwifery in the last year.

The increased pressures of working through the Covid-19 pandemic have not improved this picture with maternity services reporting increases in attrition rates of midwifery staff (Health and Social Care Select Committee 2022) which is resulting in an unsustainable level of pressure in maternity services (Ockenden 2022).

One of the greatest barriers to implementing continuity of care models is resistance towards models among the midwifery population (Tyler et al. 2019; Harris et al. 2020). A 2019 survey of 798 NHS midwives, most of whom did not have experience of continuity models, found that 65% of respondents felt that they would be unable or unwilling to work in a continuity of care model which included cover for intrapartum care in the hospital setting (Taylor et al.). A further 19% of participants reported

willingness to work in a continuity model which had a reduced or no cover for intrapartum care. Many midwives report that they feel uncomfortable or nervous working outside of the environment in which they usually worked and that felt they had specialised skills suited to an area of maternity care (Taylor et al. 2019; Harris et al. 2020). Some midwives shared concerns regarding quality of care when midwives are asked to become “a jack of all trades” (Taylor et al. 2019, p.133).

Midwives in the literature highlight concerns that working in a model providing continuity of care could have negative influences on their wellbeing (Taylor et al. 2019; Harris et al. 2020). Midwives may have previous negative experience or knowledge of NHS continuity of care models implemented in the past, where midwives were reported to experience increased levels of burnout and emotional exhaustion (Sandall 1997; Stevens and McCourt 2002). Midwives may have little confidence in their employer to learn from research on previous unsustainable models and protect their wellbeing (Harris et al. 2020): just 15% of midwives in the NHS Staff Survey felt that their employer was taking positive action to look after their health and wellbeing (The Royal College of Midwives 2019). Taylor et al. (2019) affirm that a population of midwives experiencing high levels of work-related stress and low levels of confidence that their employing organisation will support their ongoing wellbeing, may be less willing to try working in a new continuity of care model. An increasing levels of vacancies in the midwifery workforce (Health and Social Care Select Committee 2022) is associated with higher levels of emotional exhaustion and stress within the workforce (Hunter et al. 2017).

Another widely shared barrier to implementing continuity were practical challenges such as caring responsibilities, which were reported by 65% of respondents to Taylor et al.’s survey (2019). Many midwives are primary carers and report a need for regular and predictable hours to fit around often inflexible childcare and care providers (Taylor et al. 2019; Harris et al. 2020). Other midwives discussed their own health conditions or transport issues which impacted on their ability to work unpredictable

hours. Some of these barriers are not permanent and some midwives expressed that they may be willing to try working in a continuity of care model if they experienced a change in personal circumstances (Taylor et al. 2019).

3.5 Midwives' experiences of working in a continuity model: A review of the existing literature

My literature search identified relevant publications for my literature review. I then began synthesising the themes by comparing the findings of each piece of literature, a process which evolved over time. Additional literature was published during the research process and the findings of these papers were considered. The final themes were 'real midwifery', 'meaningful relationships', 'flexibility', 'boundaries and expectations' and 'wider integration'.

The literature reports that working in continuity of midwifery care is associated with positive experiences for midwives. Midwives reported pride in working within the full scope of their professional role and fulfilment from the strong relationships with the women they cared for and with their midwifery colleagues.

"*As far as the actual working as a midwife, it's probably the most rewarding thing I've done. I've been a midwife for twenty-five years…[it's] because of the relationship you build up with the women*". Quote from Ange, Interview 2 in Newton et. al (2016, p.228).

The literature which compared the emotional wellbeing of midwives working in continuity of care to those in standard care demonstrated reduced levels of burnout and increased levels of satisfaction (Dawson et al. 2018b; Fenwick et al. 2018).

"*While there is potential for burnout in working in a caseload model of care, there also appears to be protective factors within the model in the*

perceived benefits that the work brings" Quote from Dawson et al. (2018b, p.66)

The literature also contained some negative experiences of working in a continuity model. Some of these were related to the difficulties of working in a model which was outside of the norm, leading to tensions between standard care colleagues and continuity midwives:

"*It was just the most bizarre thing. On Friday I was a birth suite midwife. On the Monday I was an MGP [Midwifery Group Practice] midwife. I had attended a birth and I was treated completely differently, and nothing had changed about how I practiced*." Quote from Menke et al. (2014, p.1100).

Other challenges were associated with an adjustment period to the way of working. Some midwives successfully integrated their continuity role into their lives, but for other this was just not possible:

"*…parts of it were fantastic, and parts of it were awful……there were bonuses, because the majority of the time I was home, which was quite a nice novelty, but I thought I would be able to get a better body clock. I thought I'd be able to go to bed at the same sort of time and get up at the same sort of time compared to [what was possible with] shift work ….so the on-call was really the thing that did me in…I sort of had six months of not sleeping, just having the phone with me - every time [thinking] 'go to sleep, go to sleep – because it's going to ring any second! Now go to sleep'…. I was so distracted because I was on-call so I just didn't feel like I could wind down."* Quote from Newton et al. (2016, p.227).

3.5.1 Real Midwifery

Midwives working in continuity of care in the literature highlight a vocational connection to their midwifery identity and role, and this pride sustains them in their practice (Engel 2003; McAra-Couper et al. 2014; Newton et al. 2016). Midwives who work in continuity models report great satisfaction in providing 'real midwifery care' across their full scope of

professional practice (McCourt et al. 2006; Edmondson and Walker 2014; Newton et al. 2016; Jepsen et al. 2017; Barker et al. 2020). They take pride in assuming full responsibility for the care of their caseload (Finlay and Sandall 2009; Newton et al. 2016; Jepsen et al. 2017).

"The MGP [Midwifery Group Practice] for me then, was the opportunity to live the dream. To be that midwife and to be able to provide that degree and level of care." Quote from Barker et al. (2020, p.148).

Several studies have identified that the advocacy role of a midwife may be enhanced through working in a continuity model of care (Finlay and Sandall 2009; Boyle et al. 2016). Midwives in a study by Newton et al. (2016) reported an increased ability to facilitate informed decision making with the women in their caseload, compared to when how they worked in standard care.

The professional role of the midwife in a continuity of care model may be developed to demonstrate greater autonomy and establish deeper and more meaningful relationships with the women in their care (Finlay and Sandall 2009; Newton et al. 2016):

"*I'm looking at … first time mums that maybe need a lot more support … mums without good English language or use of the community … mums with anything that's identified as a known difficulty, particularly difficult social circumstances … because again you've got a constant, you can start beginning to trust a constant, you build up a relationship with the constant, it's much easier to say things quicker, you haven't got to start from scratch every time, and in some way you begin to feel someone's rooting for you"* Quote from Finlay and Sandall (2009, p.1232)

3.5.2 Meaningful relationships

The development of meaningful midwife-client relationships contribute to feelings of value and purpose within the midwifery role. Participants described these relationships in a different way to the relationship in

standard care. Mutual relationships were formed and midwives felt that the women they cared for recognised them as distinct individuals as well as their midwife role: “They are very attentive to my needs, too. A much greater recognition…that I am also a human being” (Jepsen et al. 2017, p.e66). McAra-Coupa et al. (2014, p.31) terms this “reciprocal relationship” and McCourt et al. (2006, p.148) term this “partnership”. Menke (2014, p.1099) describes this relationship as a “dependable friendship”. Continuity midwives reported a holistic understanding of the woman and her world which was a source of great fulfilment (Engel 2003; McCourt et al. 2006; Edmondson and Walker 2014; Newton et al. 2016; Jepsen et al. 2017). Midwives reflected that their relationship and knowledge of the mother allowed them to offer optimum intrapartum support and reduced their own anxiety (Huber and Sandall 2009). Empowering women in their own knowledge, judgement and capabilities was a key feature of the relationship (Engel 2003; Menke et al. 2014). Midwives in the study by Menke et al. (2014) recognised that their impact on a mother’s life could continue after discharge with the journey through caseload care a potentially transformative one.

For midwives who work in a team continuity model, strong working relationships within continuity of care team and the wider health care setting are considered essential (Gilkison et al. 2015; Hunter et al. 2016; Vasilevski et al. 2020). Midwives working in successful team continuity models provide emotional and practical support to one another which supports the wellbeing of the team members (Yoshida and Sandall 2013). Fereday and Oster (2010, p.314) identify this as the concept of providing “reciprocal assistance” to one another and Hunter et al. (2016, p.51) term this “generosity of spirit”. Open and truthful dialogue between team members and clarity regarding mutual expectations are considered essential to support sustainable team working in a continuity model (Fereday and Oster 2010; Edmondson and Walker 2014; Vasilevski et al. 2020). Constructive discussions between colleagues can support midwives to establish appropriate boundaries between their work and

personal life, to maintain professional distance and to reflect on their practice (Hunter et al. 2016).

In team midwifery models, midwives placed an importance on shared values which meant that they were able to trust that their colleagues shared a similar philosophy of care (Engel 2003; Edmondson and Walker 2014; Gilkison et al. 2015; Crowther et al. 2019):

"…this is the best place for me to have been working because we're all of the same…well we've all got the same philosophy, philosophy of midwifery care…" Quote from Edmonson and Walker (2014, p.35).

For the midwives, knowing that women in their care were receiving informational continuity was an important element which allowed them to trust that their colleagues would provide a similar standard of care.

3.5.3 Flexibility

Midwives in a continuity of care model are available for unscheduled care, often through 'on call' systems. The concept of being on call is one of the greatest concerns highlighted by midwives who are not yet working in continuity of care models (Taylor et al. 2019; Harris et al. 2020). In the literature, after an initial transition period, most midwives working in a continuity of care model become comfortable with being available to work (Collins et al. 2010; Fereday and Oster 2010; Donald 2012) and adapt to a lifestyle which promotes a greater fluidity between work and home life (Fereday and Oster 2010): "It's not a clock on, clock off job... It's very much a lifestyle…" (Hewitt et al. 2022, p.175). Others reported that they lived in a state of "constant anticipation" (Fereday and Oster 2010, p.315) and were unable to integrate their work and home lives satisfactorily.

In the literature, midwives who successfully integrated the role into their lives valued the autonomy to schedule their work in a way to suit their personal lives and report that they feel more able to balance personal and family life, many highlighting that they felt more present in their personal

and family life than when they worked in a shift based model, because they are able to adapt their working schedule to allow for their attendance (Fereday and Oster 2010; Edmondson and Walker 2014; Newton et al. 2016; Jepsen et al. 2017; Vasilevski et al. 2020). Compared to working standard shifts, midwives in Newton's (2016) study reported that they worked fewer unsocial hours. This is well illustrated in a participant quote:

"I've had a few snide comments. I've had a midwife tell one of my women on the postnatal floor …. "Oh so did you enjoy having your midwife and her being available and all that sort of stuff" and the woman said "Yes, yes it was great" and then she said "Oh well I don't do it because I actually like my children". I'm thinking "Well I have dinner with my kids every night, you don't!" You know, I'm home a lot more … but yes there's been a few comments like that... But they don't understand, I don't think they understand how good it is." Quote from Newton et al. (2016, p.227).

Organisational support for autonomous time management is associated with sustainable continuity models which increase the wellbeing of the midwives working within then (McAra-Couper et al. 2014; Jepsen et al. 2017; Lewis 2020). Reduced levels of control of working pattern has been associated with an increased level of stress and risk of burnout (Homer et al. 2019). This may happen due to working in the associated maternity unit in times of high acuity escalation or poor cover within the team for holidays and sickness (Newton et al. 2016; Homer et al. 2019; Styles et al. 2020). It can be a challenge for midwifery leaders to promote an organisational culture which respects this well-documented need for autonomy. It can also be difficult for managers and staff more used to working in conventional shift patterns (Hewitt et al. 2019; Hewitt et al. 2021)

3.5.4 Boundaries and expectations

Midwives moving into a continuity model from standard care may not initially develop adequate boundaries and are often found to invest unsustainably in the midwife-mother relationship (Edmondson and Walker 2014). Findings by Menke (2014), Stevens and McCourt (2002) and Engel

(2003) suggest some midwives continue to struggle with levels of emotional involvement with women in their care. Menke refers to midwives becoming ‘emotionally enmeshed’ with the women they care for (Menke et al. 2014). Allen (2017) identifies that providing care in a continuity model may breach the emotional capacity of a midwife, and that pushing past this boundary may be damaging to the midwife. Leinweber and Rowe (2010, p.78) describe this as “the cost of caring” and suggest that continuity midwives may be at increased risk of secondary post-traumatic stress disorder.

Midwives discussed the importance of managing the expectations of the women they cared for (Fereday and Oster 2010; Donald 2012; Edmondson and Walker 2014; McAra-Couper et al. 2014; Gilkison et al. 2015). Midwives needed to provide clarity about their working practices and availability with women, their colleagues and themselves to manage their work-life balance. Some midwives experienced feelings of guilt (Hunter et al. 2016) when they were unable to meet a woman’s expectations, for instance when a colleague attended a birth because they were not available. Stevens and McCourt (2002) note that presence at a birth was perceived to be more significant for the midwife than the woman.

3.5.5 Wider integration

Midwives identified that establishing clear expectations around their role within the wider midwifery service was beneficial in maintaining professional and personal boundaries. The development of a clear structure for care provision supported sustainable midwifery care and improved work-life balance (Engel 2003; Fereday and Oster 2010; Donald 2012; Edmondson and Walker 2014; McAra-Couper et al. 2014; Gilkison et al. 2015; Newton et al. 2016). When expectations of the midwives within the continuity of care service were clear, this led to reduced conflict with the wider team (Menke et al. 2014; Newton et al. 2016; Leavy and Leggett 2022). When the role of the continuity midwife was well understood and well-integrated into the wider maternity system, midwives reported that

they felt respected and valued in their role (Stevens and McCourt 2002; Edmondson and Walker 2014; Hewitt et al. 2022). Conversely, conflict with the wider maternity care staff was identified as a source of distress for some midwives, particularly during the early implementation stages of a continuity of care model (Yoshida and Sandall 2013; Menke et al. 2014; Styles et al. 2020).

3.6 Conclusion

The literature reflects a range of experiences of providing continuity of midwifery care from elation and joy within the role to challenging lows where midwives' personal lives suffer, and their boundaries are depleted. A qualitative systematic review of the topic undertaken by Pace et al. (2021) reported similar themes to those identified in my review. This systematic review included the experiences of some participant groups which I had excluded, such as those of independent midwives (private practice midwives) in the UK. I was concerned that the very small number of independent midwives working in the UK may reflect a poor integration into the NHS system, and that their experiences of providing continuity of care may be significantly altered as they experience working outside of the dominant system and the additional demands of running a business.

Business management and financial pressures were present in the literature from some midwives, particularly in research from New Zealand. Pace (2021, p.e225) reports these under the theme "counting the personal costs" and reflects that although this was present primarily for self-employed midwives, some employed midwives working in continuity of care services also reported poor remuneration and working excessive hours.

Whilst the reported experiences of the midwives have been documented under themed headings, they are interconnected and must be viewed in a holistic context, interwoven throughout the life of the participants. Providing care in a relational continuity model reflects the human experience of interconnectedness and living in community. Many of the

participants adopted a lifestyle which supported them to fluidly move between their midwife and home roles, the midwives supported by their friends and family, supporting other midwives, to support women and families. Negative experiences were present in all of the reported literature. Additional research into some of these challenges may encourage continuity of care services to become more sustainable for the midwives working in them. It may be that for some midwives, such as those with personal health issues or with minimal support for childcare, these challenges are insurmountable and innovative ways of working which increase relational continuity but offer midwives more predictable working hours may be a solution.

4.0 Methodology

This chapter explores the methodological choices I made in the process of developing two research studies during my postgraduate research programme. As a novice researcher, my knowledge of research methodology and theory was limited, and this was something I recognised and prioritised in my learning. I undertook training and wide background reading in order to deepen my understanding of qualitative methodologies in general and more specifically the theoretical and philosophical underpinnings of Participatory Action Research, which was the methodology specified in the initial studentship research proposal. Following the disbanding of the continuity of care team within the NHS organisation who match-funded the studentship, the study was refocused, and the methodology was no longer the most appropriate approach. I had gained a deep understanding of my own epistemological stance and thus I was able to consider alternative methodological approaches which would be most appropriate for the refocused topic because they embodied my philosophical perspective (Crotty 1998; Creswell 2018).

4.1 Philosophical worldview of the researcher

A methodology can be seen as the underpinning which ensures that research makes sense and generates valid knowledge (Silverman 2022). Details about the methodological choices made during the development of a piece of research may not be explicitly written in publications, but the assumptions inherent in the design will directly influence the manner in which research is undertaken, analysed and the findings. In qualitative researcher, the researcher is recognised as the key research ‘tool’ (Creswell 2018). For this reason, it is vital to be clear on one’s own philosophical worldview to justify the design of the research (Creswell 2018). Crotty (1998) highlights the importance of clear distinction between the elements which combine to build the ‘philosophical worldview’ of the researcher. Whilst these elements can be discussed in isolation, in

practice they are intertwined and decisions made in one area will influence the other (King et al. 2018).

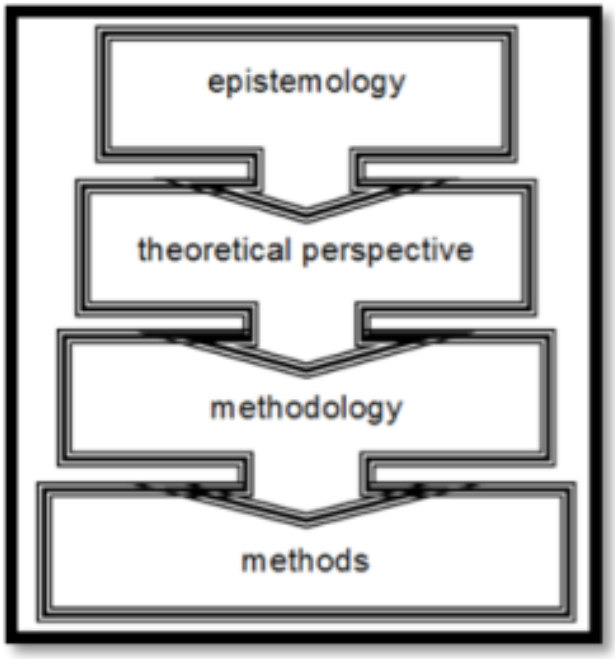


Fig 4. From Crotty (1998), The four elements of research.

Epistemology is an understanding of how knowledge is constructed (Crotty 1998). As a researcher, it is important that I identify, explain, and justify my epistemological stance so that I am able to theoretically contextualise research and justify the methodological decisions I made (Crotty 1998). The epistemology is embedded in the theoretical perspective or philosophical viewpoint of the researcher. This theoretical perspective grounds the assumptions made about the world and can be embodied in various methodologies (Crotty 1998). Methodology refers to a process or design which can inform the methods used to collect and interpret the data (Crotty 1998; Silverman 2022).

The contemporary western society I have been exposed to is founded on post-modernist thinking which has informed my understanding of reality and the nature of knowledge. Inherently as a midwife, I understood that each individual has their own lens in which they interpret the world and from this build their own context-bound reality. I resonated with the

perspective that the world and objects within it exist in a meaningless state until meaning is constructed though human interaction. Knowledge is constructed in the interaction between a human and their world. It was clear to me that when studying participants' experiences of a phenomenon, there could be no one measurable and external truth. Reality only exists for one person, thus multiple realities exist simultaneously within any situation, the reality of one single person holding no power over another.

As a novice researcher I recognise that I have limitations in understanding of complex epistemological and ontological arguments. I noticed that by deciding on a name or a label to communicate my research methodology could limit or box in the stance. A purist approach may not have been the best way to gain understanding of the midwives' experiences and analyse this. Crotty (1998) asserts that each piece of research should have a unique methodology, appropriate to the unique context and topic. I am aware that without naming a methodological world view, it can be harder to succinctly communicate with my academic examiners and in research outputs. Tensions exist between the flexible interpretation of methodological approaches and an inconsistent application of methodology common among novice researchers which could damage the integrity of the research and lead to 'method slurring' (Holloway and Galvin 2017). I aim to describe methodology using terminology as it is widely understood.

My epistemological lens most resonated with a social constructivist viewpoint which means that individuals construct their reality through social interaction and language. The theoretical perspective which is associated with this in an interpretivist lens. This was further developed when exploring the ideas of Habermas and Freire, who critically developed this viewpoint to reflect that research ought to be intertwined with politics and a political change agenda to confront social oppression at whatever level it occurs around social critical and transformational approaches.

4.2 Participatory Action Research

The initial design for the studentship research used a methodology of Participatory Action Research (PAR) to explore the experiences of midwives working in an established continuity of care team. PAR was developed by Kurt Lewin in the 1940s and focuses on encouraging a group of people to critically examine their social environment in the belief that this will prompt collective action (McIntyre 2008). This can be seen as building on philosophical ideas by Foucault and Freire that a group can deconstruct oppressive power of the dominant classes by examining and identifying (McIntyre 2008). This can occur because knowledge and power are dependent upon one another, those holding the power also creating and owning knowledge, and those who hold knowledge having power (Corbett et al. 2007). There are many interpretations of PAR and practitioners may hold differing epistemological, methodological or ideological assumptions (McIntyre 2008).

A PAR study is inherently context specific, and the design of an action research study should be responsive to the environment of the group or community participating in the research (McIntyre 2008). Whilst there is a strong history of employing a PAR methodology in research engaging with underprivileged, marginalised or oppressed communities, PAR has also been successfully developed in business management and organisational change programmes (Tiffany 2006). The unifying feature of PAR studies is that the research goes beyond critical analysis and theoretical knowledge generation, and goes on to create change in the environment or community (Stringer 2007). PAR has transformative potential because it asks how we can improve a situation whilst trying to understand it (Donnelly and Morton 2019). This outcome focused approach may challenge conventional academic belief on the creation and sharing of knowledge (Reason and Bradbury 2001). PAR differs from other forms of action research because it places an emphasis on redistribution of social powers and equity of resources and holds a commitment to recognising participants as experts by experience, engaging them as co-researchers

who share a commitment to the outcomes of the research (Corbett et al. 2007; McIntyre 2008).

In PAR, change is facilitated using an iterative cyclical process of engagement, collaboration, reflection and evaluation (Corbett et al. 2007). In the research I initially designed, this cycle would begin by engaging my fellow midwives in the continuity team as co-researchers to undertake research collaboratively into our own experiences and implement changes to benefit the group's personal and professional life. The group would come together to reflect on their experiences and consider where improvements could be made. Co-researchers would collaboratively decide on a plan of action to implement, and later reflect on the effects of these actions and the implementation process. Further changes and adjustments would be made responsively to the ever-altering landscape of the professional environment. A PAR approach can be a method to readdress top-down organisational change and empower the participants because the changes are owned by the group (Corbett et al. 2007). This was a major advantage of adopting a PAR approach in the context of implementing continuity of care services, where the changes to the midwives working life would significantly affect their lives outside of work: the midwives needed to take ownership of the model and ensure it worked for them to ensure the long-term satisfaction and sustainability of the model. Ensuring that midwives have a sense of ownership of the model in which they work is a factor positively influencing the sustainability of a new way of working (Styles et al. 2020). Staff input into the design of services they work in ensures that the needs of the midwives and the needs of the women they care for are met (McInnes et al. 2018).

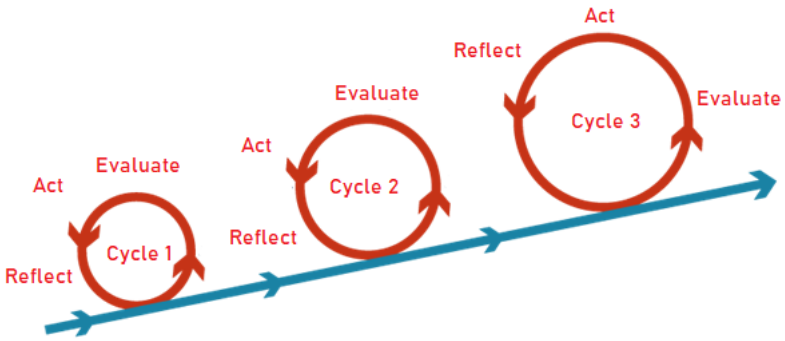


Fig 5. PAR cycle adapted from: Australian Institute of Family Studies (2015)

PAR has been successfully undertaken in a range of healthcare organisations (Donnelly and Morton 2019) and has been noted to have great potential in improving health service delivery in bureaucratic, complex, and change-resistant hierarchical organisations such as the NHS (Corbett et al. 2007). Healthcare culture can be transformed through collective critical reflection on the organisation and policy environment (Donnelly and Morton 2019). Donald (2012) utilised a PAR approach in their New Zealand based research exploring how a group of midwives who worked as Lead Maternity Carers could improve their work-life balance. This research is particularly pertinent as LMC's are midwives working in a continuity of care model in a similar societal structure to the UK (meaning the effects on the midwives' personal life could be experienced in a similar way). Whilst this research noted PAR to be effective in this context, the midwives in Donald's study (2012) were able to implement changes more easily to their working and personal lives than in an NHS context because they work as private self-employed midwives who receive government payment for each woman they care for. It could be more challenging to implement changes which will affect a larger group of midwives, and in the context of a large and bureaucratic organisation like the NHS.

PAR can be undertaken by a researcher external to the community or organisation. Other modes of action research are often undertaken by an

‘outsider’ to the group who may share the identity, values or culture of the group but bring an outsider perspective and insight to the project (Corbett et al. 2007). Often the leader or initiator in an action research study holds a form of power, for example, they may be in a management position within the organisation. PAR as a discreet mode of action research has focused on inclusive research ‘with’ rather than ‘on’ a group who are often disempowered (Corbett et al. 2007). The participatory action researcher is often an insider to the group. Reason and Bradbury (2001) acknowledge that in order to have the knowledge and skill to initiate and facilitate a PAR project, this person inevitably holds a form privilege within the group. In my position, I carried both insider and outsider perspectives: I joined the continuity team specifically to undertake research with them; however, I also worked alongside them whilst developing the research, becoming a team member and sharing in aspects of the experience of providing continuity of midwifery care in the organisation. I continually reflected on my positionality as both a researcher and continuity midwife.

4.3 Implementation Science

I developed the PAR methodology in the original design by underpinning the design with theoretical concepts from the field of Implementation Science. The application of Implementation Science supports the understanding of the multiple levels of influence which factor into the success of sustainable change in an organisation: from a micro level (individual and social factors to adopting change), meso level (local or organisational barriers to adopting change) and macro level (wider culture in which the organisation is situated including governmental and financial influence) (Cheyne et al. 2019; Corrigan et al. 2020). The introduction of continuity of care teams within maternity is a significant alteration of the maternity care system, and implementation science theory could provide a framework through which to understanding the dynamics of this change. I explored, compared and contrasted many published implementation science theories. Some theories such as Barriers Scale (Funk et al. 1995) were too simple for such a complex intervention. Other theories such as

COM-B (Michie et al. 2014)and the Theoretical Domains Framework (Atkins et al. 2017) focussed too heavily on implementing behavioural changes. Normalisation Process Theory (NPT) (May and Finch 2009) is a sociologically derived theoretical framework which seeks to explore how a complex intervention becomes embedded or normalised (or barriers to this occurring) in complex organisations by examining the sociological influences on the people and organisation adopting the change. Forster (2011) first identified that the utilisation of NPT can support enhanced understanding of the complex factors influencing successful implementation of continuity of midwifery care models. A paper by Corrigan et al. (2020) develops the application of NPT further as a useful framework to plan and evaluate midwifery continuity of care schemes in an NHS context.

Within NPT, four components are explored which explain the mechanisms involved in organisational change. These are presented below:

Coherence:	Collective action:
How is a practice understood by participants?	How do participants make it work?
How do they compare it with other practices?	How are their activities organised and structured?
Cognitive participation:	Reflexive monitoring:
How do participants come to take part in a practice?	How do participants evaluate a practice?
What keeps them motivated to continue taking part?	How does this change over time and what are its effects?

Table 4: Four components of NPT From Finch et al. (2018)

These four core components fan into 16 sub-constructs, presented as an 'NPT toolkit'. By examining each of the 16 sub-constructs May asserts that the researcher will have examined the complex factors which influence the uptake of a change within an organisation (May et al. 2015). This framework made sense in terms of examining the multifaceted nature of change associated with exploring the implementation of continuity of core. The founder of NPT authored many publications which supported my understanding of this theory and I felt confident applying the constructs through the accessible NPT toolkit (May et al. 2015).

I recognised that there were some limitations in the strict application of NPT which focused on the implications during the 'working life' but did not fully evaluate the impact of the continuity of care on the participants' lives outside of their work, given the wide-ranging implications of working in continuity model rather than a shift-based model. The methodology

developed by the NPT scholars is flexible in its application (May et al. 2015) and additional elements of other methodologies can be incorporated into the evaluation of a service. Elements from alternative implementation science theories from the Consolidated Framework For Implementation Research (CFIR) (Damschroder et al. 2009) and Diffusion of Innovations in Service Organisations (DISO) (Greenhalgh et al. 2004) were incorporated into a unique framework which developed to support a deeper and more holistic understanding of the experiences of the midwives working in a continuity model. Both CFIR and DISO analyse the needs, motivations and values of the 'adopter' or person who is living the change. This was important, as existing research on continuity of care models report an increase in personal satisfaction in the midwives working within them (Pace et al. 2021). I recognised that this conclusion could be criticised as the 'early adopters' who actively chose to work in new continuity of care teams as an alternative to standard care, could have inherent personality traits associated with feeling comfortable trying new things or which are in line with this model of care. By including the traits and 'psychological antecedents' of the people who are affected by the change, I would understand more about their experiences. The assimilation of DISO meant I also considered the sociological influences associated with adapting to a new change, for instance how social and peer interaction can impact on uptake of a change.

Appendix 7 shows the development of the theoretical framework to support the understanding of implementing continuity of care. NPT (May and Finch 2009) , CFIR (Damschroder et al. 2009), and DISO (Greenhalgh et al. 2004) are compared and ideas from a paper by Corrigan (2020) are included.

4.4 Changing Focus

A PAR methodology was appropriate to the intended outcomes from the initial studentship research project. When the topic of the research was refocused due to changes in the clinical area, I spent time considering how

to refocus the study. I was somewhat restricted in this because I was undertaking a funded studentship with a focus on continuity of care. This was match-funded by an NHS organisation, and I had to ensure that their research interests were satisfied within the research. The original brief would have directly benefitted the organisation through deeper understanding of local needs and a strengthened continuity team. It was important that any refocused study would continue to provide benefit to the NHS funder. Through a process of reflection and discussion with clinical leaders in the organisation, I was able to identify that many midwives were employed on a part-time basis and that this was recognised as a challenge to implementation of continuity of care in the service. My initial literature review had identified a gap in the literature around part-time midwives in continuity of care practice. Senior clinical leaders were engaged in discussion which reinforced the value of this research and illuminated an additional gap in the research knowledge- the perspectives of midwifery leaders in implementing continuity of care. Thus, the focus of the research in understanding the experiences of part-time midwives who worked in continuity of care teams became the focus of the study, with additional aims to explore the perspectives of clinical leaders in supporting part-time midwives to work in practice.

I began to explore alternative qualitative methodologies and considered their potential application in research. Initially I considered a grounded theory approach, which would have been a methodologically flexible approach to generate new theories surrounding this topic. I rediscovered Appreciative Inquiry which had informed a PAR study undertaken with midwives in New Zealand by Donald (2012). Appreciative Inquiry is a strengths-focussed approach which supports transformative organisational change through the co-creation of a shared vision of possibilities (Ludema et al. 2006) and seeks to understand the wholeness of complex human experience. Where traditional deficit focused research approaches may highlight inadequacies, Appreciative Inquiry points to answers about how to implement effective and sustainable change (Stavros et al. 2015). I saw

an opportunity to learn from the existing continuity of care models which had been implemented in the NHS since the Better Births guidance was published in 2016 (NHS England).

In order to meet the aims of providing a local benefit, the COMPart study was initially designed to have two phases. The first would explore the experiences of midwives who had worked in continuity of care models on a part-time basis. Participants would be recruited from across the UK for an individual online semi-structured interview. Through analysis of these interviews, vignettes presenting pertinent experiences would be developed. These vignettes would be used as conversation stimuli in focus groups in Phase 2 of the study. Phase 2 involved a focus group of clinical midwives and a separate focus group of clinical leaders who would have management responsibility for any continuity teams implemented in the NHS Trust. These focus groups were planned to initiate a process of co-design for re-introduction of continuity teams in the NHS Trust, in which the unique requirements of the local context and local staff could be considered. This was consistent with the concept of using Appreciative Inquiry as a form of action research in which research output could be measured in both knowledge gained, and in a tangible action in practice: the co-creation of a pragmatic vision of a continuity of care team in the local NHS Trust.

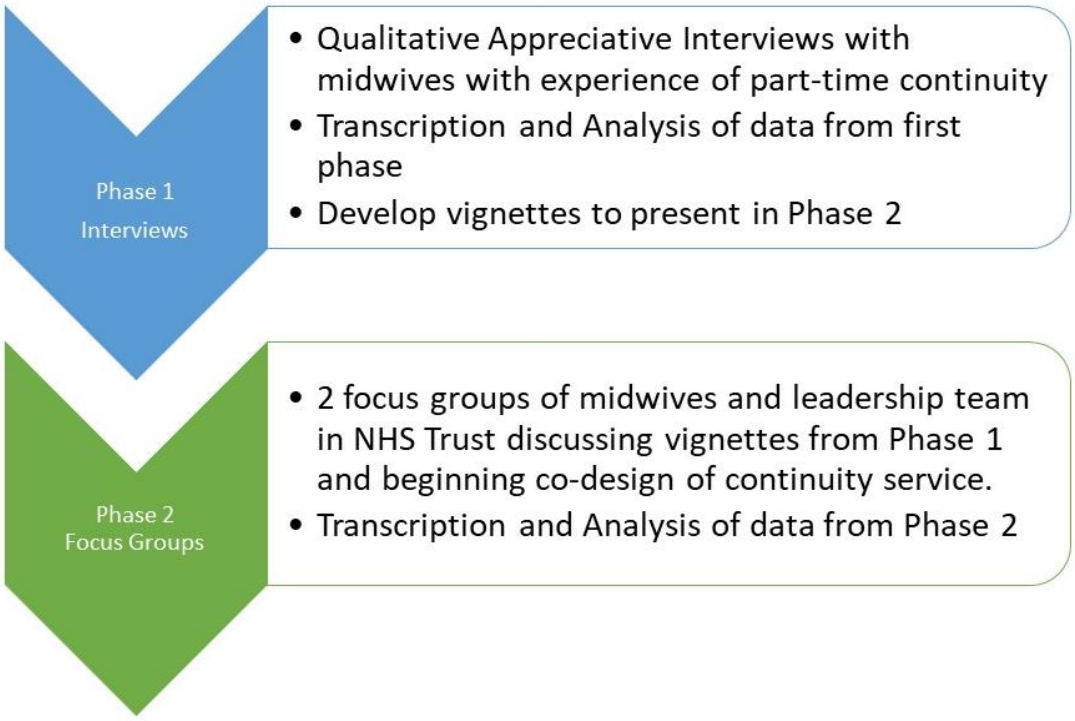


Fig 6. The design of the initial COMPart study

4.5 Appreciative Inquiry

Appreciative Inquiry is based in a social constructivist paradigm whereby reality is created in the moment, and multiple realities exist alongside one another (Gergen and Gergen 2015). An organisation is recognised as a "relationally alive" system made up of the individuals within it (Cooperrider and Fry 2020). In the COMPart study, the organisation is the NHS maternity service in which the research is undertaken.

Appreciative Inquiry was developed from action research by Cooperrider and Srivastva (1987). They considered that the problem-focused approach in action research was insufficient and that the heavy focus on the outcome of action within the context of a piece of research lead to inadequate generation of theory and knowledge which would be of benefit to the wider world. They claimed "good theory may be one of the best

means human beings have for affecting change" (Cooperrider and Srivasta 1987, p.129).

By utilising a psychological theory which states that, that which is focused on becomes amplified, Cooperrider and Whitney (1999) argue that by asking a question, we can initiate transformative change though Appreciative Inquiry. The Heliotrophic Hypothesis of Appreciative Inquiry (Cooperrider 1990) states that all life gravitates towards light: individuals or human groups will naturally move to achieve the most aspirational image of themselves (Bushe 2001). This is in many ways similar to the Pygmalion effect considered within education where high expectations of a pupil may lead to improved performance (Cooperrider and Whitney 1999). If the humans who make up the system/organisation can envision a more positive future, they can take motivation and courage from being able to see this and thus take action to move there (Hammond 1998).

Gergen (1994, p.148) asserted that problem-focused research created a 'culture of enfeeblement' whereby the individuals who collectively make up the spirit of an organisation can learn about and reinforce negative vocabulary and theories which weakens the life-giving force of an organisation. Individuals may learn to problem-solve to combat deficiencies of an organisation, but they do not become creative visionaries, able to transform the culture and create a new reality. Negative discourses can become further entrenched and social hierarchies can be strengthened (Gergen 1994). Through participation in an Appreciative Inquiry into continuity of care, the individuals who make up the maternity care organisation in the COMPart study could envision a future with a well-functioning and sustainable continuity of care service. A culture of possibilities can be created and transformation of the service can occur through the focus on what could work rather than potential problems and barriers to achieving this goal. By strengthening and encouraging each individual who makes up the organisation, the life force within the organisation will be strengthened and motivated to commit to what is required to transform services.

The act of asking questions, being curious and encouraging participants to dream of the possibilities, can support the development of a new reality. This research seeks to use the principles of Appreciative Inquiry to envision and cultivate a future where part-time midwives are supported to work in continuity of care models. An appreciative approach has the power to liberate participants and allow them to unleash a transformational discourse which affirms the forces which are successful, nourishing and sustaining within their experience (Cooperrider and Srivasta 1987; Ludema et al. 2006).

Appreciative Inquiry has drawn some criticism from academics who assert that the focus on the 'best of what is' could have the potential to repress and discourage meaningful conversations (Clouder and King 2015). In their Appreciative Inquiry with marginalised Pakistani women in the UK, Duncan and Ridley-Duff (2014) reported that the focus on positivity could cause discomfort for their participants, who felt their painful stories were minimised. The researchers note that these stories recorded new knowledge and insight into the experiences of an oppressed group, which could have compounded the power imbalances inherent in the research and prevented the generation of new knowledge. Reason and Bradbury (2001) highlight the "danger of ignoring the shadow" through a purely positive focus. Pratt (2002) highlights the multifaceted nature of human existence and suggests that ignoring negative experiences is to deny the existence of the complexity of life in an organisation. Grant and Humphries (2006) suggest that a wider definition of appreciation could be embraced by Appreciative Inquiry researchers, considering that appreciation can mean "to be conscious of, to take full or sufficient account of" (p403). It is clear that there are some situations where an Appreciative Inquiry project could be disrespectful of the experiences of participants, a form of toxic positivity which could invalidate the lives of participants and encourage dysfunctional attitudes and behaviours within an organisation (Rogers and Fraser 2003).

Rogers and Fraser (2003) raised a concern that an Appreciative Inquiry methodology could be seen to encourage organisations to avoid problems which they are already aware of (Rogers and Fraser 2003). In the context of maternity care, this could have dangerous consequences such as widely publicised organisational failings in maternity services in Shrewsbury and Telford Hospital (Ockenden 2022) and Morecambe Bay (Kirkup 2015). This research project was limited in scope, not seeking to undertake a whole-service organisational development but to initiate a project of co-creation of a service. Through careful reflection, I decided that this methodology remained appropriate to the research and that it uniquely held potential benefits which would not be found in other approaches.

Given that the focus of this research on facilitating part-time employed midwives to work in continuity of care models, the use of an Appreciative Inquiry methodology was ideal. The history of unsuccessful attempts to implement continuity of care historically (Homer et al. 2019) and an exhausted and burned out workforce (Hunter et al. 2017) had created a culture of intransigence to this change and an unwillingness to try out the model (Taylor et al. 2019; McInnes et al. 2020). This methodology is therefore an ideal fit because it can build courage and infuse the organisation with burst of positive energy (Rogers and Fraser 2003).

5.0 The Process and Methods

In this chapter I examine the research methods planned for use in the COMPart study. My intention is to provide academic justification for these choices and to demonstrate my generic understanding of research methods in qualitative research. The COMPart study consists of two phases, which were designed to achieve different aspects of the research objectives. The phases share in the Appreciative Inquiry methodology and area of research interest but have separate designs to reflect their discreet aims. I will first discuss the first phase of the study, and then move on to explore the second phase.

5.1 Formulating a research question

The process of developing the research was a journey with many setbacks. As described in the previous chapters, the initial research proposal utilised a Participatory Action Research approach. This proposal was further developed to involve my fellow midwives in the continuity of care team as co-researchers through attendance at ‘action research groups’ where they would enquire into the experiences of themselves and the group, guiding and developing the research.

The study was redesigned when it became clear that the original research project was no longer viable due to the closure of the continuity service. My research was part of a funded studentship project, so the focus of the research was required to stay in the general theme of qualitative exploration of continuity of midwifery care. A research study often reflects the interests or personal experiences of the researcher (Silverman 2022). I reflected on my experiences of providing continuity of care as a midwife and also on my new role as a mother and how I felt this would impact my ability to undertake the role of full-time continuity of care midwife. I observed other midwives raising similar challenges to working in continuity of care models in-person and on social media. From my literature review, I knew that there was a gap in the knowledge around facilitating part-time employed midwives to work in continuity of care. Discussion with the

clinical leadership team in my funding organisation, and reflection with my supervisory team, demonstrated that this focus was workable and worthwhile (Silverman 2022). Holloway and Galvin (2017) note that it can be ‘seductive’ to study a topic which exerts an emotional reaction in the researcher. I was aware that there could be a danger that my own experiences could cloud my engagement with the experiences of my participants. I planned to combat this by consciously recognising the possibility and reflexively engaging in critical analysis of my own involvement and influence as an ‘instrument of the research’ (Cresswell 2017). This is particularly important as an insider researcher where I have been socialised into professional culture and assimilated its accepted ways of being, interpreting and responding (Holloway and Galvin 2017).

I considered the sensitivity of the vocabulary used to describe my research question. The way a research question is presented can reflect assumptions made about the context and the epistemological lens of the researcher from the outset (Silverman 2022). I was aware that simply using the phrase ‘part-time midwife’ did not reflect the identity of a vocational career such as midwifery. This was particularly pertinent when midwives were working in a continuity of care model which rejects the industrialised model of employment where midwives work shift patterns and instead emphases a role more integrated with the life of the midwife. In some iterations of continuity of care services, a midwife may be considered part-time because they care for a reduced number of women per year, but they could theoretically be available or ‘on-call’ the same duration of time as a full-time employed midwife, only needed less often to reflect their reduced workload. I identified ‘part-time employed midwife’ as a term to sufficiently describe the status of an employment contract without an assumption of the nature of being a midwife.

When I decided that an Appreciative Inquiry approach would be the most appropriate methodology to understand the topic, I refined the research question to frame it as an ‘affirmative topic’ (Cooperrider and Whitney 2005). This is central to the appreciative methodology because it facilitates

participants to construct the best version of the future (Clouder and King 2015). An assumption made in the research question which initiates the transformational approach of this methodology is that part-time employed midwives indeed can be successfully facilitated to work in continuity of care services. This is the first step in framing the research in a way to envision the highest potential. Participants begin with the assumption that it is, indeed, possible to work in continuity of care models as a part-time midwife.

The final iteration of the research question in the COMPart study is below:

> *"What are the experiences of part-time employed midwives working in continuity of care services and how can they be facilitated to work in these settings?".*

Aims and objectives for the research were developed, which describe the purpose and intent of the research (Creswell 2018). This supported clarity in designing the research and selecting appropriate methods. These are detailed in section 1.5.1.

5.2 COMPart study Data Collection Phase One: Interviews

I identified that the participants for the first phase of this research would be midwives who had experience of part-time continuity because they would offer the rich data which would answer my research question.

5.2.1 Sampling Method

A purposive sampling method would allow the selection of participants who would be of interest to the research (Silverman 2022). I aimed to select participants who would reflect a diverse range of experiences, career stages and geographical locations because this would provide a diversity of experiences and perhaps reflect some innovations in how part-time staff had been facilitated to work in continuity of care. There may be multiple reasons why midwives are part-time and I hoped that I would be able to begin to understand the experiences of midwives who were part-

time for varying reasons such childcare responsibilities, returning from retirement, or health reasons. To ensure I was able to gain enough contextual demographic information on potential participants to purposively select them, I designed a short online form on Microsoft Forms for potential participants to fill out and express an interest in participation. This data was later used to support analysis of the data, ensuring I had sufficient contextual information to understand the holistic background to the experiences shared by participants.

I identified a number of inclusion and exclusion criteria to ensure that the experience of the participants would be relevant to the research question (Silverman 2022).

Inclusion criteria are:

Qualified registered midwife,
Experience of working in NHS funded continuity of midwifery care setting in last 5 years,
Employed on <30h/week basis whilst working in continuity setting,
Able to attend a 1-hour interview on Microsoft Teams.

Exclusion criteria are:

Staff roles other than midwife
Employed on 30h+basis
No experience of working in continuity of care setting in last 5 years

Table 5: Inclusion and Exclusion Criteria of the COMPart Study

5.2.2 Sample size

Sample size in qualitative research is often guided by the concept of ‘data saturation’ (Braun and Clarke 2021). This refers to the concept where no

further codes or themes are uncovered from continuing with data collection (Silverman 2022) and researchers report achieving this concept somewhere between 6-16 interviews. Data saturation is a concept widely shared within qualitative research and has been included on qualitative research appraisal tools such as COREQ (Tong et al. 2007) as a measure of data quality.

Initially, I hoped to undertake 10 interviews because I posited that double figures seemed appropriate for generating enough data to reach data saturation. I examined my epistemological stance and read further around qualitative research methods. Braun and Clarke (2021) reject the concept of data saturation when using reflexive qualitative analysis, arguing that it is based on an ontological assumption that meaning is concrete within the data and saturation can be achieved because no further codes can be applied to the data(Braun and Clarke 2021). Conversely, in reflexive thematic analysis, the researcher inductively codes the data for both semantic (explicit, obvious coding such as participants referring to the concept of 'time' within data and latent codes (underlying meanings in the data) (Braun and Clarke 2006). The meaning "is not inherent or self-evident in data… meaning resides at the intersection of the data and the researcher's contextual and theoretically embedded interpretative practices – in short, that meaning requires interpretation" (Braun and Clarke 2021, p.1). By understanding myself as a research tool to interpret meaning, I recognised that my intention to achieve data saturation was not in keeping with my methodological stance.

Some experts in qualitative research advocate an in-situ approach for deciding on sample size, considering factors such as adequacy of the initial data to address the research question, desired diversity of participant characteristics, expectation within the discipline and scope and pragmatic constraints of the project (Braun and Clarke 2021; Silverman 2022). This was not a practical approach for my research because I was required to provide a sample size for my ethics application before beginning my data collection. I considered the practicalities of recruitment,

time available for interviews, transcription and analysis. I factored in the time commitment of additional interviews and associated duration of transcription and analysis. Reflective discussion with my supervisory team supported me to identify that I can best do justice to the data though the quality and depth of analysis which I am able to undertake, a view shared by Jensen and Mason in Baker (2012) and (Silverman 2022). The final design of the study would include six participants for this phase of the study.

5.2.3 Recruitment

I hoped to recruit participant midwives from across the UK for the first phase of the study. I chose to exclude midwives working outside of NHS funded settings such as international midwives and independent/private practice midwives because their context would be less transferrable to working within the constraints of the NHS funded maternity care system. I carefully worded the inclusion criteria to reflect that midwives who had previously worked for innovative social enterprises which provided NHS funded care outside of standard NHS services such as One to One midwives and Neighbourhood midwives, would be included as participants. During my undergraduate elective placement, I spent time working with One to One midwives and I recognised that midwives from these services may have had valuable experiences and developed innovative ways of working which could contribute to the research.

I considered possible sources of recruitment such as using email networks or professional magazines to reach participants. There were barriers to using these such as my lack of access to the email networks and possible payment for advertising space in professional magazines. I identified that I was a member of social media groups on Facebook which were very active. Midwives were using these groups to connect with other midwifery services and learn best practice. This echoed the underpinnings of Appreciative Inquiry, where knowledge is generated through understanding of the best or peak experiences of participants (Cooperrider

and Whitney 2007). There were some limitations to using social media as a recruitment method: I considered if I would be able to reach some midwives who would be valuable participants but did not utilise social media or midwifery related social media groups. To attempt to combat this, I added a brief written explanation to be published with the poster which encouraged users to share the research poster with other people who may be interested, known as Snowball sampling (Silverman 2022). I designed a recruitment poster (see appendix 5) to share on social media groups which briefly explained the research and who I was seeking to interview. When designing the poster, I was aware of ensuring the poster was attractive, simple and inclusive of those with learning differences such as dyslexia. I was mindful of my own professionalism and wanted to ensure that I was not approached on my personal social media account regarding the research, so I planned to share the poster with the administrators of the group to publish. The poster shared my university email as a central point of contact for the study, which would ensure that I was able to keep track of all responses and comply with my data management protocol.

I produced a Participant Information Sheet (see appendix 6) which would have been shared with people interested in the study. I planned to share this and a link to the electronic Participant Agreement Form (e-PAF) form by email. The e-PAF was a secure way to collect demographic data on the participants, and ensured I had a clear record of their consent to participate.

5.2.4 Consent

The consent process is dynamic and requires good communication skills and knowledge of ethical and regulatory procedures. I undertook training in good clinical practice to ensure that I understood how to ensure consent was given freely. The concept of consent as a dynamic process was something familiar to me as a midwife, where it is a key tenant of care provision (Nursing and Midwifery Council 2018). Prior to commencing an interview, I ensured that the written e-PAF form provided clear agreement

with the terms of participation. I also verbally ensured the participant gave their continued consent at the start of each interview.

5.3 Data Collection

To gain a deep understanding of the experiences of participants, I needed a way to engage with them. I could have used a written questionnaire with free text answers. This might have gained a larger number of participant responses than interviews. The sample may have better represented the midwifery workforce and therefore findings may have been more generalisable. This would not have been in keeping with my methodology as I recognised that in order to understand the experiences I needed to deeply engage with individuals.

I decided that individual interviews with participants would produce the data to answer the research question. Individual interviews would allow me to engage with individuals and would support a deep understanding of the experience of each participant. I knew from my own experience that the experience of working in continuity of care affects an individual's life, both at work but mostly outside of work too. Interviews can be seen as a natural choice within healthcare research and are commonly used by novice researchers (Holloway and Galvin 2017). As a midwife I was familiar with the concept of one-on-one conversations in a professional context when providing care or taking a history. However, research interviews have a different purpose and dynamic to midwife-mother interactions and it was important to develop my skills in qualitative research interviews (Holloway and Galvin 2017).

The experiences would be deeply personal, and some individuals may not feel comfortable sharing this within a focus group. In focus groups, the narrative can become unbalanced and some individuals may be more prominent in the conversation (Holloway and Galvin 2017). Expert facilitation can support more balanced participant contribution (Sim and Waterfield 2019), but I was aware of my own limitations as a new

researcher with limited experience of facilitating focus groups. This would be more challenging if focus groups were held online.

The Covid-19 pandemic began within a few months of my postgraduate research training. The outlook initially was very uncertain and society adopted new ways of connecting as face to face contact was discouraged. Online services such as Zoom and Microsoft Teams were increasingly used within social and professional scenarios. This presented a challenge for the design of my research. I quickly realised that this presented an opportunity to utilise online technology to engage participants who were not geographically close. Research undertaken prior to the pandemic-driven increased uptake of online technology, noted that for most participants, this was acceptable and that the quality of data appeared to be comparable to face to face data collection. For some people online media is as normal and normalised as natural face to face communication (Silverman 2022).

Despite this, I had some reservations about using online interviews because I felt that it cheapened real human connection. Qualitative interviewing prizes “presence” with the participant in the moment (St. Pierre 2008) and the quality of my presence as a researcher online felt compromised. I was concerned that my distance from the participant, both viewing each other from the shoulders up on a screen might detract from the nuance in non-verbal communication from my participants. I also recognised that gaining the trust of my participant and using my skills to build rapport quickly may be harder when my eyes would be focused on a screen, never making direct eye contact with my participant.

Using technology to make video calls became an increasingly normal way to communicate within my own life and I became more comfortable with this communication method. Maternity services began to utilise online video appointment services (Tavener et al. 2022). I posited that my midwife participants too would have become more comfortable with using online video calling in their personal and professional lives. There were

clear benefits to using online video calling software for my interviews: participants could be comfortable in an environment of their choosing and the burden of participation would be reduced (Howlett 2021). From a practical perspective, the software offered a recording function which presented a clear means of collecting and storing data.

I developed an interview guide to provide some structure to the interviews. This meant that I would be able to cover the same questions with participants and allow me to make comparison between their responses. It supported me to enact an appreciative methodology by pre-structuring questions. This meant I was able to present the strengths-based approach I was looking for. I did not want my participants to leave the interview feeling down and depressed, rather I wanted to provide a space for them to reflect on what went well, whilst acknowledging the inevitable challenges of balancing work as a midwife and life outside of this. A semi-structured interview remains flexible and allowed me to respond appropriately, encouraging my participants to continue to explore topics relevant to the research (Holloway and Galvin 2017). I reflected on my personal experience as an interview participant in research, which had sometimes felt awkward and unfulfilling. I was clear that I wanted to promote a sense of comfort, warmth and openness. Bushe (2001, p.121), a leader in Appreciative Inquiry, discusses the concept of 'open hearted inquiry' by which he meant that the interviewer should take time to check in with themself and notice how their thoughts and questions are forming. Influenced by Jungian psychology, he states that "inquiry with the head only can never heal as the head is concerned with analysis which only serves to cut things up and examine them in parts. The heart, however, is concerned with bringing things together and wholeness and it is from here that inquiry can be healing" (Bushe 2001, p.119). This recognition of the wholeness and complexity of the midwife participants' experiences of part-time continuity of care was important to me. I resonated with the power of Appreciative Inquiry as a healing force, affirming what is successful and nourishing for the midwives working within continuity of care services

(Cooperrider and Srivasta 1987) and unseating more negative discourses which I observed within my professional world and which highlighted the deficiencies of maternity care services, struggling to implement continuity of care models in a sustainable fashion.

5.3.1 The development of an Appreciative Inquiry focused interview guide

Appreciative Inquiry is a process in which participants are prompted to move through stages of identifying what already happens in their personal or professional world, exploring what the future could look like and then, using what has been identified, to begin to design and build innovative new practices (Cooperrider and Whitney 2005). This can be seen as the 4D's of Appreciative Inquiry: Discover, Dream, Design and Destiny. The way in which the process is applied is not prescriptive and should be adapted to the unique setting in which the approach is utilised (Cooperrider and Whitney 2005). My understanding of the methodology informed the development of the interview guide, supporting me to facilitate the Appreciative Inquiry process with participants.

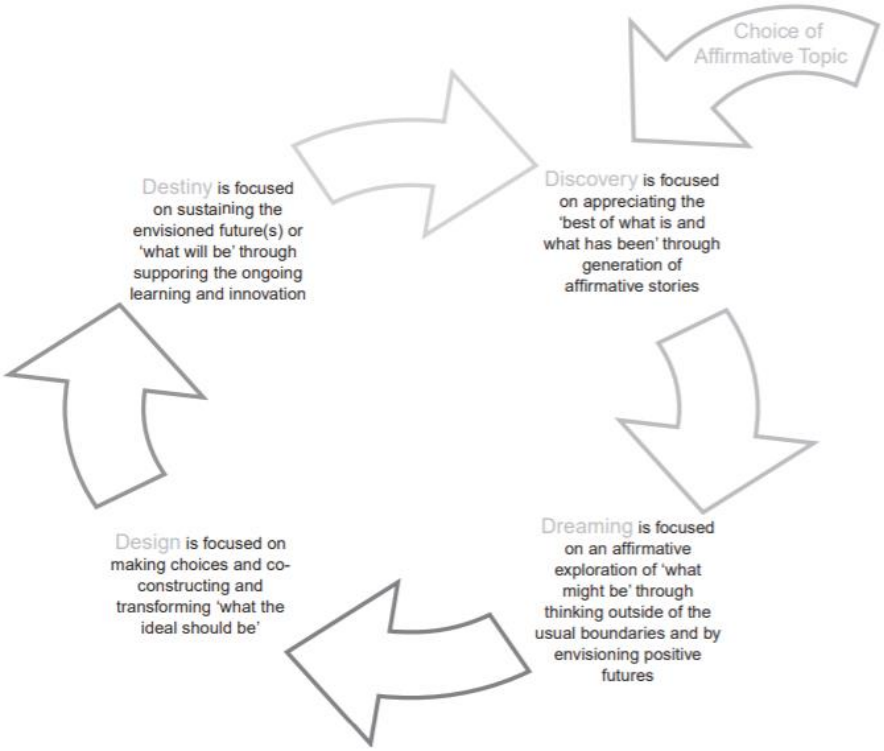


Figure 7: The 4 Ds of Appreciative Inquiry

This was an opportunity to explore the opportunities for part-time staff within a model of midwifery care which provides continuity, to support the identification and development of strategies at personal and organisational levels which support and facilitate part-time midwives to contribute to continuity teams at their highest and most successful potential. As a strengths-focused methodology, an Appreciative Inquiry does not seek to explicitly identify challenges and difficulties (Ludema et al. 2006). During interviews, midwives may report problems which they have encountered during their experience, and these are reported in the research where they arise. The 4D's of Appreciative Inquiry informed the development of the interview guide, which directs the participant to move through a personal

Appreciative Inquiry of their own experience. The chart below illustrates the journey though the inquiry in the interview guide.

4D Phase	Type of AI Question	Questions
Introduction	Establishing rapport and background	Could tell me a little bit about yourself? Tell me about your role in the continuity team? Prompts: What led to you joining the team? What led to you leaving the team? Can you tell me about working part-time in the team and how that works?
Discovery	High Point Experience	Can you tell me about the best experience (an experience which filled you with passion, energy and excitement) you had as a midwife in a continuity setting? Prompts: What were the factors and forces which made it such a great experience? What was it about you, others and the organisation which made it such a great experience for you?
	Valuing	When you feel best about work, what do you value about it?
	Core life-giving factors	Is there anything your organisation or team have done which you feel has been particularly supportive to you?
Dream	Images of a future	If there were no organisational or personal barriers to your vision, what would make being a midwife in a continuity of care setting perfect? Prompts: Tell me about how your role would look? How would the structure of the team look?
Design	Images of the future	What strategies could be put in place to make your vision for midwifery a reality? Prompts: What would be needed at organisational level to make it happen? What would be needed for you at an individual level to let the vision become a reality?
Closing questions		Is there anything else you would like to mention? Is there anything you think is important for me to know about being a part-time continuity midwife?

Table 6: Appreciative Interview Guide

Initial questions focussed on building rapport between researcher and participant, encouraging them to feel at ease to informally share stories which explore their rich experiences. In the questions relating to the discovery, participants were asked to share 'the best of what is' (Cooperrider and Whitney 2007) through reflecting on their high point experiences. Participants were encouraged to share stories which may illuminate their inner dialogue. Questions which facilitate the discovery phase of the research include discussion of participants' best experiences as continuity midwives and what they feel the values and practices of their organisation are when it is at its best. In the dream stage of this inquiry, participants were asked to imagine how their role would be if barriers were removed to facilitating their dream continuity of care role and maternity service. They were asked to construct a vision of their dream role as a part-time continuity midwife, considering factors relating to their own lives and to the structure of the organisation in which they would work. Participants then moved to a more pragmatic design stage where they considered what would be necessary for the dream to be reality and

considered if any parts of their dream vision could reasonably be implemented in a real-life setting.

The final D, destiny, refers to a post-research stage which examines if any changes have been made from an organisational development perspective. This is beyond the scope of this postgraduate research study. In Appreciative Inquiries by Carter (2006) and Donald (2012), research participants spontaneously moved to the destiny phase by implementing strategies in their own environment which they could personally affect. Some participants in this study may have reached this stage outside of the boundaries of the research because they have spent time reflecting on their own experiences, but this is not formally reported in the study.

5.4 COMPart Study Data Collection Phase Two: Focus Groups

Phase two would utilise two focus group discussions to explore the views of midwives and managers in the local setting, as to how themes from phase one could be used to support the local service in understanding the opportunities for part-time workers within a continuity model. The focus groups would construct a shared vision of what could be possible in their organisation and move towards co-creation of continuity of midwifery care services.

The focus group itself is a tool to begin the process of organisational change: participants can share what is important to their journey and learn from the viewpoints of others. Appreciative Inquiry would support focus group participants to reframe the discourse surrounding implementation of continuity of care as a positive, opportunity focused view (Stavros, Godwin and Cooperrider, 2015). This does not hinder the discussion of potential negative viewpoints but allows participants to move from a negative focus to co-create solutions to challenges. Participants can be released from any limiting assumptions which surround continuity, and midwives and managers would begin to co-construct a new, visionary plan for how continuity services could look in their own area. This collaborative approach has been identified as a factor to support sustainable midwifery

continuity service design (Pace 2021, McInnes et al 2020). Participation in the study may have been the first step in generating renewed commitment to continuity of midwifery care from the participants and may ripple out to midwifery colleagues, gently dissolving pockets of intransigence to the model.

Recruitment for the focus groups was planned via posters displayed in the hospital and distributed by global email to ensure equal opportunity of access for community-based staff. This ensured that staff based in all settings would have the opportunity to participate if they wished, which would support staff with varied experience to provide insight into the development of the model.

Two focus groups were planned: a focus group consisting of midwives and a separate focus group for staff with managerial responsibility. It was important to recognise the potential influence of power dynamics affecting the ability of participants to fully express their inner dialogue (Ayrton 2019). If participants felt that they needed to self-censor and provide a narrative which fitted within the professional norms of the organisation, the study would not understand the truth of the experience in the organisation (Bushe 2001). It was hoped that holding separate focus groups would encourage participants to feel open to honest discussion when their focus group consisted of their peers.

5.4.1 Midwifery staff focus group

This focus group was planned to consist of midwives with an interest in the development of continuity services in the local area. 6-12 participants would attend in person focus groups. If the focus group was held online, then 5 participants would be invited to attend to support optimal online focus group discussion (Nobrega et al. 2021). Should excess participants apply, participants would be selected to ensure a diverse range of experiences (see table 7, below). Whilst these characteristics would be desirable in an ideal world, a pragmatic approach was planned and a less diverse focus group was acceptable if there were limited participants.

Desirable characteristics of midwife focus group participants:
- Experience of continuity work locally - Experience of continuity work in a previous midwifery role - Some participants to have experience of part-time working through personal experience - A mix of midwives who work part time and full time would consider the differing needs of the team as individual midwives and as a whole team - A range of personal experience: parent, lone parent, other caring responsibilities, return from retirement, disability or health challenges. - A range of career stages (early, mid and late)

Table 7: Desired characteristics of COMPart Focus Group Participants

It was hoped that the process of participating in a focus group within an appreciative inquiry approach, would provide participants with a space to reframe the discourse around continuity and allow them to explore the possibilities for how continuity of midwifery care settings could be within the local area.

5.4.2 Midwifery manager focus group

I hoped to gain insight into barriers to implementation of continuity of care from a wider organisational, logistical and managerial perspective by constructing a focus group consisting of local clinical managers who were responsible for overseeing the design and implementation of continuity of care services.

These midwifery managers would have been asked to contribute based upon their own experience as clinical midwives combined with their experience and understanding of managing midwifery services. In the local development stages of this research, it was highlighted that the experiences of NHS midwifery management in service development are rarely reported. All midwifery managers within the local NHS Trust would

have been invited to participate in this research. As with the midwifery staff focus group, if the focus group was held online, then five participants would be invited to attend (priority of attendance will be given to those with a direct continuity service management role).

The second phase of the research project was planned to utilise two focus groups in the local setting. Vignettes developed from the interviews with midwives in other NHS organisations would frame the 'discover' stage within this element of the research. Participants would be encouraged to appreciatively examine the vignettes and reflect on their own experiences to identify what resonates for participants within their local NHS organisation. Focus group prompts would start the 'dream' phase, where participants will be asked to envision what might be possible for midwifery continuity of care if there were no barriers to their vision. The design phase would restore an element of pragmatic vision to the group, supporting them to co-create ideas of how continuity of midwifery care could function in their real-life setting. The visions created in the design phase of the focus group were planned to be shared with teams responsible for transformation within the clinical setting with the hope of supporting the implementation of continuity of care services which could facilitate local staff to work optimally.

5.5 COMPart Study Analysis Phase

Analysis of the data is the process in which the researcher interrogates the data set to understand patterns and themes which represent what is being said (Byrne 2021). Thematic analysis is a widely used method within qualitative research which is known to be a flexible and accessible method of analysis for early career researchers (Braun and Clarke 2006). Reflexive thematic analysis guided by Braun and Clarke (2006, 2019) recognises the generative role of the researcher in identifying codes and themes in the data. Meaning is created at the intersection between what participants have shared and how the researcher analyses and interprets this. Other forms of thematic analysis utilise a 'reliability approach'

encouraging the use of an external code book which can be pre-planned before gathering data, or utilising participants or critical friends to confirm the reliability of the coding (Byrne 2021). This is based on an epistemologically positivist assumption that meaning is concrete and inherent to the data itself. My own social constructivist lens meant that for me, meaning was socially produced and subjective.

Reflexive thematic analysis involves “the researcher’s reflective and thoughtful engagement with their data and their reflexive and thoughtful engagement with the analytic process” (Braun and Clarke 2019, p.594). Throughout the research process, I engaged a reflexive stance regarding my positionality as a researcher. My own insider knowledge as a midwife who had worked in continuity of care services and had experienced part-time employment as a midwife provided a unique lens through which I was able to engage with the experiences of my participant. I was mindful that I must engage with the varied experiences of my participant and seek to understand their truth rather than impressing my experiences onto their stories. To ensure my continued reflexivity and challenge any assumptions which I may have been building during the analysis process, I planned to regularly check in with my supervisory team who would be able to ‘sense check’ my ideas around meaning and collaboratively work with me to generate meaning from the data (Byrne 2021). I followed guidance by Braun and Clarke (Braun and Clarke 2019) which provides a six-step process to analysis.

The first step of the process is becoming familiar with the data. As the primary researcher I had planned to undertake each of the interviews with my participants. Following each interview, I planned to keep notes of any pertinent feelings or interpretations I had experienced during the interview. This would have assisted my analysis by reminding me of what I felt in the moment. I then planned to transcribe each interview, adding annotation to reflect meaning which may be lost textually (Byrne 2021).

By this point I would have been familiar with the data and in a position to move to the next analysis phase. I planned to utilise Qualitative Data Analysis Software (QDAS) and undertook training in the NVivo 12 programme. I was mindful that the use of QDAS could be criticised because it can overemphasise the process of adding codes to data. Silverman (2022) raises that there is a danger that the researcher under engages in the complex intellectual analysis exercise, reducing the rigour and quality of the analysis process. I hoped that my early awareness of this and my reflexive practice as a researcher would have limited this occurring. The alternative to using QDAS would have been coding without the support of software such as the use of highlighters and post it notes on paper. Whilst I was attracted to the tactile and immersive nature of paper analysis, I recognised that the skill of using NVivo software as an early career researcher would be very useful to develop, even if the use of QDAS did not save me time (Silverman 2022). I also recognised the practical and organisational challenge of having many pieces of paper spread across a room. There was the possibility the quality of my analysis could be reduced because I may have struggled to keep the analysis papers organised as I no longer had access to a fixed university desk, instead ‘hot desking’ or working from home.

The second step of thematic analysis is generating initial codes. A code is “a word or short phrase that symbolically assigns a salient, essence dash capturing and slash or evocative attribute for a portion of language- based or visual data” (Saldaña 2021, p.4). The process of coding my data would involve marking a section of text and labelling it with an appropriate code to represent my interpretation of what it meant or represented to me through my unique contextual and epistemological lens as a researcher (Braun and Clarke 2021). I would then continue through the data adding codes which represented the data I was engaged with. The process of coding would be predominantly inductive with codes which reflected the content of the data. Later in the coding cycle, I planned to add some deductive codes which would link to conceptual theories supporting

elements of a constructivist view, and to the research question. I had planned to code for both explicit referrals to things within the data (semantic coding) and latent meaning within the data.

It is commonly reported by experts in the field that the coding process rarely feels complete and that new interpretations can continue to rise through engagement with the data (Braun and Clarke 2021). I planned to make a pragmatic judgement when I had interrogated the data fully with an open mind to explicit and latent meaning; and then move to the next analysis stage of developing themes from the initial codes.

A theme can be represented as a coherent and meaningful pattern in the data relevant to the research question (Braun and Clarke 2006). Theme generation shifts the focus from the participant-provided data set to the aggregated meaning of the codes. I planned to actively engage with the codes to understand how they may represent similar narratives of meaning and thus could be combined to form a theme or sub-theme. I recognised that some themes would be obvious to me and be easily generated. Others would be less apparent and require deeper analysis and engagement. It was important to reflect that although some codes may be numerically less represented in the data, what they represented in terms of meaning was important and therefore rather than disregarding them because they came up less frequently, to continue to represent them as individual sub-themes within the analysis.

In order to be able to represent the data themes with clear headings, I planned to engage additional tools such as visually representing the emergent themes in a map. I also planned to reflectively discuss the analysis and themes with my experienced supervisory team. It was important to ensure that the names I assigned to the themes would communicate an important aspect of the meaning and well-represent the theme. Byrne (2021) suggests that catchy extracts of primary data can represent the theme’s meaning and grab the attention of the reader.

Whilst I did not have the opportunity to actively utilise the methods in data collection and analysis, I gained insight into the varied methods and approaches to undertaking research. By designing and redesigning my research, I was able to deeply reflect and consider the influence of the chosen methods on the research output; how the underpinning epistemological assumptions which may encourage a researcher to utilise a certain data collection or analysis method may alter the knowledge they go on to create. This understanding of how research findings are not always what they seem is a vital insight into research. A critical awareness when reviewing research findings will support me in my ongoing career in research, and as a potential midwifery leader.

6.0 Developing ethical research

Ensuring the ethical and academic integrity of the research was a central principle within the research design process.

I reflected on potential ethical challenges which were specific to my circumstances as an embedded researcher in a clinical area. I also considered what it meant to undertake insider research within a group, and my positionality. It was essential that I understood and applied general ethical research principals in line with guidance from Good Clinical Practice. I was in an unusual position of entering a group as both a clinical midwife and as a researcher. My clinical colleagues knew that I held a dual role, and that the research may invite their participation. I was mindful that my own relationship with the group could potentially lead to a possibility of coercive participation:

"Reflexivity requires the researcher to be aware of themselves as the instrument of research. This is a particularly important issue for action researchers who are intimately involved with the subject of the research, the context in which it takes place, and others who may be stakeholders in that context." (Borg et al. 2012 Section 3.3)

I practiced reflexivity which supported me to reflect on my own relationships and roles within the group and I bore this in mind within my encounters. I employed tools such as academic supervision and reflective journaling to support both self-reflection on my own values and experiences, and a more epistemological refection of the potential limitations or influence of the methodological and data collection and analysis methods which I had selected (Borg et al. 2012). I was aware of the tension between my roles within a participatory action research methodology. I would become both a researcher, and a participant, yet I had more at stake than my co-researchers as this project was my own academic work.

I considered what it meant to be a midwifery professional whilst being a researcher, and additional principles which guided my conduct and the design of the research. I considered how the NMC Code, which sets out the responsibilities of a registered midwife, may apply to me. My responsibilities as a registered midwife in terms of safeguarding, candour and the reporting of poor practice applied at all times. I considered my possible responses if a research participant disclosed a matter which required escalation and included this in my study documentation.

I prepared applications for ethical approval by the local university ethics board. My initial research study involved NHS staff within their roles, so I also prepared a detailed application for approval by the Health Research Authority. I prepared a second ethics application when the research was redesigned to focus on part-time midwives in continuity. The change in methodology and recruitment strategy presented different ethical considerations, but the same principals of ethical practice applied. These ethics applications have been included in appendix 3 and appendix 4. A comprehensive data management plan was created to ensure that I complied with the data management regulations.

7.0 Discussion Part 1: Critiquing the evidence around continuity experience

7.1 Limitations to the literature

Many studies within the literature review identified that working in a continuity of care model may increase job satisfaction for midwives (Newton et al. 2014; Dawson et al. 2018b). The midwives in these studies who reported improved wellbeing had actively chosen to work in a continuity model and this may influence their experience of working in a continuity of care model (Dawson et al. 2018a). Allen et al. (2017) and Newton et al. (2016) identify that the midwives who choose to provide care in this model may have different personal qualities or attributes which enhance their satisfaction with their job role in a continuity of care model. Research undertaken in Australia (Fenwick et al. 2018) and New Zealand (Dixon et al. 2017) found that midwives working in continuity models experience reduced levels of work-related stress and burnout compared to midwives working in standard maternity care systems.

It is unclear if the improvement to midwives' wellbeing reported in the literature would be generalisable to the NHS setting; and exactly which factors are associated with the improvement in wellbeing scores in the research. If restructuring of NHS maternity services to provide continuity of care was to resume, many midwives could be compelled to work in a continuity role who may not have actively chosen to work this way. Research is required to understand the effect on the wellbeing of these midwives who may not otherwise have chosen to work in such a model.

It is likely that the flexibility required to work in these roles may be a better 'fit' for some midwives than others. For many UK midwives, who trained and worked in a midwifery role involving shift patterns where one is either 'on' or 'off duty', models where boundaries are more blurred this may not fit their inherent preferences, and result in significant stress (Van Bogaert and Clarke 2018). Participants in research exploring midwives' perceptions of continuity of care described past negative experiences of

continuity-based models which are consistent with research findings relating to midwife burnout (Sandall 1997; Stevens and McCourt 2002). Many perceived continuity models as impacting negatively on their wellbeing and raised concerns about midwives leaving the profession if compelled to work in a non-shift-based model (Taylor et al. 2019).

Concerns regarding changes of working pattern are highlighted as a major concern to midwives who were not yet providing continuity of care (Taylor et al. 2019). Taylor et al.'s survey (2019) reported that participation in an on-call system was a significant barrier to midwives' willingness to work in a continuity of care model. Midwives reported significant concerns on the effect that continuity of care could have on their personal wellbeing. Issues regarding burnout and high stress were factors which have been historically associated with attempts to implement continuity of care in the NHS (McCourt et al. 2006).

Midwives working in a standard care model in the UK are known to be at high risk of stress and burnout (Hunter et al. 2017), so it may be that a wider move to working in a continuity model could improve the national picture of professional wellbeing.

7.2 Midwifery as a business and the finances of maternity care

Many of the studies which highlight the benefits of shared philosophy come from New Zealand, where midwives design their own business model and seek to work with and collaborate with midwives with whom they share a philosophy (Gilkison et al. 2015; Hunter et al. 2016). Whilst the pressures of running a business adds complexity to the experience of being a midwife, the midwife has increased autonomy over their working life. Midwives caring for women in continuity of care models within the NHS may not have the same level of autonomy over the design of the service in which they work, the guidelines and routines they work within and colleagues with whom they work. These factors significantly alter the working experience of the midwives in these models, and this may impact

the willingness of staff to join models, and the longer-term sustainability of working within these models.

In the UK, some innovative care providers have delivered midwifery continuity of care services on behalf of the NHS. Social enterprises 'Neighbourhood Midwives' in London and 'One to One Midwives' in Cheshire were examples of social enterprise which offered midwifery services based on continuity of care models. As a student midwife, I undertook an elective placement with 'One to One Midwives' and noted that midwives working for the organisation had autonomy over their working model, for instance some midwives chose to be available for their clients for week- or month- long blocks of time before taking extended leave, whilst others collaborated as small groups to offer a more structured approach to time off work. The literature suggests midwives having this level of autonomy over their working practice may increase sustainability of the model (McAra-Couper et al. 2014; Jepsen et al. 2017; Lewis 2020). Neither care provider is now offering midwifery services (Birthrights 2019; Serle 2019). One to One Midwives closed, citing difficulties with financial operations: the founder of One to One Midwives criticised the NHS funding tariff, stating that it was unworkable (Cotogni 2020).

7.3 The impact of continuity model on relationships

The development of a therapeutic relationship between midwife and woman enables care to be individualised and responsive to the needs of the individual (McCourt et al. 2006). Whilst some research supports the development of care in a team continuity model, it can be considered contentious (Page and McCandlish 2006). Teams of up to eight individual midwives have been implemented as part of the Better Births initiative (NHS England 2017). This is considered by some experts in the field as a "diluted" version of relational continuity (Dawson et al. 2018a). It can be considered questionable if the clinical benefits of a therapeutic relationship could be built in a single interaction between a midwife and client, for instance at a single antenatal appointment or meet and greet type event.

The widespread introduction of team midwifery models rather than caseloading models in response to the Better Births continuity agenda, fits within an industrialised model of maternity care, which is more easily operationalised for an organisation.

Future research to determine if one form of delivering midwifery continuity has a greater effect than another model may provide vital information to support the delivery of optimal maternity care services. The mechanisms of the improved outcomes which are observed when continuity of care is received are not yet fully understood (Pace et al. 2021).

8.0 Discussion Part 2: The history of the midwife and its influence today

This section will present wider discussion and consider the history and the future of continuity models.

Society, and the midwives who are part of it, has been heavily influenced by an industrialised model of life in which there are clear distinctions between work and home. Many of the challenges have occurred because midwives have accepted that institutionalised maternity care is normal and have altered their expectations of their role. The next section of this chapter will explore the development of the midwife role and the world of work in contemporary society. I had intended to dedicate a chapter within a doctoral thesis to exploring the evolving cultural and societal narrative of childbirth, and this chapter is formed from an early iteration of this.

8.1 Situating the contemporary role of the midwife in history: The changing workforce landscape

The ability or willingness of midwives to work in a continuity model of care is a major factor influencing the success of a continuity of care model (Homer et al. 2019). This section explores how the historical context of the midwife and wider context of the continued evolution of societal understandings of work, may impact the willingness of midwives to work in a continuity model.

Women have been supporting one another during birth throughout history. Historically, the role of the midwife was undertaken by experienced women within a woman's community (Ehrenreich and English 2010; Reed 2021). These women may have had knowledge of supporting childbirth complications or providing pain relief through the use of folk medicine, which may have involved ritualised procedures, chants or the use of herbal plant medicine (Reed 2021).

Whilst midwives held status and respect among the communities to whom they provided care, they were historically viewed with suspicion by men. Birth was an exclusively female event with unpredictable outcomes (Reed 2021). The rise of Christianity across Europe reinforced the belief that women should suffer pain in childbirth due to the sins of Eve, and any attempts to ameliorate this pain was sinful (Ehrenreich and English 2010).

Midwives were specifically targeted during medieval witch hunts (Ehrenreich and English 2010; Reed 2021). Between the 1600s and 1800s the proliferation of modern science spread, based upon the laws of reason and understanding. Women were viewed as inferior to men, a development from ideas such as Greek philosopher Aristotle who wrote that women were simply deformed men (French 2008). The body became understood in terms of mechanisms, and men began to study the mechanism of childbirth. Barber surgeons developed the use of instruments for use in childbirth such as forceps (Reed 2021). Women, seen as inferior to men, were prohibited from the use of instruments in childbirth. Whilst initially only called for during complicated labours, over time it became more acceptable for men to attend women in birth. Men, benefitting from education and status in society, were able to communicate and promote their knowledge of the mechanism of childbirth, and spread rumours about the ineptitude and poor practice of female midwives. The female midwife, who had no formal education or voice in society, was less able to defend herself and her reputation and business was greatly reduced (Donnison 1988; Ehrenreich and English 2010; Reed 2021).

In the early 1900s in Britain, the Midwives Council sought to gain recognition as a distinct professional group. This led to the passing of The Midwives Act of 1901, which aimed to improve safety for women by ensuring midwives had appropriate training and regulation (Hunt and Symonds 1995).

By the 1930s, midwives were professionally trained autonomous professionals who were generally employed by local authorities to provide care for women based in a local area. District midwives cared for women through pregnancy, birth and postnatally in the women's own home (Robinson 1993). However, some women were opting for care in lying in hospitals – specialist hospitals where mothers would have care provided by obstetric teams during birth and the postnatal period. Some first-wave feminists argued that mothers had a right to access the pain relief of modern medicine. Pain relief in the early 1900's generally consisted of strong opioid drugs which had a sedative effect on the women, who would be restrained in the bed. Birth would often occur through the use of forceps and mothers would wake to a baby being nursed in the hospital nursery (Reed 2021)

The NHS was founded in 1947 and aimed to reduce maternal and infant mortality through the provision of universal access to maternity care. This care was based on regular surveillance of women throughout pregnancy by a GP or midwife. At this point, midwifery training was open to qualified nurses, unmarried or childfree women who devoted their lives to midwifery, many living in nurses homes within the community which they served (Robinson 1993; Hunt and Symonds 1995). Midwifery had developed from women-led support during pregnancy and birth. In contrast, the nursing profession had developed to support the delivery of industrialised medical practice. Midwifery was no longer considered a distinct profession, serving women, but became a branch of nursing, serving an industrialised system of care.

District midwives in the mid 1900's were essentially 'on call' at all times, other than the days they were 'off duty' (Hunt and Symonds 1995) (Interestingly, this system is still echoed in modern language today, where staff rota is often referred to as the 'off duty'). When these midwives married or became mothers, they left the midwifery workforce. Some of these midwives would return to employment part-time or full-time in the

future (Robinson 1993). This reflected historically normal expectations of women in employment at the time.

Over time, it became more common to continue to work post-marriage, thus increasing numbers of midwives began balancing competing pressures of care giving at work and at home. Between the 1950's and 1970's increasing numbers of women gave birth in hospitals (Torres and Reich 1989). In order to meet the changing demands of caring for an increased number of women giving birth in a hospital system, a shift-based model became normalised. This ensured that midwives were available to look after the women, and midwives themselves had a clear distinction between work and home life. Industrialised shift-based models compartmentalise time into units which supports a clear distinction for staff members and is easy to manage on an organisational level. Community midwives continue to provide some antenatal and postnatal care outside of the hospital system, often running clinics in GP surgeries working in partnership with GPs to provide care to pregnant women.

More recently, many maternity units have moved towards a two-shift model, with shifts extended to around thirteen hours in duration (Ball et al. 2017). This may increase continuity for inpatient women, who may see fewer midwives during their hospital stay. Midwives working in this model work fewer shifts a week and have a greater proportion of their days at home. Midwives of today, who have trained and worked in a long shift model, experience a clear distinction between their work as a midwife and their life. On a day where the midwife is rostered to work a shift, it is difficult to fit anything else into their day. Could it be that the ubiquity of long shifts could feed into the unwillingness of staff to work in a continuity model which asks them to blur the lines of their work and home lives?

The requirement for a nursing qualification prior to undertaking midwifery education was dropped in the late 1980's (Leap 1999). However, midwifery students continue to be trained in an industrialised model of care developed when nurse-midwives served the needs of the care

system before serving the women who are being cared for within the system. Whilst some midwives have rediscovered the authentic roots of the midwifery profession, and many passionate individuals work within the hospital system (and some choose to work outside of it, offering independent midwifery care) to promote women centred care, the identity of the midwifery profession remains blurred between being ‘with women’ and ‘with service’.

8.2 Workforce challenges and generational differences

Something rarely considered in literature surrounding the implementation of continuity of care models is the impact of generational work differences. Tyler et al. (2019) highlight profound generational differences in values, expectations, and motivations regarding the workplace for midwives. This information is an important consideration concerning a change to the way midwives work, for instance when implementing a continuity of care model. Whilst generalisations about groups of people can lead to stereotyping and are not true for each individual, they are useful to consider how to best meet the needs of the changing workforce (Lester et al. 2012; Baird 2015). Commonalities around attitudes towards work within generational groups have been reported in research in nursing and midwifery staff from countries such as a UK (Jones et al. 2015; Health Education England 2019b), America (Jones et al. 2015) and New Zealand (Jamieson 2012). Some attitudes were reflected across all generational groups. All generations reflected that they were ambitious and wanted to engage in meaningful work where they perceive they can make a difference (Jamieson 2012; Jones et al. 2015).

A 2019 report by Health Education England examines the impact that these differences may have on the NHS workforce, and how best to plan and adapt, to retain and recruit the next generations of staff. In the same year, the Maternity Workforce Strategy, also published by Health Education England (2019a) failed to consider how this may impact upon

maternity staffing and the implementation of the Better Births plan (NHS England 2016) for continuity of care.

Midwives born before 1980 are more likely than younger midwives to view their midwifery work as a vocation or long-term career and are committed to their profession and workplace (Jones et al. 2015). However, it is recognised that increasing numbers of experienced midwives are planning retirement and early retirement in response to limited flexibility within their roles to meet their own needs (Jones 2016).

In contrast, younger generations have been found to expect to have various job roles throughout their working life. Whilst the Millennial generation (born between 1980-1994) tend to show commitment to their role as a nurse or midwife, they are more likely to switch between employers to have their working needs met (Jones et al. 2015). Whilst ensuring an acceptable and flexible work-life balance was shared by all generations, it was of increasingly high value to younger generations (Jones et al. 2015). This is well highlighted by a quote in a vignette describing Generation Z nurses and midwives in a report by Jones (2015, p.13): “Don’t force fit me into a traditional work environment”. The Covid-19 pandemic increased opportunities for hybrid and home working for many sectors, and this is likely to further influence the expectations and desires of the workforce.

In order to maintain a strong and motivated midwifery workforce and reduce staff attrition, some authors argue that the way in which maternity care is provided must change (Tyler et al. 2019). The successful implementation of continuity of care services may meet the changing expectations of a younger midwifery workforce, who may experience increased flexibility and hybrid working options in a continuity model. Innovative models of continuity of care provision may also support the retention of experienced generations of midwives. There could be opportunities to autonomously manage a reduced caseload, support and supervise new midwives in continuity or to provide experienced support

within acute areas. It has been well established that teams with generational diversity perform better than teams of a single age group, so it is important to retain and attract all staff (Health Education England 2019b).

It is clear that well implemented, flexible and autonomous continuity of care provision has the potential to benefit the midwifery workforce, however attracting and retaining midwives will require that they are able to visualise how working in a continuity of care model may work and trust that their employer would provide adequate autonomy to manage their working life in a way which suits them.

Ensuring exposure to successful continuity of care models during midwifery training may support new generations of midwives to understand the model, however there are limited examples of this within the NHS. Gaining the buy in of the existing midwifery workforce could be a challenge in current times.

8.3 A philosophical shift in the values of maternity care

The role of a midwife grew from a supportive interpersonal role focused on the woman and her unique needs. The centring of ‘scientific knowledge’ from the 1600s through to our modern times; and an increase in the perceived value of technological advances, has developed the role into what we understand of the role today. It could be argued that these developments place demands on the midwife which compromise the supportive role from which it developed (Aune et al. 2018).

The increase in technological surveillance of the physical aspects of pregnancy can be seen as philosophically reductionist because it fails to account for the holistic, physical, emotional and social aspects within the perinatal period (Walsh 2004; Aune et al. 2018). Use of these technologies can provide numerical evidence to document the assumed physical wellbeing of a mother and baby, such as a fetal heart rate reading. It can be quick and easy to utilise these technologies to provide surveillance-

based care for a large number of women. These aspects are useful within an industrialised model of maternity care to monitor physical wellbeing and, increasingly, to defensively prove that high quality care was provided should a practitioner be required to attend a court hearing (Spendlove 2018).

Important but less quantifiable measures of wellbeing in a mother and baby may only be noticed within a relationship with a known caregiver. In a continuity of care model, midwives can undertake the physical health checks deemed necessary within an industrialised healthcare model and may also notice early signs of physical changes before they are clinically apparent such as mild oedema in the development of pre-eclampsia. Women cared for by a known caregiver may be more willing to discuss other important aspects of the process of having a baby, which can be equally as important within their experience as the physical changes of the childbearing process, such as mental health, personal identity and relationship changes (Finlay and Sandall 2009). A continuity of care model can be seen to support and value a more holistic understanding of wellbeing within maternity care (Homer et al. 2019). Whilst the mechanism of improved outcomes associated with maternity care is unproven, perhaps this could account for some of the beneficial effects.

Provision of continuity of care could be seen to enhance the identity and role of the midwifery profession. The acknowledgement of the wider factors which influence the wellbeing of a mother and baby throughout the perinatal period may influence societal views of pregnancy and motherhood and support the wellbeing of mothers and babies through improved physical and mental health.

9.0 Foucauldian concepts and maternity care

During this academic journey, I have explored many philosophical theories and developed my skills of critical analysis. I have reconsidered and interrogated my own beliefs about midwifery, gender, society through my transition from the role of clinical midwife to academic, and from maiden to mother. I examined how my epistemological lens has been shaped through my own life experiences. I began to recognise that my worldview can sometimes sit in conflict with the medical and technological hegemony shared in wider society.

Early in my academic journey I began exploring theories around power, social control and discipline in society by reading the work of philosophers such as Bourdieu and Foucault. During the process, I gained a deeper critical understanding of my professional field, which increased the resonance of some of these ideas. Keshet and Popper-Giveon (2018) drew on work by Foucault and coined the concept ‘undisciplined patient’ to refer to patients who may not follow the typical healthcare recommendations. Undisciplined patients shared four common behaviours or beliefs:

1. A critical awareness of medical hegemony,
2. Continually questioning the dominant narrative
3. Make decisions based on principals which are not valued by the dominant discourse such as following their own instinct
4. A willingness to appease their own anxieties and fears.

I recognised aspects of the undisciplined patient in myself and my own choices in healthcare. Reflecting further, I realised that midwives could be considered an ‘undisciplined professional group’. Social models of holistic midwifery care can sit uncomfortably alongside the dominant biomedical discourse that women’s pregnant and birthing bodies pose a risk to themselves and their babies (MacKenzie Bryers and van Teijlingen 2010; Spendlove 2018). I recognised that the midwifery profession could have internalised an uncomfortable conflict of holding control and power as a

care provider in a standard model of surveillance-based maternity care, and the desire of an ‘undisciplined professional’ to alter the power structure and return the power to the women in their care. The ‘disciplinary force’ of the care system flowed through the midwife who performed regular antenatal surveillance, encouraging women to behave as good citizens and accept ‘expert guidance’ at the expense of the woman’s own self-knowledge and intuition.

Foucault (2012) considers that medical organisations could be institutes of power. Power held in these medical institutions can be internalised by the individuals exposed to it as a sense of self-discipline, where an individual polices themselves and their own behaviour in order to fit in and not be at odds with the dominant way to think and behave. I recognised this in my own experience of midwifery practice and in conversations with colleagues.

I noticed the change in wider society regarding personal choice and self-responsibility in healthcare (MacKenzie Bryers and van Teijlingen 2010): I absorbed the experiences shared by women around me about their own pregnancy and birth experiences and I read accounts of midwifery practice in the past. I considered how medical and midwifery staff had previously held the power and patient choice was limited. Neoliberal western ideals shift the responsibility for the decision making onto the woman receiving care: women are superficially encouraged to make their own choices but care providers continue to hold power over these groups and women are socialised to revere the expert professional opinion (Ayo 2012). Maternity care providers hold power in the form of knowledge, for example a superior understanding of the workings of the maternity care system or physiology of pregnancy and birth (Clancy et al. 2022). The concept of risk, and the examinations and interventions offered to women in order to mitigate risks, such as the increased use of ultrasound scanning and fetal monitoring equipment, had become increasingly important within maternity during the decade of my own midwifery practice. The Foucauldian perspective of risk considers it a key method of social control within a

neoliberal society; that is encourages fear in individuals and emphasises the dominance of the prevailing narrative (Keshet and Popper-Giveon 2018). Women receiving standard maternity care are generally presented with care options within a narrow scope of what is considered an acceptable level of risk by the dominant narrative; conversations with care providers centre risk and fear (Spendlove 2018). This dominant risk discourse undermines women's confidence in themselves and returns the power to maternity care professionals (Lou et al. 2022).

Doubts about a woman's ability to grow and birth her baby may emerge from the risk focused discussion and surveillance of the pregnant body (MacKenzie Bryers and van Teijlingen 2010; Lou et al. 2022). This may start to interfere with biologically normal physiological processes which can protect mothers and babies from many of the risks we are so concerned about. The discourse could be seen to reduce women to vessels carrying a baby; rather than individual humans going through a normal bio-psycho-social life stage. Midwives working within this system can become fearful of pregnancy and birth, intolerant of risk and modulating their own professional thoughts and behaviours to fit within the dominant ideology.

Continuity of care models could be seen to dismantle the institutions of power held within an established industrialised model of maternity care and reorganises these systems to return 'power' in the Foucauldian sense, to women and midwives. It could be questioned if an element of the challenges associated with the widespread implementation of continuity of care could be attributed to these concepts surrounding power.

10.0 Continuity of care: looking forward

The clinical benefits to women who receive relational continuity of care are undeniable. This gold-standard model of midwifery care reduces complications for all women who receive it, and for those most at risk of complications, this improvement is even more stark (Sandall et al. 2016; Fox et al. 2022). Women report high levels of satisfaction when receiving care from a known care giver (Forster et al. 2016; McLachlan et al. 2019).

The experiences of midwives who provide continuity of care reported in the literature are generally positive, but this sample may not reflect the experiences of a wider midwifery staffing as the participants of existing research have mostly chosen to work in this model as an alternative to standard care. Midwives in the literature are able to practice an authentic model of relationship-based midwifery across the childbearing spectrum and this provides high levels of satisfaction(Dawson et al. 2018b; Fenwick et al. 2018). Central to a positive experience of working in this model are strong relationships between midwife and the women for whom she cares, and between midwives working in this model who provide high levels of support for one another (Finlay and Sandall 2009; Newton et al. 2016). This intimate nature of midwife-mother relationships in a continuity model of care could lead to midwives over-investing in the professional relationship. Midwives learned to develop boundaries and manage the expectations of the women they cared for in order to protect their own wellbeing (Edmondson and Walker 2014).

Many midwives reported that the flexibility offered by this autonomous practice model facilitated increased presence within their personal and family lives. This fluid lifestyle of being available or ‘on call’ for women took some time to integrate into a midwife’s life and for some midwives, jarred significantly with their societally influenced concept of work-life separation (Fereday and Oster 2010; Edmondson and Walker 2014; Newton et al. 2016; Jepsen et al. 2017; Vasilevski et al. 2020).

Midwives who were challenged by this way of working or who did not experience high levels of support from colleagues, managers and the wider network were at risk of occupational stress and burn out (Homer et al. 2019). The general population of midwives themselves were aware of the potential negative aspects of working in this model and reported high levels of resistance to moving to work in a continuity model. This intransigence amongst staff is a real barrier to the implementation of continuity of care models in the NHS (Taylor et al. 2019).

Midwives report low levels of trust that their NHS employer is able to protect the health and wellbeing of its staff (The Royal College of Midwives 2019; Harris et al. 2020). Midwives are working in challenging times with unsustainable clinical pressures and high rates of staff attrition (Health and Social Care Select Committee 2022). Historically, midwives have fought for recognition as an autonomous professional group, and as a predominantly female profession who are caring for women, have been subject to the oppression of a patriarchal society (Reed 2021). This history continues today, with many midwives balancing responsibilities at home and part-time midwifery employment. There is continued tension between a biomedical model of birth which focuses on risk, and a social model which values a holistic approach more aligned to midwifery practice (MacKenzie Bryers and van Teijlingen 2010; Spendlove 2018). However, there is an increasing awareness around the importance of maternity care which can successfully integrate elements of both models in order to ensure that maternity care is able to meet the diverse needs of the women it serves. It has long been argued that the optimal maternity care system would combine the appropriate use of technology with a holistic understanding of mind-body-spirit wellbeing, whilst privileging relationships with caregivers (Davis-Floyd 2001). Midwifery continuity of care models can achieve this.

Although I was not able to conduct the research I designed, I maintain that research such as the two research studies proposed in this thesis will add further insights which are needed to support the implementation of

continuity of care. Participatory research methods can redistribute the power within the maternity care research system and ensure midwives authentic voices are amplified, in order for the model in which they work to be sustainable (Corbett et al. 2007; McIntyre 2008; Donald 2012). Appreciative Inquiry research methods build on the decades of research already in existence and learn from the best of what is already working in practice (Clouder and King 2015). This is important to learn how best we can support midwives to balance their responsibilities as professionals and outside of work, especially those part-time staff who may have increased challenges in remaining in the workplace, but whose experience in midwifery practice is increasingly valuable to guide the profession.

10.1 The realistic future

The development and delivery of successful continuity of care services requires that staff are willing to work in this model (Homer et al. 2019). Midwives and other maternity care staff need to have their own needs met in order to be able to provide care for others (Smith 2021).

Carefully considered investment in maternity services can ensure that the basic needs of maternity staff are met and that they are more able to consider moving into continuity model of care. It is important to recognise that all staff working in the maternity care system require this nurturing approach. If obstetric colleagues are unable to meet their own needs and therefore feel unsafe in their current risk-based practice, they are unlikely to be in a position to value a more holistic approach (Smith 2021).

It can be argued that maternity care systems should be totally transformed to provide gold-standard care, but this risks devaluing the experiences of midwives who live in an industrialist culture and must balance work and home. The experiences of midwives and their personal needs should be considered, and it would be idealistic to assume that every individual can work in a full continuity model.

Research by Dharni (2021) explores a model of care which offers continuity in the ante- and post-natal period without the element of intrapartum care. This may be more acceptable to midwives than a full continuity model, which requires unpredictable intrapartum care (Taylor et al. 2019). This echoes a return to a more recognisable ‘community midwife’ model of care, albeit with a greater emphasis on ensuring continuity is achieved through careful planning rather than geographical luck.

In a part-continuity model, the midwives who provide intrapartum care could gain enhanced experiential knowledge of labour and birth, and be comfortable with the skills, environment and team who would be providing this care. Continuity of care midwives who would provide antenatal and postnatal services would similarly specialise their knowledge of pregnancy and postnatal care such as breastfeeding support. However, other midwives could feel a sense of loss at no longer providing the full spectrum of midwifery care in their daily midwifery practice (Homer et al. 2019).

For many women and midwives, this form of part-continuity would offer an improvement to the therapeutic relationship over what is offered in the current fragmented model of care. It is clear that further research is required to understand if this is acceptable to women and midwives, and if it improves outcomes and satisfaction levels more than standard care (Dharni et al. 2021).

Leadership in NHS maternity services may consider that they must be pragmatic about the real-world pressures and the challenges of implementing a complete continuity model for all women within the structures of the existing maternity and healthcare systems. Future research may provide evidence of an optimal model of continuity of care delivery, but this may be difficult to implement and operationalise due to organisational, professional or financial constraints (Homer et al. 2019). From reviewing the literature, it appears that supporting midwives to

provide continuity of care in a variety of models and supporting their autonomy with this may ensure that midwives are willing and able to provide midwifery care throughout their working life. Targeting full continuity (including intrapartum care) to population groups with the greatest levels of health inequalities, as recommended in the implementation of Better Births guidance (NHS England 2016), ensures that the population most vulnerable to poor health are supported to achieve best improvement in health outcomes (Fernandez Turienzo et al. 2019). Simultaneously, the wider population may benefit from a more flexible approach to continuity of care through an antenatal-postnatal continuity model (Dharni et al. 2021).

This pragmatic approach to continuity could be criticised for lacking in transformative and motivational vision. It could be argued that it is wrong to have a plethora of evidence that full continuity is the gold-standard, yet not be striving to implement this. As an academic, I can recognise the improvement that a widely adopted ante- and post- natal continuity model would bring to women's care and perhaps also to midwives' wellbeing. As a mother, I feel conflicted about recommending that this should be the future of midwifery continuity. As I detailed in the initial chapter, during my first perinatal period, I received full midwifery continuity of care and experienced this as transformational. I am now expecting a second child, in a new location which does not offer an option of continuity of care for the intrapartum period, and not knowing who my care provider will be for birth is something which concerns me.

A review by Green et al. (2000) reflected that in general, women simply want someone who is kind and competent to attend them in labour. Waldenstrom (1998) noted that when women were confident that their intrapartum caregiver shared a practice philosophy which was congruent with their known and trusted midwife, they placed less importance on intrapartum continuity. However, women who have received intrapartum care from a known caregiver place a higher value upon this (Green et al.

2000). More recent research has highlighted the benefits of a known intrapartum caregiver to women with a fear of birth (Hildingsson et al. 2019) and with previous traumatic birth experiences (Greenfield et al. 2019; Pidd et al. 2023). It is clear that care which provides intrapartum continuity in addition to ante- and post-natal care would be optimal, but that there are limitations to implementing this.

After years spent considering the research evidence, undertaking continuity of care and observing the changes in the NHS; I have come to the conclusion that any improvement to the service would be positive for the women and families using maternity care and for the staff working in it. In order to achieve transformative change such as the gold-standard implementation of full continuity models, maternity staff and women using maternity services must have adequate energy, passion and commitment to drive transformative change. Now is the time to strengthen and support staff to build themselves and the midwifery profession. Staff must be nurtured and have their basic needs met (for example, through adequate breaks and rest time) (Smith 2021). Ensuring that midwives feel supported by the maternity services in which they work may reduce the intransigence towards working in continuity services in the profession (Taylor et al. 2019; Harris et al. 2020). A continued recognition and focus on improving continuity of care in the ante- and post-natal periods may increase job satisfaction for midwives and enable a wider population of midwives (those who may have barriers to being available for unplanned care such as those with caring responsibilities, or those who are employed part-time) to work in a model which offers some continuity. This benefits women (Dharni et al. 2021) and exposes more midwives to working in a continuity model. Perhaps for these midwives, the step from a model which is focused on ante- and post-natal continuity to a model which offers full continuity including intrapartum care would be less daunting and an increased appetite may be found to implement full continuity models.

10.2 Developing a new way of being through the autoethnographic process

Through the use of an autoethnographic methodology, I have deeply reflected on the multifaceted nature of my identity as a mother, midwife and clinical academic. These differing identities have at times presented a tension or conflict in my understanding and priorities.

My dual identities as a mother and midwife were source of tension within my experience. Through the birth of my first child, I gained experiential knowledge of the value of continuity for mothers, something I had previously only known in theory. I was simultaneously presented with the challenge of meeting my own expectations as a mother and family member (being available and present for my daughter, continuing to breastfeed, and jointly with my husband, ensuring that when we were both required to work, high quality childcare was available) whilst considering how I could return to working in a continuity of care model of midwifery with unpredictable hours, or the challenge of returning to standard care clinical midwifery shifts with an expectation to be away from my daughter for long periods of time and overnight (when my daughter required my presence most strongly).

A tension also exists between my conclusions as an academic as detailed in chapter 10.1, where antenatal and postnatal continuity of care is prioritised, but intrapartum continuity of care is targeted to those who have the statistically poorest outcomes in a standard care model. In my ongoing pregnancy of my second child, I have been offered antenatal continuity by a community midwife, but my intrapartum care could be covered by any midwife who is working when I am in labour. This is a source of anxiety for me, despite the expectation of a straightforward labour and birth. I question if my academic recommendation of a pragmatic implementation of a part-continuity model is the right conclusion to come to when so much evidence exists to demonstrate the value of gold-standard full continuity of care; and my own experience as a pregnant mother tells me that I desire

to know my intrapartum midwife. Should maternity care not be aspiring to be the best possible care for everyone? This concept, however, is balanced by my academic and experiential knowledge of the difficulties on a systemic and individual level of staffing such services when the support systems required for this are lacking.

My identity as a midwife has been challenged by stepping away from working clinically during this journey. I have reflected on what it means to be a midwife who isn't 'performing' clinical midwifery. Whilst this initially created a source of tension, through reflexive critical analysis and considering the experiences of others who may hold this dual identity, I have come to recognise that there are many ways to perform midwifery and that this perspective can be a source of nurturing and leadership within the profession. I can use my new way of being as a midwife to guide other midwives who may be in a similar position or interested in research pathways.

A final discourse exists in what it means to have been a clinical academic. Whilst I have gained great insight into the research process, I have not gained a doctoral degree from this journey. Other academics may fail to value the knowledge and skills gained from this journey without the clout of a degree or publications. I have deeply reflected on this through the autoethnographic process and come to see that I can redefine what it means to be involved in research. I can claim my new identity and support others who may be in similar positions.

The methodologies in which I have gained experience share an element of disruption to reified power dynamics within the system. In many ways I have come to embody this shared element of my methodologies as I live in my newly defined 'way of being' in the identity of mother, midwife and academic.

11.0 Closing thoughts

This thesis is the culmination of an academic journey. In this thesis, I sought to explore and demonstrate the breadth and depth of my learning around midwifery, continuity of care and of research methods and philosophies. Whilst it was a challenge to do justice to the complexities of the concepts of midwifery identity and philosophy within the confines of an MRes thesis, I hope that it provides a critical representation of my experiences and reflects my understanding of the contents.

This journey provided time and support to step back from the maternity system in which I had worked, and I gained space to critically consider how the maternity system was set up and how that impacted my identity as a midwife. During the journey, I experienced maternity care for myself, and was able to advocate for my own health and wellbeing. Personal experience of the effects of continuity of care had a profound impact on my understanding of how pivotal and transformational a known and trusted caregiver can be as a mother.

At the same time, I balance my recognition of the importance of continuity of midwifery care with my increasing understanding of the challenges associated with being a working parent, and of being a midwife in the NHS in our current times. I reflect on my own aspirations for my working life and consider how I would and could work as a clinical midwife. Despite my deep knowledge of the research in support of continuity, my personal conviction as a mother who received continuity and my prior experiences of working in a continuity model, I would struggle to commit to providing full continuity of care which includes an intrapartum element.

One of my hopes when undertaking a doctoral research project was that I could affect positive change within midwifery. Whilst through my decision to withdraw from PhD level study means I will not have the letters by my name to give me clout and impact in an academic world, I now realise that I do not need that to achieve my aim of influencing change. When I stepped away from clinical midwifery and into a role in the research

network, I was awarded the role of NIHR Research Champion from Midwifery and Reproductive Health in my area. Within this role I use the skills I have developed from my academic pathway to support the development of research into reproductive health and the development of new researchers. This in itself makes a difference to women, families and the world of midwifery. I am able to draw on my own experience of academia to share possibilities and assist people into varied research routes, presenting at events and conferences which consider the opportunities and challenges in midwifery research. I have come to realise that there are many ways to be a midwife. Throughout this journey, I have discovered and developed many aspects of the midwifery role and truly discovered new ways of being, both personally and professionally.

I continue to feel thankful for the somewhat unexpected journey I have taken. Thank you for walking this path with me in reading my thesis.

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Appendices

Appendix 1 MExOC Study Protocol

Bournemouth University

NHS Salisbury NHS Foundation Trust

Continuity model of midwifery care team: a new way of working – exploring midwives views and experiences using a participatory action research approach: The MExOC Study

Short Title: The MExOC Study

Protocol: Version 0.6

This protocol has regard for HRA guidance and order of content

FULL/LONG TITLE OF THE STUDY

Continuity model of midwifery care team: a new way of working – exploring midwives views and experiences using a participatory action research approach.

SHORT STUDY TITLE / ACRONYM

The MExOC Study

PROTOCOL VERSION NUMBER AND DATE

Version 0.6 02/09/2020

SIGNATURE PAGE

The undersigned confirm that the following protocol has been agreed and accepted and that the Chief Investigator agrees to conduct the study in compliance with the approved protocol and will adhere to the principles outlined in the Declaration of Helsinki, the Sponsor's SOPs, and other regulatory requirement.

I agree to ensure that the confidential information contained in this document will not be used for any other purpose other than the evaluation or conduct of the investigation without the prior written consent of the Sponsor

I also confirm that I will make the findings of the study publicly available through publication or other dissemination tools without any unnecessary delay and that an honest accurate and transparent account of the study will be given; and that any discrepancies from the study as planned in this protocol will be explained.

For and on behalf of the Study Sponsor:

Signature: Date:

..../...../.....

Name (please print):

.....

Position:

.....

Principal Investigator:

Signature: Date:

..../...../.....

Name: (please print):

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KEY STUDY CONTACTS

Chief Investigator	Katie Gregory, RM. PhD candidate at Bournemouth University. Email kgregory@bournemouth.ac.uk.
Study Co-ordinator	Prof. Lee-Ann Fenge, Bournemouth University Dr Luisa Cescutti-Butler, Bournemouth University
Sponsor	Bournemouth University
Funder	Bournemouth University and Salisbury NHS Foundation Trust

STUDY SUMMARY

Background

In England, most women accessing maternity services receive midwifery care whereby they see a number of different midwives throughout their pregnancy, birth and postnatal experience. There are national drivers to change to a model which will enable women to have a continued relationship with a single or small group of midwives throughout their experience. Continuity of midwifery care is associated with improved clinical outcomes and satisfaction for women. Maternity services are restructuring to establish models which provide continuity of care for women. This requires that midwives work in a new way to support women throughout their experience. Existing research demonstrates that midwives working in this model may experience greater job satisfaction. Alternative research highlights difficulties midwives face when working in a continuity model of care and demonstrates a high rate of stress and burn out for these midwives. This research utilises a participatory action research approach and applied implementation science theories to understand the experiences of midwives working in a newly-established continuity of care model in an NHS Trust in England.

Methods and Design

A longitudinal qualitative study using a participatory action research approach to investigate the experiences of six to ten qualified midwives working in a newly-established continuity of care model. Participants are recognised as the experts in their lived experience and as such can influence the development of the research, in keeping with the participatory action research approach. Participants will attend action group meetings using online conferencing software over a twelve month period. During these meetings they will collectively reflect and explore their lived experiences. Video and audio recording will be transcribed and thematically analysed to support understanding.

Discussion

This research supports understanding of a key challenge to the implementation of continuity of midwifery care in England. The findings of this study may inform the development of maternity care models which are beneficial to the wellbeing of women, babies and midwifery staff. Findings will be disseminated though publication in professional journals and conference presentations.

Keywords

qualitative; participatory action research; midwifery care; continuity; implementation

Study Title	Continuity model of midwifery care team: a new way of working – exploring midwives views and experiences using a participatory action research approach.
Internal ref. no. (or short title)	The MExOC Study
Study Design	A qualitative longitudinal research study using a participatory action research methodology.
Study Participants	This project engages with the experiences of six to ten midwives working in a continuity of care model.
Planned Study Period	A study period of twelve months is anticipated.
Research Question/Aim(s)	Aim: To explore the experiences of midwives working in a continuity of midwifery care model in Salisbury NHS Foundation Trust. Objectives: 1. To engage with the views of midwives working in a continuity of care model; 2. To support midwives to collectively reflect on their lived experience of providing continuity of care; 3. To explore how a Participatory Action Research (PAR) approach may facilitate midwives to make changes to improve their experiences providing of continuity of care; 4. To explore the application of implementation science theoretical frameworks to the evaluation of continuity of midwifery care schemes.

FUNDING AND SUPPORT IN KIND

FUNDER(S)	FINANCIAL AND NON FINANCIALSUPPORT GIVEN
Bournemouth University	• Match-funded PhD studentship; • Access to Researcher Development Fund ; • Supervisory support from Professor Lee-Ann Fenge and Dr Luisa Cescutti-Butler • Office space, use of computers, stationery and printing; • Access to The Doctoral College, postgraduate research training and development programme; • Support from the central research office – Research Development and Support.
Salisbury NHS Foundation Trust	• Match-funded PhD studentship; • Access to CPD and professional midwifery revalidation; • Clinical contract to work as a midwife for 15 hours per week alongside research activities as part of the PhD programme. • Support from the central research office – Research & Development.

ROLE OF STUDY SPONSOR AND FUNDER

This project is part of a PhD studentship match funded between Bournemouth University and Salisbury NHS Foundation Trust. The initial research proposal was designed by the funders. The design of the research project has since been developed by the principal investigator with support and guidance from the study co-ordinators as academic supervisors. Salisbury NHS Foundation Trust has not influenced the design or scope of the study; however it is anticipated that midwives employed by the hospital will engage with the ongoing development of the study design in keeping with a participatory action research approach.

ROLES AND RESPONSIBILITIES OF STUDY MANAGEMENT COMMITEES/GROUPS & INDIVIDUALS

Supervisory Team

This study is part of a Doctoral project undertaken at BU by the Chief Investigator (CI), with academic oversight from the CI's supervisory team. The supervisory team are:

• Professor Lee-Ann Fenge - PhD, DProf in Further Education and Higher Education, MSc, CQSW in Social Work, BA (Hons).

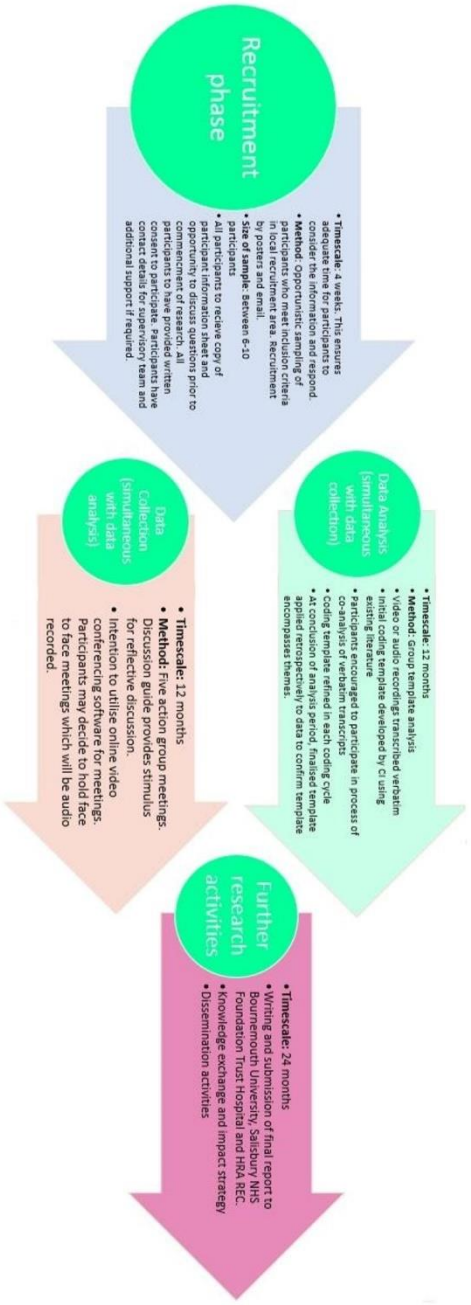
• Dr Luisa Cescutti-Butler – PhD, PG Dip Ed, MA, RM, RGN

The team has extensive and complementary experience of working and conducting research within the NHS and social care sectors. The role of the supervisory team is to guide the planning of the research project, so that it is achievable within the expected timeframe, to provide clear guidance on the key monitoring milestones, and to keep a systematic record of progress. The team meet approximately once a month and are in regular contact through email. The supervisory team has and will continue to advise the CI and contribute to:

- The scientific and ethical quality of the research proposal;
- The safety and wellbeing of participants and the CI;
- The ability of the CI to conduct the proposed research;
- The availability of time and resources to achieve the proposed research objectives;
- Active and effective arrangements to monitor and assess the progress of the research;
- Appropriate arrangements to disseminate the findings of the research and ensure that the study adheres to BU guidelines

KEY WORDS: MeSH headings: midwifery; continuity of care; continuity of patient care; action research; qualitative research; staff attitudes.

Figure 1: Study Flowchart



STUDY PROTOCOL

Continuity model of midwifery care team: a new way of working – exploring midwives views and experiences using a participatory action research approach: The MExOC Study.

1 BACKGROUND

This study seeks to understand the experiences of midwives providing continuity of care through the application of theoretical models of implementation science within a participatory action methodology. It is hoped that understanding can be drawn of factors which influence the wellbeing of the midwives who provide this gold-standard model of care in order to support the long term sustainability of this model for the benefit of childbearing women and to support the wellbeing of the midwifery profession. This section will give a background to continuity of care within midwifery, including the drivers behind the implementation of this model and the potential benefits to childbearing women. It will go on to present the experiences reported in the published literature of the midwives who provide this care and show where further research is required in order to fully engage with the experiences of these midwives.

1.1 Introduction: Maternity Care

A woman's experiences during her childbearing journey can have a profound and long-lasting effect on their own wellbeing and that of their children (Redshaw et al. 2019). Provision of maternity care which supports trusting relationships between a woman and her care providers is recommended because has been shown to provide enhanced levels of maternal satisfaction with their maternity care experience (Waldenström et al. 2000; Biró et al. 2003; Forster et al. 2016). Women cared for in a continuity model report that they value the strong relationship with their midwife and increased feelings of trust and empowerment (Perriman et al. 2018). There is strong demand from pregnant women to be cared for by a known maternity provider (McLachlan et al. 2019). A 2016 Cochrane review which compared midwifery led continuity of care models versus standard care and included over 17,000 women in 15 randomised trials found that continuity of care was associated with a range of improved clinical outcomes (Sandall et al. 2016). Both women with straightforward pregnancies and women with complex pregnancies were less likely to have a premature baby and their babies had a reduced risk of death (including miscarriage, stillbirth and neonatal death) (Sandall et al. 2016). Women were more likely to have a spontaneous vaginal birth uncomplicated by use of an epidural, episiotomy or instrumental birth such as forceps (Sandall et al. 2016). For women at greater risk of poor health outcomes such as women from minority ethnic groups or who are considered vulnerable (for example though a history of poor mental health), these improved outcomes are even further marked (Homer et al. 2017)

Recent international guidelines recommend that midwifery led maternity care which support a woman to develop a relationship with a known midwife or small group of midwives should be offered to all women (World Health 2016). Other well-resourced countries such as New Zealand and Australia have well developed systems of maternity care which offer continuity of carer (Tyler et al. 2019). In the UK, continuity of care has been a focus of government maternity policy since the 1990s. The report 'Changing Childbirth' released in 1993 supported the development of continuity of care schemes within the NHS (Expert Matenity Group 1993). More recently in 2016 the 'Better Births' report (NHS England 2016) explicitly recommended that continuity of maternity care was implemented across England. Prior to the release of the Better Births report, few women were receiving full continuity of care throughout the childbirth continuum (Sandall et al. 2019). Women who receive standard NHS maternity care women may meet a number of midwives in their antenatal and postnatal care and are very unlikely to have previously met the midwife who cares for them in labour (Sandall et al.

2019). Most NHS maternity care providers must implement significant structural alternations to service provision to successfully offer this model to a greater proportion of pregnant women (McInnes et al. 2018).

1.2 Models of continuity

The National Maternity Safety Strategy Document (NHS England 2017) sets out a strategy for health care providers to implement personalised and safer maternity care. The document explicitly recommends two different models which are hoped to achieve a high level of continuity of care to support the improvements in clinical outcomes and satisfaction. These models are 'team continuity' (whereby a woman develops a relationship with a small group of midwives who share responsibility for her care) and 'full caseloading' (where a woman is assigned a single midwife who provides the majority of her care). Both models of continuity offer improved satisfaction and clinical outcomes to the woman and are based upon the concept of 'relational continuity' whereby the woman develops a relationship with the person providing her care. Other dimensions of continuity may also be provided in these models: midwives from the same team work from the same guidelines and thus provide an enhanced level informational continuity. Women have a more seamless experience of care from differing specialities or services coordinated by a named midwife, experiencing enhanced management continuity (Cheyne et al. 2019).

There is a plethora of research available from previous attempts to implement continuity of care models in the NHS (Stevens and McCourt 2001) and from research undertaken in other countries with functioning continuity of maternity care systems such as Australia (for example Fereday and Oster (2010); Collins et al. (2010); Allen et al. (2017)), and New Zealand (for example Hunter et al. (2016); McAra-Couper et al. (2017)). In Australia, although publicly funded healthcare is available, many women seek private healthcare which is often obstetric led and midwifery led continuity of care remains outside of the mainstream (Tyler et al. 2019). Pregnant women in New Zealand also have a choice of maternity care provider which may be a general practitioner, obstetrician or a midwife (Tyler et al. 2019). Midwives working as 'Lead Maternity Carers' operate as a business either independently or in self-organised cooperatives. This offers a high level of autonomy but adds a unique dynamic to the experience of the midwives in New Zealand based studies. The NHS is a unique setting in which to implement continuity of care models which are free at the point of access for pregnant women. Despite the international differences in context, midwives from Australia, New Zealand and the United Kingdom report broadly similar benefits and challenges to the experiences of working in a continuity of care model. Research undertaken with continuity of care models in the NHS set up in response to the Changing Childbirth report (Expert Matenity Group 1993) also provide valuable insights into the experiences of midwives providing care within the unique NHS setting. Many of the models set up in the 1990s and early 2000s have not continued to the present day and much can be learned about implementation of sustainable models through examining the research from this era. Issues regarding leadership style and management support and appropriate cover for staff shortages were identified in Stevens and McCourt's research (2002) and remain pertinent to more recent studies (McInnes et al. 2020).

1.3 The present state of UK midwifery and barriers to implementing continuity

At present, the majority of NHS midwives work in a shift-based pattern (NHS England 2017). Midwives working in the community generally provide antenatal and postnatal care within core hours and may sometimes provide an element of continuity although this rarely covers intrapartum care (Taylor et al. 2019). In the hospital setting, most midwives work shifts providing clinical care to women and families such as labour and postnatal care. This rarely offers continuity of care to women because it is unlikely that a midwife she has met before is rostered onto a shift when she requires care such as in labour (NHS England 2017). Furthermore many midwives do not work full time, which further reduces the chance of continuity in this setting: In 2014, only

73% of midwives were employed to work more than 30 hours per week and many midwives reported that they struggle to achieve their desired flexibility regarding shifts. This may lead to midwives working bank or agency shifts which may further reduce continuity as midwives may work shifts in different areas or NHS Trusts (The Royal College of Midwives 2016).

The 2018 NHS England Staff Survey highlighted that midwives report among the highest levels of stress of any health care profession (The Royal College of Midwives 2019). A 2018 online survey of 2000 midwives working in a variety of settings in the UK revealed significant levels of emotional distress among the participants with 83% of respondents suffering from personal burnout and 67% experiencing work related burnout (Hunter et al. 2017a). Participants were substantially more likely than the general population to score highly for stress, depression and anxiety. In the same study, 66% of the midwives surveyed had seriously considered leaving midwifery in the last year. This may impact the motivation and enthusiasm of midwives to implement continuity of care models.

One of the greatest barriers to implementing continuity of care models appears to resistance towards models among the midwifery population (Tyler et al. 2019; Harris et al. 2020). A 2019 survey of 798 NHS midwives, most of whom did not have experience of continuity models, found that 65% of respondents felt that they would be unable or unwilling to work in a continuity of care model which included cover for intrapartum care in the hospital setting (Taylor et al.). A further 19% of participants reported willingness to work in a continuity model which had a reduced or no cover for intrapartum care. Many midwives report that they feel uncomfortable or nervous working outside of the environment in which they usually worked and that felt they had specialised skills suited to an area of maternity care(Taylor et al. 2019; Harris et al. 2020). Some midwives shared concerns regarding quality of care when midwives are asked to become “a jack of all trades” (Taylor et al. 2019, p.133).

A commonly held concern is that working in a continuity of care model may have negative influences on the wellbeing of midwives (Taylor et al. 2019; Harris et al. 2020). Midwives may have previous negative experience or knowledge of NHS continuity of care models implemented in the past, where midwives were reported to experience increased levels of burnout and emotional exhaustion (Sandall 1997; Stevens and McCourt 2002). Midwives in some studies report low confidence that new continuity models will be implemented sustainably and avoid the mistakes of the past (Harris et al. 2020): just 15% of midwives in the NHS Staff Survey felt that their employer was taking positive action to look after their health and wellbeing (The Royal College of Midwives 2019). Taylor et al. (2019) conjecture that a population of midwives experiencing high levels of work related stress and low levels of confidence that their employing organisation will support their ongoing wellbeing, may be less willing to try working in a new continuity of care model. Nearly one in ten midwifery posts were unfilled in England in 2019 (Health Education England 2019) which has been associated with higher levels of emotional exhaustion and stress within the workforce (Hunter et al. 2017a). Awareness of poor staffing within maternity organisations can feed into anxieties around continuity of care. Issues surrounding staffing including cover for maternity leave and sickness have long been highlighted as factors which affect the sustainability of continuity models (Stevens and McCourt 2002).

Another widely shared barrier to implementing continuity were practical challenges such as caring responsibilities, which were reported by 65% of respondents to Taylor et al’s survey (Taylor et al. 2019). Many midwives are primary carers for children and report a need for regular and predictable hours to fit around often inflexible childcare providers (Taylor et al. 2019; Harris et al. 2020). Other midwives discussed their own health conditions or transport issues which impacted on their ability to work unpredictable hours. Some of these barriers are not permanent and some midwives expressed that they may be willing to try working in a continuity of care model, if they experienced a change in personal circumstances (Taylor et al. 2019).

Maternity services at present are not providing optimum experiences for women or for the midwives working in them. Some proponents of continuity of care argue that in addition to providing well-evidenced benefits to

women, implementation of continuity of care may conquer some of the issues midwives currently face in their work.

1.4 Midwives experiences of continuity in the literature

As stated previously, there are two models of continuity of care recommended in the National Maternity Safety Strategy Document (NHS England 2017). In a full caseloading model a midwife takes full responsibility for the maternity care of a caseload of women. A midwife organises their working pattern to suit the needs of the caseload and is available to provide clinical care at all times. When a caseloading midwife is not available (for instance if the midwife is already caring for someone), cover is provided by a core team of hospital staff. The midwife is personally responsible for rescheduling any appointments should they be missed due to unscheduled care. of time off, for example three months of availability followed by a month of annual leave. This model offers great autonomy and flexibility to the midwife and a high level of continuity of care to the woman but has limited appeal to the midwifery population due to the profound impact of full-time professional availability on the midwives personal life (NHS England 2017). For this reason most NHS Trusts, including the site in this study, are seeking implement a team continuity model.

In a team continuity model a group of four to eight midwives share responsibility for a caseload of women. Each woman has a named lead midwife with whom they build a relationship, but they may also receive maternity care from any of the other team members. The team share the on call availability for unscheduled care such as labour care and cover one another for annual leave and sickness. In this model the midwives are able to predict their protected time off through use of a rota system but retain an element of flexibility and autonomy in managing their own diary to provide scheduled care to their caseload. This has increased appeal to the midwifery population but may result in a reduced level of continuity of care compared to full caseloading. (NHS England 2017). Ensuring that women have built a relationship with a larger team of midwives can be a challenge and sometimes midwives may provide care for women they have not previously met. There is mixed evidence to support team midwifery: until 2017 NICE guidelines explicitly stated that team midwifery was not recommended (Excellence 2016; National Institute for Health and Care Excellence 2016). Further research has since shown that team midwifery can support the improved outcomes which are thought to be associated with increased relational continuity (Sandall et al. 2016).

When compared to working in a standard care model, continuity has a profound effect on the lives of the midwives. Midwives in a continuity of care model are available for unscheduled care, often through 'on call' systems. The concept of being on call is one of the greatest concerns highlighted by midwives (Taylor et al. 2019; Harris et al. 2020). In the literature, after an initial transition period midwives working in a continuity of care model become comfortable with the concept (Collins et al. 2010; Fereday and Oster 2010) and adapt to a lifestyle which promotes a greater fluidity between work and home life (Fereday and Oster 2010). Literature shows that midwives in a continuity model value the autonomy to schedule their work in a way to suit their personal lives and report that they feel more able to balance personal and family life, many highlighting that they more regularly eat dinner with their family and attend personal events because they are able to adapt their working schedule to allow for their attendance (Newton et al. 2016). Compared to working standard shifts, midwives in Newton's (2016) study reported that they worked fewer unsocial hours. Organisational support for autonomous diary management is associated with sustainable continuity models which increase the wellbeing of the midwives working within then (Jepsen et al. 2016). Reduced levels of control of working pattern, for instance through increased workload due to poor cover within the team for holidays and sickness (Newton et al. 2016; Styles et al. 2020) or working in the associated maternity unit in times of high acuity escalation may lead to increased stress and risk of burnout for midwives (Homer 2019). Promoting a working culture which respects this delicate need for work-life balance can be difficult for managers and staff more used to working in conventional shift patterns (Hewitt et al. 2019).

The perceived role of the midwife appears to be altered and developed through working in a continuity of care model. Literature highlights that midwives working in continuity models report great satisfaction in providing

'real midwifery care' across their full scope of practice (Jepsen et al. 2016). They take pride in assuming full responsibility for the care of their caseload (Finlay and Sandall 2009; Jepsen et al. 2016). The professional role of the midwife in a continuity of care model may be developed to demonstrate greater autonomy and establishing deeper and more meaningful relationships with the women in their care (Finlay and Sandall 2009). Several studies have identified that the role of a midwife to advocate for the women in their care may be enhanced in a midwife working in a continuity model of care (Finlay and Sandall 2009; Boyle et al. 2016). Midwives in a study by Newton et al. (2016) reported an increased ability to facilitate informed decision making with the women in their caseload compared to when how they worked in standard care.

Allen (2017, p.151) identifies that midwives in a continuity of care setting are more likely to "go above and beyond" in their care of their caseload. Although this may initially seem like a positive for the women, the longer-term effects of this may be detrimental to the caseload. Deery and Fisher (2010) and Hunter (2001) identify a limit to the emotional capacity of a midwife and pushing past this boundary may be damaging to the midwife. Leinweber and Rowe (2010) describe this as "the cost of caring" and suggests that continuity midwives may be at increased risk of secondary post-traumatic stress disorder and compassion fatigue. This can be defined as the trauma like state caused by emotional stress from supporting women through traumatic situations (Leinweber and Rowe 2010). Conversely Newton (2016) identifies that the strengthened midwife-client relationship in continuity of care can be a protective factor against stress and burnout for the midwives. Midwives who successfully work in continuity teams long term draw clear boundaries around their emotional and personal capacity and ensure regular self-care through prioritising the elements of their lives outside of work which 'fill up their cup'(Hunter et al. 2016).

For midwives who work in a team continuity model, strong working relationships within continuity of care team and the wider health care setting are considered essential (Crowther et al. 2019). Midwives working in successful team continuity models provide emotional and practical support to one another which supports the wellbeing of the team members (Yoshida and Sandall 2013). Fereday and Oster (2010, p.314) identify this as the concept of providing "reciprocal assistance" to one another and Hunter (2016, p.51) terms this "generosity of spirit". Open and truthful dialogue between team members and clarity regarding mutual expectations are considered essential to support sustainable team working in a continuity model (Crowther et al. 2019). Constructive discussions between midwives can support midwives to establish appropriate boundaries between their work and personal life, to maintain professional distance and to reflect on their practice (Hunter et al. 2016). Stevens and McCourt (2002) identified that tensions within these collegial relationships had the potential to be very stressful for the individuals involved and could be extremely disruptive for other midwives in the group. It is suggested that the skills required to mediate such dynamics were poorly developed within conventional midwifery services, where avoidance tactics were more readily employed.

In team midwifery models, midwives felt teams were more sustainable when they trusted that their colleagues shared a similar philosophy of (Crowther et al. 2019). This implies that for the midwives, knowing that women in their care were receiving informational continuity was an important element which allowed them to trust that their colleagues would provide a similar standard of care to what they would (Crowther et al. 2019). Many of the studies which highlight the benefits of shared philosophy come from New Zealand, where midwives are able to design their own business model and collaborate with midwives with whom they share a philosophy (Gilkison et al. 2015; Hunter et al. 2016). Midwives working in team continuity models in the NHS will share national and local guidelines for care provision but will provide this care with their own personal style. NHS midwifery teams are likely to not be self-organised but instead formed from existing staff members (NHS England 2017). This adds a unique complexity to the model. Creation of regular opportunities for talking and relational connection may support the development of relationships between team members (Crowther et al. 2019). Crowther et al. (2019) recommends further study of strategies to support group cohesion including co-designed projects which examine practice within continuity of care such as this study.

Working in a continuity of care model may increase job satisfaction for midwives (Newton et al. 2014; Dawson et al. 2018). Research undertaken in Australia (Fenwick et al. 2018) and New Zealand (Dixon et al. 2017) found that midwives working in continuity models experience reduced levels of work-related stress and burnout compared to midwives working in standard maternity care systems. It is currently unclear if this improvement to midwives wellbeing is generalisable to the UK NHS setting and what factors are associated with the improvement in wellbeing scores, although previous attempts at implementing this model in the UK have demonstrated factors which can negatively affect wellbeing (Stevens and McCourt 2002). Midwives working in standard care in the UK are known to be at increased risk of stress and burnout (Hunter et al. 2017a) so it may be that a wider move to working in a continuity model could improve the national picture of professional wellbeing. It is important to highlight that the midwives who reported improved wellbeing had actively chosen to work in a continuity model. (Allen et al. 2017) and (Newton et al. 2016) identify that midwives who choose to provide care in this model may have different personal qualities or attributes which enhance their satisfaction with their job role in a continuity of care model. Due to the national strategy to implement continuity of maternity care, many English midwives will be encouraged to work in a continuity role. Research is required to understand the effect on the wellbeing of these midwives who may not otherwise have chosen to work in such a model.

2 RATIONALE

The Cochrane review of midwifery continuity of care provides clear and inarguable evidence that CoC benefits childbearing women (Sandall et al. 2016). A body of evidence also demonstrates that mothers report increased satisfaction with their care (Sandall et al. 2016) and that these services are desired by service users (Bath 2018). Various published research has explored the experiences of midwives who provide care in a CoC model. Much of the research published in the last ten years has been undertaken in countries outside of the UK with the majority of studies being undertaken in Australia (Fereday and Oster 2010; Edmondson and Walker 2014; Newton et al. 2014; Allen et al. 2017; Dawson et al. 2018; Fenwick et al. 2018) and New Zealand (Donald et al. 2014; McAra-Couper et al. 2014; Dixon et al. 2017; Hunter et al. 2017b). Whilst the personal effects of working in a continuity model are likely to be comparable, implementation of this model in the NHS provides unique challenges and therefore direct transfer of the findings of these studies should be approached with caution. The research listed above was undertaken on small groups of midwives who have chosen to work in an alternative care model to mainstream midwifery services (Australia); or in the case of Lead Maternity Care midwives in New Zealand, are business owners who are financially reliant on holding a caseload. In the UK, national drivers such as the Better Births report (Cumberlege 2016) are driving the implementation of continuity of care schemes within existing NHS services and generally involve midwives who haven't experienced working in such a model previously and who may no longer have a job role within a standard care system available to them.

Historically the NHS has failed to implement sustainable midwifery continuity of care schemes and the memory of this may live on through maternity staff Additionally, the British midwifery workforce is facing an unprecedented mental health crisis with occupational stress and burnout highly reported in staff surveyed in standard care settings. The antecedent climate of NHS midwifery services presents real challenges to the implementation and uptake of continuity of care by staff.

The literature offers inconsistent findings on the experiences of working in a continuity of care model for midwives. Some literature suggests that working in a continuity of care model may increase job satisfaction for midwives (Newton et al. 2014; Dawson et al. 2018). Research undertaken in Australia (Fenwick et al. 2018) and New Zealand (Dixon et al. 2017) found that midwives working in continuity models experience reduced levels of work-related stress and burnout compared to midwives working in standard maternity care systems. Other literature suggests that working in continuity models has the potential to be detrimental to midwives' wellbeing (Taylor et al. 2019; Styles et al. 2020).

Evidence supports the idea that well managed continuity schemes which support midwives' autonomy may support midwives to have a positive experience of providing continuity of care and thus support the sustainability of these services (Jervis 2016). Through the application of theoretical frameworks developed in the emergent field of implementation science, it appears that new knowledge can be gained regarding sustainable implementation and design of continuity of care schemes in NHS maternity services (Forster et al. 2011; Cheyne et al. 2019; Corrigan et al. 2020). It is hoped that development of continuity of care services which are acceptable to the staff within them will benefit the profession through improved job satisfaction and decreased levels of stress and burn out. This will in turn ensure that high quality continuity of midwifery care services become available to mothers which are evidence based and proven to improve outcomes. The knowledge gained through this research is focussed on the local environment of the study, and the value

3 THEORETICAL FRAMEWORK

This research study will embrace a qualitative approach to engage with lived experiences of the midwife participants. Participatory action research ensures that the voices of the midwives are central to the research process by engaging them as co-researchers and acknowledging their knowledge as experts in their own experience (Donald 2012). This emancipatory approach seeks to readdress the imbalance of top-down organisational change. Through group reflection, participants may gain deeper understanding of their shared situation. For example, sharing experiences of a similar issue may support participants to understand the root cause of the problems they face. Participants are empowered to take ownership of their practice and to make changes to ensure the sustainability of the model (Donald 2012).

The reseach design is guided by theoretical frameworks developed though the emergent field of implementation science. Normalisation Process Theory (NPT) (May and Finch 2009) informed the initial design of the research. This sociologically derived theoretical framework seeks to explore how a complex intervention becomes embedded or normalised in complex organisations such as the NHS (or barriers to this) through examining the sociological influences on the people and organisation adopting the change. Although a relatively new theory, the use of NPT has been validated (Finch et al. 2018) and it has been identified as a useful framework for the planning and evaluation of maternity continuity of care services (Corrigan et al. 2020).

The effects of implementing continuity of care on the experiences of the midwifery staff are not limited to the work environment but affects elements of their personal lives and how they view their role. NPT's focus on the action taken by people adopting the change was identified as a restrictive factor in its utility when applied to such complex interventions. Therefore, factors from other theories of implementation were adopted in addition to NPT: Greenhalgh's (2004) 'Diffusion of innovations in service organizations' (DISO) and Damschoeder's (2009) Consolidated framework for Implementation Research (CFIR). May and Finch (2009) highlight that NPT should not be prescriptively applied and highlights the benefits of applying additional perspectives to widen and deepen the evaluation of an intervention. CFIR (Damschroder et al. 2009) and DISO (Greenhalgh et al. 2004) were identified as they provide an additional perspective on the characteristics of the individuals who successfully adopt the change. The combination of the slightly differing perspectives offered by the three theories identified above will ensure that the experiences of the midwives are considered from a broad range of angles. It is hoped that this research will identify factors not yet understood regarding sustainable implementation of continuity of care models within the wider NHS context. The focus of this study will be guided by the expert participants who may feel it is appropriate to explore issues outside of this framework or to focus on specific tenets they feel are most relevant. Participant researchers are recognised as the experts in their experience and therefore the study does not seek to limit what they choose to explore.

4 RESEARCH QUESTION/AIM(S)

4.1 Aims and Objectives

Aim: To explore the experiences of midwives working in a continuity of midwifery care model in Salisbury NHS Trust.

Objectives:

1. To engage with the views of midwives working in a continuity of care model;

2. To support midwives to collectively reflect on their lived experience of providing continuity of care;

3. To explore how a Participatory Action Research (PAR) approach may facilitate midwives to make changes to improve their experiences providing of continuity of care.

4. To explore the application of implementation science theoretical frameworks to the development of continuity of midwifery care schemes.

4.2 Outcome

The intended outcomes of this research are as follows:

- To explore and gain an understanding of the experiences of the midwife participants who are providing continuity of care. Participants will be supported to reflect on their experiences of providing continuity of care. Should it be identified that change is necessary, participants will be supported to make changes. Experience and changes made will be recorded as part of data collection and reported in research findings and future literature for scientific publication.
- To gain understanding of the utility of participatory action research methodologies in exploring midwives' experiences of continuity of care and to support them in making changes where necessary to benefit their practice. To explore the application of theories of implementation science in planning and evaluating complex interventions such as the implementation of continuity of care schemes in a health care setting. This data to be reported in research findings report and future literature for scientific publication.
- To produce a research report and literature for publication in relevant journals. To disseminate research findings with the wider research community to benefit implementation of continuity of care models in the NHS and other healthcare systems.

5 STUDY DESIGN and METHODS of DATA COLLECTION AND DATA ANALYIS

5.1 Design

This project will use a design informed by participatory action research. Participants will be invited to attend a series of five 'action group meetings'. These will run in the style of a traditional focus group of six to ten participants. The lead researcher will act as facilitator for the focus group and will also act as a participant.

5.2.1 Data Collection

It will be proposed to the participants that action group meetings will be held virtually on a secure online video conferencing system. Due to the participatory design of this study, should midwives feel more comfortable with a traditional face to face action group meeting then this element of the study will be altered. Literature shows that the qualitative data collected from online focus groups is of similar depth and quality to that of face to face meetings (Kite and Phongsavan 2017). Midwives can participate from any location and may find it easier to schedule an online call in their busy and somewhat unpredictable diaries. The study utilises online participation to deal with potential disruption caused by the Covid-19 pandemic and any future issues of a similar nature. The midwives who will be eligible to participate in the research study have access to an internet enabled smart phone or laptop with video conferencing facility. Due to practice change as a result of the Covid-19 pandemic, midwives have become familiarised with video conferencing apps and undertake tri-weekly video conferences with the management team and telehealth appointments with their caseload. Participants of an online action group would be asked to ensure that they are in a private location where they will not be overheard or disturbed given the sensitive nature of the discussion. Should face to face action group meetings be adopted, they will be held in a private space to ensure participants feel able to freely express themselves.

Action group meetings will be scheduled for 90 minutes duration, with around one hour of planned discussion from the stimulus provided. This is to ensure that the participants remain focussed, do not become fatigued and to ensure that the sessions are acceptable within the daily timetable of a continuity midwife.

It is possible that participants may find the sessions emotionally tiring as they reflect on personal experiences. The lead researcher will therefore be available for support following each session which will not be recorded.

Participants will also be signposted to support services offered though their employer's occupational health department and their union.

5.2.2

Discussion topic guides have been designed in advance through analysis of main themes in the chosen theoretical frameworks of implementation. These are attached as appendices. These discussion guides have been produced to support and guide reflection and analysis of key discourses around the implementation of continuity of care. They will not be used prescriptively and should participant discussion move away from the guide and is felt to be relevant to the themes of implementation, the participants will retain control of their discussion. It is acknowledged that relevant topics to the implementation and experiences of provision of continuity of midwifery care may not have been previously identified in the design of the guide.

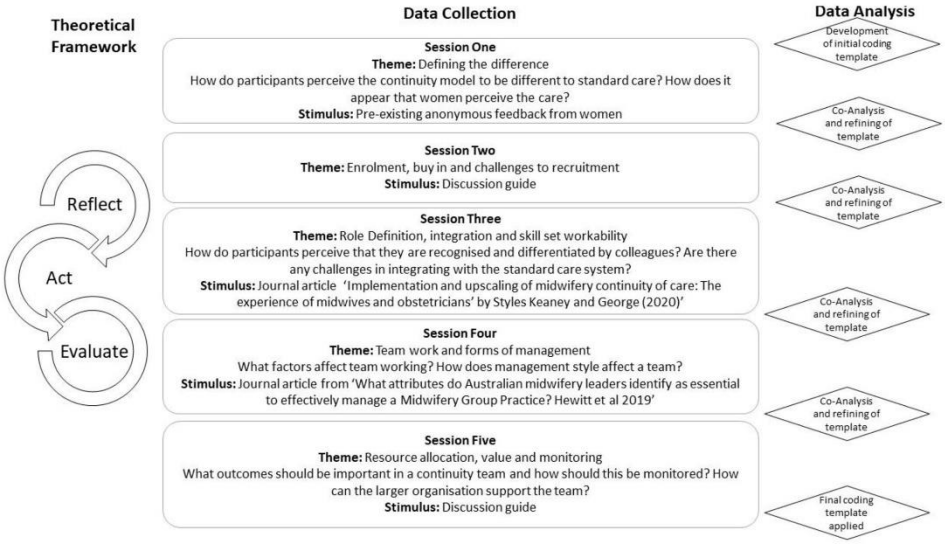
5.2.3 Data recording and storage

With permission from participants, the action group discussion will be recorded. Should online conferencing occur, the full conference will be recorded in video format. Should face to face discussions occur, data will be recorded as an audio recording.

Please refer to the data management plan for full details of the systems in place to ensure data is held securely. Data will be securely stored within the university in line with ethics agreements and will be destroyed following completion of the study. Transcription of audio recordings will be undertaken by the lead researcher. Should external transcription services be employed, it is understood that they will be sourced through the university and will sign a confidentiality policy in line with current policy. Audio or video recordings will be transcribed verbatim and verified by the lead researcher. All recordings will be kept until the conclusion of the project to support data analysis and will then be securely deleted.

Pseudonyms will be used to protect the confidentiality of participants. Due to the nature of the project, it is possible that participants may be identifiable to those who are familiar with the service. It is intended that participants should feel able to fully contribute to the study without fear of retribution or a change in treatment in the workplace. The participatory aspect of the study will ensure that participants retain control over the published work and can approve any findings. The findings of the study will be shared with the clinical management team at the completion of the project through the final report. Should the action group decide as a result of their shared reflection that a change is required in the workplace, this will be approached as a group rather than as individuals.

Figure 2: Project process and discussion themes



5.2.4 Discussion Guide

As detailed in the action group discussion guides listed in the appendices, additional data will be presented to act as a stimulus for discussion. Figure two provides a guide to the intended process of the research project and the intended themes for discussion. This discussion guide has been developed through extensive reading and reflection on elements of implementation science. Implementation science frameworks have developed from research which explores the barriers and enablers of change in real world contexts such as large organisations like the National Health Service (Nilsen 2015). The stimulus for the initial design came from Normalisation Process Theory (May and Finch 2009) as applied to a continuity of midwifery care setting by Forster et al. (2011) A strength of NPT is that it addresses the wider organisational context which influences the midwives' readiness to adopt change and seeks to understand the alteration to the 'work' of assimilating the change. The framework developed by the NPT scholars is flexible in its application and should be adapted to the needs of each research project (May et al. 2015). Elements of the theories of Consolidated Framework For Implementation Research (Damschroder et al. 2009) and Diffusion of Innovations in Service Organisations (Greenhalgh et al. 2004) were incorporated into the evaluation of a service to supports a deeper and more holistic understanding of the experiences of the midwives working in a continuity model: continuity of care affects every aspect of the midwives' professional and personal life and it was vital to recognise this effect outside of the workplace setting.

Although a discussion guide has been developed, it will not be considered prescriptive and participants will be free to discuss topics pertinent to their experience. Should conversation turn to subjects outside of the research area or to areas which will be covered in other sessions, the CI will gently prompt a return to the intended theme of the session.

The theme of session one is 'defining the difference'. In this session it is hoped participants will reflect on what makes the continuity of care model different to standard care and how this is viewed by the women in their care. The stimulus of feedback from mothers who have experienced continuity of care will be anonymously presented. This written information has already been collected from feedback forms issued as part of standard

care and collated to an excel spreadsheet as part of internal audit processes. Permission has been granted to utilise this anonymous feedback as part of the research and is already available to the continuity team.

Session two focuses on 'enrolment, buy in and challenges to recruitment'. The use of discussion prompts as detailed in the discussion guide (Appendix A) seeks to stimulate reflection from participants about what factors affected their choice to embrace the change to continuity of care and what factors may support others in doing so.

Prior to session three participants will be given full text access in print or online to a journal article. This article reports on the experiences of midwives and obstetricians implementing continuity of care in Australia (Styles et al. 2020). Participants will be encouraged to engage with the full text to understand the specific context of the research and to highlight any quotes they would like to bring to group discussion. It is hoped that through reflecting on the experiences of others, the participants will consider their own experiences of working with other professionals and how they feel they are perceived by the wider team. The theme of this session is 'role definition, integration and skill set workability'.

Session four will focus on team working which has been widely identified as an important aspect in the sustainability of continuity of care teams (Stevens and McCourt 2002; Fereday and Oster 2010; Yoshida and Sandall 2013; Hunter et al. 2016; Crowther et al. 2019). Discussion prompts as detailed in Appendix A will be used to focus discussion on aspects of team working. Another aspect explored in this session will be leadership and management. Participants will be provided with a print or online access to a full text journal article which considers attributes of effective leaders in Australian continuity of care models (Hewitt et al. 2019). Midwives will be encouraged to engage with the full article to understand the contextual differences and similarities of the Australian care setting. The group will them be asked to reflect on the paper. Non-directive prompts have been designed to stimulate and guide discussion should this be required.

The fifth and final session theme is 'resource allocation, integration and monitoring'. This will be discussion focussed with no external discussion stimulus. The group will be asked to reflect on factors which they feel demonstrate a successful continuity of care team and the process of monitoring the ongoing performance of a team. They will also be asked to consider resource allocation in regard to appropriate training and equipment should this not have already been covered in previous sessions. Finally, participants will be asked to consider how large organisations such as the National Health Service can ensure that small teams such as continuity teams feel valued and supported within the wider context.

Each session will follow a similar format to encourage a reflection-action-evaluation cycle. At the start of each session, participants will be asked to reflect on the previous session and any changes they felt necessary to make following group reflection. At the conclusion of each session the group will be encouraged to reflect on the session and asked to contribute any remaining ideas and consider if they feel necessary to implement a change in their practice.

In addition to the five action group discussion sessions, participants will also be invited to engage in the process of co-analysis. Details of this process can be found in section 5.3.

5.3 Analysis

Data analysis will be undertaken by the principal investigator in collaboration with the research participants who are recognised as co-researchers in this methodology. The experienced supervisory team will provide oversight to ensure consistency with the chosen methodology. Data analysis will be undertaken throughout the data collection period.

Template analysis is style of thematic analysis which aims to identify organise and interpret themes in the data (King 2018). This approach to analysis has been chosen as it supports the participatory methodology and allows for ongoing data analysis concurrent with the data collection. The procedural steps offered by Brooks and King (2014) will be followed as a guide to support the analysis of this data.

1. An initial data analysis coding template will be developed prior to data analysis by the principal investigator. These a priori themes will be identified following careful consideration of the existing literature on midwives' experiences of continuity of care provision and from implementation science theoretical frameworks which have guided the development of the study design. These a priori themes are tentative and will be refined or removed if they are not reflected by the data. They provide a logical starting point for analysis (Brooks and King 2014) and may act as an initial guide for co-design and refining of the coding template with participant midwives. Although the ontological and epistemological stance of participatory action research often requires a more open approach to data analysis to allow the voice of the data to guide the research, the use of a priori themes has been sensitively examined. Provision of an a priori coding template for the novice researcher group to engage in co-production of the analysis of their own words will guide the group through the initial analysis process (Brooks and King 2014). This will also support the research to build on existing theory (Vadeboncoeur and Bopp 2020). The group will be encouraged to remain open to other themes and will critically reflect on the coding template in an iterative process whereby the template is refined throughout the research period. Furthermore the involvement of participant midwives in the full research process including data analysis is in keeping with the tradition of participatory action research (Schubotz 2019), empowering ordinary people to engage in research of their own experiences.
2. The raw audio or video recording data of the first action group meeting will be transcribed verbartim by the principal investigator. This will support the process of familiarisation with the data set.
3. Participant midwives will be encouraged to engage with the transcript. The verbartim transcript will be shared with the group for preliminary analysis of the transcript data. The aim of this will be to highlight sections which appear relevant to the research question. This further supports the familiarisation process for the principal investigator and the participant midwives.
4. The initial coding template will then be shared with the group to support preliminary coding of the extracts highlighted by participant midwives.
5. The group will discuss and critically reflect on the initial coding template. This feedback will be used by the principal investigator to refine the coding template to be applied to the transcript of the next action group meeting.
6. This process of co-analysis and refining the template will continue with each action group meeting transcript. Following the co-analysis of the final group transcript, the template will be discussed. Participant midwives will be encouraged to reflect on the previous iterations of the coding template. A final coding template will be agreed.
7. The principal investigator will then apply this final coding template to each transcript. This will support and confirm that this coding template sufficiently encompasses the themes in the totality of the transcript data (Dakin et al. 2020).

Although initial co-analysis will likely be undertaken by hand to ensure accessibility to all participant midwives, a clear record of this analysis will be kept by the principal investigator using a computer aided analysis software program such as NVivo 12.

It is understood that there may be varying levels of engagement from participants throughout the research process. Should the analysis process prove to be too large a commitment from participant midwives, the principal investigator will engage with the above process and share the results of this process with participants for feedback. This feedback will enrich the data analysis (King 2018) and ensure that the identified themes reflect the truth of the participant experiences.

A critical element to thematic analysis is reflexivity of the principal investigator and co-analysts. The researcher is also a member of the participant group being studied. Some themes may reflect unfavourably on the participant group or cause discomfort. Furthermore, as with all thematic analysis, the experiences, world view and proximity of the analysts to the research area will influence the development of the analysis (King 2018).

Therefore, ongoing reflection and reflexivity is vital to ensure that the data is truly represented by the chosen themes. Reflexivity will support the CI and co-participants to gain insight into the evolving influences of their

journey through the research project and the ways in which this may affect their interpretation and analysis of the data (Bolton 2010)

6 STUDY SETTING

This is a single centre study. The study will be undertaken at Salisbury NHS Foundation Trust Hospital. This site is where the lead researcher is employed. Maternity services at Salisbury are in the process of implementing continuity of care teams in line with recommendations form the government report Better Births. At present there is one team of midwives working in a continuity of care model. It is anticipated that on commencement of the study additional continuity of care teams will be operational. Midwives working in these teams will be invited to volunteer to become participants in the study by email and poster.

The location of action group meetings will be decided by the participants in the project in to ensure a mutually convenient setting which affords participants privacy to freely explore their experiences. As previously identified, this is intended to be an online video conferencing software. Should participants decide face to face meetings are more acceptable; it is anticipated that a number of locations within Salisbury NHS Foundation Trust may be acceptable to participants. These can be booked through the hospital room booking system. The site specific requirements are the availability of a suitable room for action group meetings and the availability of participants to attend action group meetings.

7 SAMPLE AND RECRUITMENT

7.1 Eligibility Criteria

Inclusion criteria	Exclusion criteria
• Midwife • Employed at Salisbury NHS Foundation Trust • Experience of working in a continuity of care model at Salisbury NHS Foundation Trust • Band 5 or 6	• Staff employed in role other than midwife • Midwives employed outside of Salisbury NHS Foundation Trust • Midwives without experience of working in continuity of care model • Midwives working in managerial capacity

7.2 Sampling

7.2.1 Size of sample

It is hoped that six to ten midwives will participate in the study. Morgan (1997) suggests that fewer than six participants may detract from the process of understanding the experience. The sample size limit has been identified for a number of reasons: practical reasons concerning meeting room available in a mutually convenient space and methodological reasons concerning cohesive group understanding. Use of theoretical frameworks from implementation science will support understanding of both the individual lived experiences of the participants and how this fits the organisational level.

7.2.2 Sampling technique

There are a small number of eligible participants within the area being studied. The sampling will be opportunistic and will close to new participants when ten participants are engaged in the project.

7.3 Recruitment

7.3.1 Sample identification

Participants will be identified by the principal investigator who is situated in the field of the study as a midwife colleague. Participants will be recruited through publicity in the form of posters and informational emails sent to a cohort email address. A single research team is operating this study.

Participants will enter the study voluntarily and will not accrue payment for participation itself. It is understood that participants will attend meetings regarding the study within work time. Their hours and possible travel expenses will therefore be covered within their clinical contracts with the study co-funder. Participants already have access to smart phones and laptops with internet capability to enable them to attend online video conferencing.

7.3.2 Consent

Informed consent will be sought from all participants and this can be withdrawn at any time. Eligible participants will be presented with a study information sheet (see attached) which details the scope of the study, possible harm and benefits to them as individuals, their expected level of involvement, and why they are eligible to participate. Participants will be asked to sign a written consent form which will be securely stored in line with the data management plan. Contact details for the principal investigator and the research team will be provided to ensure potential participants can ask questions prior to participating. The principle investigator will also be available for informal discussion as she works clinically in the field. All participants will be actively employed as clinical midwives. It is therefore assumed that all will have the capacity to consent.

8 ETHICAL AND REGULATORY CONSIDERATIONS

8.1 Assessment and management of risk

The risks associated with this study are minimal for participants and the research team. A risk analysis undertaken by the research team has identified the following risks:

8.1.1 Risks to participants

It is hoped that participation in this project will empower midwives and positively affect their wellbeing. However, it is possible that pre-existing or newly developed negative impacts on wellbeing may be disclosed during the project. All co-researchers are registered professionals who are anticipated to be able to signpost peers to relevant support services if required. Self-referral to employer, NHS or RCM/RCN union provided support services are widely available.

8.1.2 Risks to researcher

The doctoral researcher is also a participant in the project. As such, the same risks identified above apply. The added multiplicity of roles and potential to be seen as a 'change agent' may add additional pressures on the doctoral research candidate. Regular reflection, supervisory meetings and additional training will be used to combat this. In addition to support services identified above, university support services are available if required.

8.1.3 Safeguarding

Should safeguarding issues be identified in this study, clear mechanisms are in place within the clinical setting. The principal investigator remains an NMC registered professional and has a responsibility to work within the NMC code and research ethical framework to ensure the safety and wellbeing of staff and service users.

8.1.4 Poor practice

It is possible that poor practice or training issues may be identified through this research. As a researcher and a midwife, the lead researcher has a responsibility to act within the NMC code and within a research ethical framework to ensure the safety and wellbeing of staff and service users. Dependent on the severity of what is reported it should be discussed and reflected on by the supervisory team. It will be necessary to report a concern raised from feedback to line manager of the continuity teams from a safety perspective to ensure that serious allegations are investigated through appropriate channels. It will not be in the lead researcher's scope of practice or that of midwife team member or researcher to investigate allegations.

8.2 Research Ethics Committee (REC) and other Regulatory review & reports

Research protocol to be submitted the NHS REC for approval prior to commencement of the study.

8.3 Peer review

This project was subject to high quality peer review as part of the award of a match-funded studentship.

8.4 Patient & Public Involvement

This research has not been subject to Patient and Public Involvement. This research focuses on the experiences of a staff group and it was not deemed necessary to involve patients or the public in the design of this research.

8.5 Protocol compliance

Protocol deviations, non-compliances, or breaches are departures from the approved protocol. Should accidental deviation from the protocol occur this will be adequately documented on the relevant forms and shared with the investigatory team. The team will continuously reflect to ensure the risk of deviation from the protocol is reduced.

8.6 Data protection and patient confidentiality

All investigators will comply with the requirements of the Data Protection Act 1998 with regards to the collection, storage, processing and disclosure of personal information and will uphold the Act's core principles.

- All personal information is collected, kept secure, and maintained. This will involve:
- The creation of coded, depersonalised data where the participant's identifying information is replaced by an unrelated sequence of characters.
- Secure maintenance of the data and the linking code in separate locations using encrypted digital files within password protected folders and storage media.
- Limiting access to the minimum number of individuals necessary for quality control, audit, and analysis.
- Confidentiality of data will be preserved when the data are transmitted to sponsors and co-investigators

- Data will be stored securely by the university for five years from the date of completion of this PhD project.
- The principal investigator, Katie Gregory, is the data custodian for this project.

8.7 Indemnity

Full indemnity cover will be provided for the entire research project through Bournemouth University and the NHS indemnity scheme. This will meet the potential legal liability of the sponsors, employers, and investigators should any harm arise. All queries concerning this should be directed to the university legal team.

8.8 Access to the final study dataset

Participants will have access to transcripts during the process of co-analysis. The final dataset will be accessible only by the named study investigators.

9 DISSEMINIATION POLICY

9.1 Dissemination policy

Data arising from the study will be owned by the lead investigator and Bournemouth university. On completion of the study the analysis of the data and a report on the study will be written. This will be published in the PhD thesis of the principal investigator and available through Bournemouth university. It is also intended that a study report will be submitted for publication in a relevant journal. Study participants will be informed of any publication via email and will have access to journal publications through their employer's library license. Participants may request access to the final study report upon its completion at the end of the study. It is intended that the approved thesis will be available within four years of the completion of the study. The participatory nature of this study ensures that the outcome of the study will be known to all participants and they will contribute to the development of the outcomes. Prior consent will be gained in the event that the data provokes a secondary research project.

The study protocol will be made available upon approval by the NHS HRA through publication. Anonymised data sets will not be made publicly available given the intimate nature of the data and the potential for participants to be identified though this.

9.2 Authorship eligibility guidelines and any intended use of professional writers

The principal investigator and study coordinators will have authorship of the study.

10 REFERENCES

List the literature and data that are relevant to the study, and that provide background for the study. Please ensure the text contains appropriate cross references to this list.

11. APPENDICIES

Appendix A : Action Group Topic Guide

Session schedules draft 0.1

Reviewed focus group prompt document to identify key themes and work into coherent focus group schedules.

[Questions should not be overtly personal and should instead ask participants to reflect on something they may have thoughts on so as not to make them too vulnerable in the group setting and hopefully ensure people feel comfortably to answer honestly.]

Session 1: Defining the intervention:

Why do you feel that there is such a focus on CoC?
Who/ what is driving the changes to implement CoC? Who makes the decisions in your organisation?
What differences might be noticed in the 'practice' or 'work done' of midwives in CoC teams as opposed to standard care midwives?

STIMULUS: Use of anonymised feedback from service users collected from routine audit of the service and reflect on this as a group.

Reflecting on this feedback, do women cared for in a continuity team view the role of the midwife differently to standard women cared for in a standard care model?

How might a CoC midwife view their relationship with the families they care for? How might it be different from a standard care midwife's views?

REFLECTION: How has the session gone?
ACTION: Do you feel there should be changes on a personal, group or organisational level to address anything identified in the session?

Session 2: Enrolment, buy in.

Did anything change as a result of the first session? This could be a change as a group or a change in mindset of an individual.

What are the greatest challenges faced by midwives working in a *standard* care model?

Are there particular personal characteristics which might best suit a CoC midwife specifically as opposed to midwives in general?

What do you feel is the greatest hurdle or barrier to other midwives joining CoC teams?

What would need to be different for more midwives to find working in a CoC team attractive?
What advice would you give to a midwife joining a CoC team for the first time?

What practices might support a CoC midwife who is finding the role difficult?

Looking to potential future roll-out of more continuity teams, would it make a difference to the success of a team if midwives volunteer/choose to join a team?

REFLECTION: How has the session gone?
ACTION: Do you feel there should be changes on a personal, group or organisational level to address anything identified in the session?

Session 3: Role definition; integration and skill set workability

Did anything change as a result of the last session? This could be a change as a group or a change in mindset of an individual.

STIMULUS- Share quotes from 'Implementation and upscaling of midwifery continuity of care: The experience of midwives and obstetricians' by Styles Keaney and George (2020)'. The full text will be supplied to participants in advance to aid greater reflection on the paper. Participants will be encouraged to read the full text to understand the context of the research and how it may differ from their own context. Participants will be encouraged to highlight any quotes they would like to discuss.

The main theme of this session is reflection on how the role of a CoC midwife might be perceived by other professionals.

Reflecting on the experiences of obstetric and standard care midwives reported in this paper:

Would anyone like to share a quote they have highlighted?

What themes are reported in this quote?

Do you perceive that similar themes would be found in this practice setting?

Do the experiences reported in this paper resonate with your perception of this setting? In what way are they the same or different?

Should further prompts be required:

See quote from Core MW 10:

"Sometimes that work is still left up to us, and I think the challenges have been, potentially, that there's been no… clear guidelines about what their scope is, exactly, what they'll do when they come in, what they won't do…sometimes that depends on the midwife… (Core MW 10)"

Has anyone got any reflection on this quote? How should responsibilities for tasks be decided?

See quote from Obs2:

"*…certainly with really complex patients that a midwife comes to a doctor antenatal clinic appointment would seem reasonable. So they have a good idea of the plan going forward and can be a coordinator…but we do have instances where one or even two midwives come to a fairly straightforward appointment which would seem to - you know, when you have two people being paid to do what we usually do as one person, and occasionally come into postnatal appointments and things like that, seems to be a little bit of a waste of time in my opinion (Obs2)"*

Has anyone got any reflections on this quote?

See quote from Obs5B:
"*I've also seen a couple of women actually change their birth plan, mode of delivery, because of the [CoC midwife]…how they actually manage to cope with their anxiety regarding certain mode of delivery. That is actually a positive impact as well (Obs 5B)"*
Would anyone like to reflect on this quote? How does this obstetrician appear to perceive CoC? Is this experience shared in this setting?

> **REFLECTION:** How has the session gone?
> **ACTION:** Do you feel there should be changes on a personal, group or organisational level to address anything identified in the session?

Session 4: Team working

Did anything change as a result of the last session? This could be a change as a group or a change in mindset of an individual.

STIMULUS: Share excerpts from 'What attributes do Australian midwifery leaders identify as essential to effectively manage a Midwifery Group Practice? Hewitt et al 2019'. The full text will be supplied to participants in advance to aid greater reflection on the paper but only excerpts presented will be discussed to allow for midwives to reflect on the spot.

See Session 3 stimulus document which will be shared on screen with participants.

[If this is too much, explore the questions 'What qualities would be useful in a leader or manager of a continuity team?'; 'What attributes might negatively affect the CoC team?']

Reflecting on the paper we have shared. If prompts are required:

- What qualities are the most important in a CoC manager?
- Do we need a CoC manager?
- How involved should a manager be in the day-to-day running of the team?

Moving on:

How do you think the level of experience in a CoC team affects the team development?

What benefits and challenges might there be to including newly qualified midwives in a CoC team?

If you could design a dream midwifery continuity team, what might it include? Would you include other staff roles such as MCAs or obstetricians?

What challenges might a team face when navigating full time and part time staff?

Developments such as mobile phones and video calls have changed the ways midwives practice over the last few decades. How important is technology to your role?

REFLECTION: How has the session gone?
ACTION: Do you feel there should be changes on a personal, group or organisational level to address anything identified in the session?

Session 5: Integration and monitoring

Did anything change as a result of the last session? This could be a change as a group or a change in mindset of an individual.

What factors would demonstrate that a CoC team is working well? Prompt: not just clinical outcomes.

Are there clear objectives for the CoC team?

How do the team receive feedback?

What resources are essential for a sustainable team?

What training would useful for CoC midwife?

How do you feel valued by the organisation for the role you provide?

How do guidelines and policies support or detract from your care as a CoC midwife?

REFLECTION: How has the session gone?
ACTION: Do you feel there should be changes on a personal, group or organisational level to address anything identified in the session?

Round-up: We have covered a lot of ground over the past few months. Have any significant changes occurred to how CoC is practiced in the organisation?

Thank-you everyone!

Appendix B- Stimulus for session 3

Session 3: Role definition; integration and skill set workability

Extracts/Quotes from: Styles Keaney and George (2020) Implementation and upscaling of midwifery continuity of care: The experience of midwives and obstetricians

…if we're going to introduce it, we have to know that it's better than what we're currently doing. I think it's stupid to break up what has been a very functional system. I think in the last few years we've had a very good system of care here. I think the outcomes of care are really good. (Obs 2)

…certainly with really complex patients that a midwife comes to a doctor antenatal clinic appointment would seem reasonable. So they have a good idea of the plan going forward and can be a coordinator…but we do have instances where one or even two midwives come to a fairly straightforward appointment which would seem to - you know, when you have two people being paid to do what we usually do as one person, and occasionally come into postnatal appointments and things like that, seems to be a little bit of a waste of time in my opinion (Obs2)

Don't you think continuity of care is important? Of course we think it's important, but it's also important that we provide an equitable service and spend the money that we get allocated in the best possible way (Obs 4)

… a more FTE team, but also, I see a lot of people rushing off on annual leave, and somebody else comes in to join, and somebody else comes in, and someone's leaving, and someone's sick; there seems to be a really disjointed lot of people, and I don't think that can give good continuity to the woman (Core MW 8)

I am concerned about some of the MGP [CoC] staff. The senior ones in those teams…they look exhausted. Haggard, they drag their feet, and no one likes coming to night shift; whether that's their time management skills, whether that's the system, whether that's not enough support from their NUM, I mean I don't know? (Core MW 6)

The other concern that I have about the MGP [CoC] is the sustainability of it. Having worked in the private obstetric sector for a number of years it is pretty demanding being on call seven days a week. I know that. But I can foresee that this is - this could be- a problem and it's certainly been a problem in other MGPs [CoCs] that I'm aware of… (Obs 2)

…a lot of birth suite midwives who are doing now postnatal care *or haven't set foot into the postnatal ward for many, many years, not really knowing what they're doing…when you look at our purpose out here is to prepare this woman and her family, her partner for taking this baby home, if you're not doing it to the highest possible standard you possibly can, we can't guarantee we're giving her the best start (MW2)*

I see it a little bit unfair that the MGP midwife is expected to do a neo-natal screen, or a bath, or even post-natal discharge education, because I would think that the woman should just get everything from us. Then, if she gets a little bit of top-up at home, that's a bonus for her. But yeah, I was surprised that MGP came in to do thing… (Core MW2)

I think it is a wonderful model of care. There are still quite a few things to iron out, a few things to process…I know that it's been talked about expanding it, but I think it's better just to leave it at the moment to improve it before we expand any further (Obs 2)

So I think expanding it is probably a good idea, but is it cost effective? Can we afford it? Have we got the midwives to do it? We've got to be mindful of the provision of other services, the sort of core services for the women - our sickest women, yeah, the ones that I tend to care more for (Obs 3)

Sometimes that work is still left up to us, and I think the challenges have been, potentially, that there's been no… clear guidelines about what their scope is, exactly, what they'll do when they come in, what they won't do…sometimes that depends on the midwife… (Core MW 10)

…is there some way of coordinating midwifery group practice with a group of obstetricians as well? So you can have - extend the team into the medical group as well. (CoC MW 3)
…think it's a good idea that MGP [CoC] could be aligned with a consultant (Core MW1)

Appendix C - Stimulus for session 4

Session 4: Team working

From 'What attributes do Australian midwifery leaders identify as essential to effectively manage a Midwifery Group Practice? Hewitt et al 2019'. Could you ask the participants to identify these from their reading to encourage engagement?

[This can be presented on a powerpoint to encourage participant engagement.]

Some elements identified:

- Being 'visionary'
- Passion for women, for evidence-based woman-centred care and for making a difference in women's lives and midwifery
- courageous', authentic, being trustworthy, and having 'integrity. 'humility':
- 'trust'
- be 'brave' and willing to 'take risks':
- 'Emotional intelligence' (EQ)
- 'listening'
- 'power of persuasion'
- 'charisma'
- a deep commitment to their belief

The study also goes on to note:

'They should protect, guard, promote and safeguard the service'

'Someone with their hand on the steering wheel '

The participants believed that to manage the service, MGP managers should not only understand the practice but 'promote the service' as well, especially within the hospital hierarchy.

'Midwifing the midwife'

- The participants discussed that another aspect of the job of 'midwifing the midwives' is to help midwives have professional boundaries, encouraging them to not be 'everything to every woman'.
- One participant said, 'They actually need managing carefully to make sure that the staff are okay' (Jane), or as described by another participant: 'Midwifing the midwife in the best possible way, so as we midwives are with the woman' (Julie).
- One participant identified that 'understanding the role [of the caseload midwife], and being prepared to stick up for it, is another part of it' (Julie). 'Protection of the midwives' is described as warding off misinformed criticism, investigating complaints, standing up for the service and shielding the midwives.
- Being aware that midwives need to move out of MGP from time to time to develop different skills or for family/personal reasons was highlighted by the participants. They also explained that midwives need to be encouraged to keep 'developing professionally'.
- facilitate healthy relationships between midwives. One way mentioned was to encourage them to meet each week as 'regular meetings' to enable midwives to catch up and check in with each other, and develop their relationships.
- skilfully deal with conflicts within the group.

Appendix D

Exploring Midwives' Experiences of Continuity

The MExOC Study will explore midwives' experiences of working in continuity of care models. This research is being funded by Salisbury NHS Foundation Trust and Bournemouth University.

- Research shows that women experience improved clinical outcomes and report a high level of satisfaction with continuity of care.
- There is mixed research on the experiences of midwives providing this care.
- This research aims to provide insight into the experiences of midwives providing this model of care by supporting them to reflect on their own experiences. It is hoped that this project will support the sustainability of this model by encouraging the group to make changes in their practice which will improve their experience.

- ✓ *Are you a midwife who has worked in a continuity of midwifery care model in the last 3 years?*
- ✓ *Do you currently work in a band 5 or 6 role?*
- ✓ *Would you like to get involved in research and learn some new skills?*

- ✓ If you choose to take part, you become a co-researcher. This means you share ownership of the project and are recognised as an expert in your experience of continuity. You can influence the aspects of your experience which should be researched.
- ✓ The research group will meet 4-6 times over a twelve-month period to share and reflect on different aspects of their experiences of providing continuity of care. These meetings will be using a video conferencing platform so you can participate from home using your work iPhone or laptop. The meetings will last around 2 hours and have been agreed as part of your working hours.
- ✓ You are encouraged to get involved in all parts of the research process including analysing the discussion to identify common themes shared by participants.

Contact Katie Gregory (Lead Researcher) for further information or to take part in the study

☎ 07927 208630

✉ kgregory@bournemouth.ac.uk

✗ Risks to participation

The process of reflecting on your experiences may be uncomfortable or distressing at times. For many midwives continuity of care is more than a 'job' and touches many aspects of their lives.
You can choose how much you share with the group.
Conversation stimuli have been designed to support reflection.

✓ Benefits of participation

Participating in this research may benefit you by giving you an opportunity to reflect on your experiences.
It is hoped that this research will support the group to improve their experiences of practice. You may gain research skills and experience.

Data: Recordings of our discussions on the online video conferencing software will be recorded and stored securely. These will be transcribed with pseudonym names to protect your identity. Due to the nature of this study it may be possible that your contribution may be identifiable by persons familiar with the midwifery team. The group will establish ground rules which are expected to cover participant confidentiality within the research group. Only the group participants and the university supervisory team will have access to the research data and your personal information. All research data will be securely stored in line with university policy, ethical requirements and current data protection laws. This data will only be used for the purposes of this study. BUs Research Participant Privacy Notice sets out further information about your rights as an individual and the responsibility of the university as the data controller. **You can withdraw from participation in the study at any time without giving a reason or**

You can seek additional support from external sources such as your local PMAs or your staff union such as the RCM. Free telephone counselling is available through occupational health.

suffering detriment. It may not be possible to withdraw information you have already contributed to the study which may include your personal identifiable information. Your legal rights to access, change or delete this information is limited as we need to manage your information in specific ways to ensure the

research is reliable and accurate. If you have concerns about how this could affect you personally please raise this with the research team

Results: This work will form part of a doctoral research thesis. The results of the research project will also be submitted for publication in relevant journals. A final research report will be available to participants and funders. Most importantly, the results of this project should be apparent to you as a participant as the group reflects on their experiences and implements changes to improve their working lives.

In case of complaints please contact: researchgovernance@bournemouth.ac.uk or project supervisors Prof. Lee-Ann Fenge: lfenge@bournemouth.ac.uk or Dr Luisa Cescutti-Butler: lcbutler@bournemouth.ac.uk

Appendix E

Participant Consent Form

NHS Logo BU logo

Project Title: Continuity model of midwifery care team: a new way of working – exploring midwives views and experiences using a participatory action research approach.

Project Supervisor Lead: Lee-Ann Fenge

Researcher: Katie Gregory

☐ I have read and understood the information provided about this research project in the Participant Information Sheet dated XXXX

☐ I have had an opportunity to ask questions and have them answered.

☐ I understand that the identity of my fellow participants and our discussions in the action group is confidential to the group. I agree to keep this information confidential.

☐ I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.

☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

☐ If I withdraw, I understand that while it may not be possible to destroy all records of the focus group discussion of which I was part, the relevant information about myself including tapes and transcripts, or parts thereof, will not be used.

I understand that any 'allegations' of bad practice will be escalated or similar terminology

☐ I agree to take part in this research.

☐ I wish to receive a copy of the report from the research (please tick one):

Yes ☐ No ☐

Participant signature .....
Participant Name .....

Participant contact details:

Email ..... Telephone .....

Date:

Researcher name

13.3 Appendix 3 – Amendment History

Amendment No.	Protocol version no.	Date issued	Author(s) of changes	Details of changes made

List details of all protocol amendments here whenever a new version of the protocol is produced.

Protocol amendments must be submitted to the Sponsor for approval prior to submission to the REC.

Allen, J., Kildea, S., Hartz, D. L., Tracy, M. and Tracy, S., 2017. The motivation and capacity to go 'above and beyond': Qualitative analysis of free-text survey responses in the M@NGO randomised controlled trial of caseload midwifery. *Midwifery*, 50, 148-156.

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Appendix 2 COMPart Study Protocol

Continuity of midwifery care: Exploring the experiences of midwives employed part-time and understanding strategies which sustain their practice. The COMPart study

SHORT STUDY TITLE / ACRONYM

COMPart: Continuity of midwifery part-time study

PROTOCOL VERSION NUMBER AND DATE

3.0 03/05/2022

RESEARCH REFERENCE NUMBERS

BU Ethics ID 44055

KEY STUDY CONTACTS

Chief Investigator	Katie Gregory, RM. Post-graduate research student at Bournemouth University. Email kgregory@bournemouth.ac.uk.
Study Co-Ordinator	Prof. Lee-Ann Fenge, PhD supervisor, Bournemouth University Dr Luisa Cescutti-Butler, PhD supervisor, Bournemouth University
Sponsor	Sponsor representative – Julie Northam, Head of Research Development & Support, email jnortham@bournemouth.ac.uk For governance and ethics enquiries – Suzy Wignall, Clinical Governance Advisor, email clinicalresearch@bournemouth.ac.uk Bournemouth University Bournemouth Gateway Building St Paul's Lane Bournemouth BH8 8GP
Joint match-funder	Salisbury NHS Foundation Trust Oddstock Hospital Salisbury Wiltshire SP2 8BJ

STUDY SUMMARY

Continuity of midwifery care is associated with improved outcomes and satisfaction for women and babies (Sandall et al. 2016). NHS maternity services are undergoing transformation in order to provide continuity of care to women. Women who receive standard NHS maternity care may meet a number of midwives in their antenatal and postnatal care and are unlikely to have previously met the midwife who cares for them in labour. Continuity of midwifery care means that care provided by the same midwife or small team of midwives throughout a women's pregnancy, birth, and postnatal period. The role, expectations and working pattern of a midwife working in a continuity model may be very different to those of a standard model.

The COMPart study utilises an appreciative inquiry approach to explore the experiences of midwives working in continuity of care settings on a part-time employment basis. The research seeks to understand the personal, professional, and organisational practices which support part-time employed midwives to offer this model of care. Little research already exists on part-time midwives in continuity of services, yet a large proportion of NHS midwives are employed on a part-time basis (Department of Health 2010). This knowledge is urgently required to support transformation of maternity services to offer continuity of midwifery care.

Semi-structured interviews will explore the personal and practical experiences of midwives who are employed on a part-time basis in continuity settings across the UK.

Study Title	Continuity of midwifery care: Exploring the experiences of midwives employed part-time and understanding strategies which sustain their practice. The COMPart study
Internal ref. no. (or short title)	COMPart: Continuity of midwifery part-time study
Study Design	Qualitative design utilising an appreciative inquiry methodology.
Study Participants	6 Midwives with experience of providing continuity of care
Research Question/Aim(s)	Aim: To explore how midwives employed on a part-time basis can provide midwifery continuity of care services. Objective: To explore the experiences of part-time midwives working in continuity of care settings and develop insights into practices which support them.

FUNDING AND SUPPORT IN KIND

FUNDER(S)	**FINANCIAL AND NON FINANCIALSUPPORT GIVEN**
Bournemouth University	• Match-funded PhD studentship; • Access to Researcher Development Fund; • Supervisory support from Professor Lee-Ann Fenge and Dr Luisa Cescutti-Butler • Office space, use of computers, stationery, and printing; • Access to The Doctoral College, postgraduate research training and development programme; • Support from the central research office – Research Development and Support.
Salisbury NHS Foundation Trust	• Match-funded PhD studentship; • Access to CPD and professional midwifery revalidation; • Clinical contract to work as a midwife for 15 hours per week alongside research activities as part of the PhD programme. • Support from the central research office – Research Development & Support.

ROLE OF STUDY SPONSOR AND FUNDER

This research project is part of a match funded PhD studentship between Bournemouth University and Salisbury NHS Foundation Trust. The initial research proposal was designed by the funders. The design of the research project has since been developed by the lead researcher with support and guidance from the study co-ordinators as academic supervisors. Salisbury NHS Foundation Trust has provided feedback on the design of the study.

Bournemouth University, the sponsor, is responsible for the overall responsibility for the initiation and management of the trial. They hold legal and liability responsibility for the conduct of the trial and employees of Bournemouth University.

ROLES AND RESPONSIBILITIES OF STUDY MANAGEMENT COMMITEES/GROUPS & INDIVIDUALS

Supervisory Team

This study is part of a Doctoral project undertaken at BU by the Chief Investigator (CI), with academic oversight from the CI's supervisory team. The supervisory team are:

• Professor Lee-Ann Fenge - PhD, DProf, MSc, CQSW, BA (Hons).

• Dr Luisa Cescutti-Butler – PhD, PG Dip Ed, MA, RM, RGN

The team has extensive and complementary experience of working and conducting research within the NHS and social care sectors. The role of the supervisory team is to guide the planning of the research project, so that it is achievable within the expected timeframe, to provide clear guidance on the key monitoring milestones, and to keep a systematic record of progress. The team meet approximately once a month and are in regular contact through email. The supervisory team has and will continue to advise the CI and contribute to:

• The scientific and ethical quality of the research proposal;

• The safety and wellbeing of participants and the CI;

• The ability of the CI to conduct the proposed research;

• The availability of time and resources to achieve the proposed research objectives;

• Active and effective arrangements to monitor and assess the progress of the research;

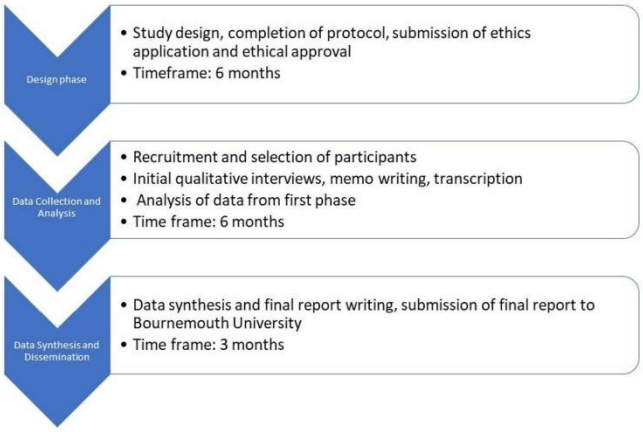
• Appropriate arrangements to disseminate the findings of the research and ensure that the study adheres to BU guidelines

ROLES AND RESPONSIBILITIES OF STUDY MANAGEMENT COMMITEES/GROUPS & INDIVIDUALS

PROTOCOL CONTRIBUTORS

Katie Gregory	Principal Investigator, Postgraduate research student, Bournemouth University	Research design, conduct, data analysis and interpretation, manuscript writing, dissemination of results.
Professor Lee-Ann Fenge	Prinicipal Academic Supervisor, Bournemouth University	Research design, review of analysis, interpretation, writing.
Dr Luisa Cescutti-Butler	Academic Supervisor, Bournemouth University	Research design, review of analysis, interpretation, writing.
Suzy Wignall	Clinical Governance Advisor, Bournemouth University	Sponsor review and governance requirements

STUDY FLOW CHART



STUDY PROTOCOL

Continuity of midwifery care: Exploring the experiences of midwives employed part-time and understanding strategies which sustain their practice. The COMPart study

1 BACKGROUND

Continuity of midwifery care is associated with improved outcomes and satisfaction for women and babies (Sandall et al. 2016). Directives from the World Health Organisation (2016; 2018) recommend that all countries with well-developed midwifery services provide continuity of midwifery care. Maternity policy in the UK advocates that continuity of midwifery care is offered within the National Health System (NHS). In 2016 the 'Better Births' report (NHS England 2016) explicitly recommended that continuity of midwifery care was implemented across England. Prior to the release of the Better Births report, very few women were receiving full continuity of care throughout the childbirth continuum (Sandall et al. 2019). Women who receive standard NHS maternity care may meet a number of midwives in their antenatal and postnatal care and are very unlikely to have previously met the midwife who cares for them in labour (Sandall et al. 2019). Most NHS maternity care providers must implement significant organisational alterations to service provision to successfully offer this model to a greater proportion of pregnant women (McInnes et al. 2018).

There is increasing research into the experiences of midwives who provide continuity of care services including a recently published systematic review by Pace et al. (2021). Midwives who provide continuity of care may experience increased job satisfaction (Newton et al. 2014; Jepsen et al. 2016). Midwives form deeper and more meaningful relationships with the women in their care and with their colleagues in continuity teams which leads to high levels of personal fulfilment (Pace et al. 2021). Midwives providing continuity of care can provide a full spectrum of midwifery care and develop a strong sense of professional autonomy. The flexibility associated with self-management of planned work meant that continuity midwives report that they were more able to be present in their home life than when they worked traditional shifts (Newton et al. 2016).

Pace et al. (2021) identified a number of challenges for midwives who provide continuity of care. Midwives found it difficult to balance the demands of their personal life with their work. Some midwives felt burdened with an increased level of responsibility and guilt. They also reported some distress as a result of conflicting demands on them as professionals working within the wider maternity care system. Research by Taylor (2019) and Newton (2014) identified factors within midwifery practice which increase the chance of stress and burnout and many of these factors remain present in a continuity setting. These include working mixed days and nights, long hours, high workloads and being on-call (Fereday and Oster 2010; Yoshida and Sandall 2013). Research which investigates the willingness of midwives to adopt a continuity model highlight concerns about a perceived detrimental impact of continuity working patterns on their lives (Taylor et al. 2019; Harris et al. 2020). Part-time midwives may experience these factors differently to their full-time colleagues because the proportion of time spent in their midwifery role is reduced.

The most recent NHS workforce statistics from 2010 showed that part-time midwives make up the majority of the midwifery workforce, and this proportion was increasing (Department of Health 2010). One of the challenges in implementing continuity of care is ensuring that part-time staff are able to perform their midwifery role in a way which ensures relational continuity for women and also ensures that continuity services are sustainable within the wider maternity service and for the midwives themselves (NHS England 2017). Taylor (2019) and Harris (2020) conclude that further research is required to successfully design and adapt services which meet the needs of midwives and mothers. The co-design of midwifery continuity services

with the midwives who will staff the service has been identified as a means of ensuring services are sustainable and function optimally (Pace 2021).

Midwives who do not work full-time have been precluded from working in many continuity teams (Taylor 2019) and there is minimal literature which examines the experiences of part-time continuity midwives. Pace (2021) notes a desire from midwives providing continuity to explore options for part-time working. Only one study (Vasilevski et al. 2020) specifically explored part-time midwives working in continuity teams. This Australian project trialled the implementation of two midwives sharing one full-time equivalent position within a continuity team. Women gave positive feedback about their experience of care and the part-time midwives were well regarded by other team members, who reported that these colleagues brought additional energy into the team and showed an increased chance of intrapartum continuity provision. Only two part-time midwives sharing a single midwife job contributed to this research, but they were clear that the experience had been positive for their midwifery career and enabled them greater flexibility for their own childcare responsibilities. This is a pertinent finding as British researchers Taylor (2019) and Harris (2020) identified that midwives' caring responsibilities are a major barrier in midwives joining continuity teams.

The research will recruit nationally and seeks to engage with the experiences of part-time midwives UK continuity of midwifery care settings in order to develop an understanding of personal and organisational strategies which sustain their practice.

2 RATIONALE

Aim: To explore how midwives employed on a part-time basis can provide midwifery continuity of care services.

Objectives:

- 1) To explore the experiences of part-time midwives working in continuity of care settings and develop insights into practices which support them.

This research seeks to explore how midwives employed on a part-time basis can provide midwifery continuity of care services. This information is vital to the successful development of continuity of midwifery care services within the NHS but there is very limited research on this topic at present. Government drivers such as the Better Births report (2016) recommend the transformation of maternity services to provide this model of care in order to improve clinical outcomes and service-user experience.

The most recent NHS workforce statistics from 2010 showed that part-time midwives make up the majority of the midwifery workforce, and this proportion was increasing (Department of Health 2010). One of the challenges in implementing continuity of care is ensuring that part-time staff are able to perform their midwifery role in a way which ensures relational continuity and also ensures that continuity services are sustainable within the wider maternity service and for the midwives themselves (NHS England 2017). Taylor (2019) and Harris (2020) conclude that further research is required to successfully design and adapt services which meet the needs of mothers and midwives. This research aims to provide information which will support the development of NHS continuity of midwifery care services involving part-time midwives.

3 THEORETICAL FRAMEWORK

This research study will embrace a qualitative approach to engage with lived experiences of the participants. The approach used is based in a social constructivist paradigm whereby reality is created in the moment, and multiple realities exist alongside one another (Gergen and Gergen 2015).

The development of this research has been informed by Appreciative Inquiry. This is a mode of action research which supports transformative organisational change through the co-creation of a shared vision of possibilities (Ludema et al. 2006). This philosophical approach tries to understand the wholeness of complex human experience and seeks to identify the possibilities for growth by reflecting on existing strengths and successes in the field. Where traditional deficit focused organisational change research may highlight inadequacies, appreciative inquiry points to answers about how to implement effective and sustainable change (Stavros et al. 2015).

This strength focussed approach has been described as an approach which liberates participants and allows them to unleash a transformational discourse which affirms the forces which are successful, nourishing and sustaining within the organisation (Cooperrider and Srivasta 1987; Ludema et al. 2006) . This is pertinent in the context of implementation of midwifery continuity of care: The dominant discourse in recent publications and observed within midwifery areas is one of intransigence and negativity around this change (Hall 2021, Ockenden 2021, McInnes et al 2020).

This theoretical framework is based on the assumption that what we focus on becomes our reality. Our words we use create the worlds in which we interpret our own reality: “the language used in everyday life continuously provides me with the necessary objectifications and posits the order within which these make sense and within which everyday life has meaning for me” (Berger and Luckmann 1966, p.22). The act of asking questions, being curious and encouraging participants to dream of the possibilities creates a new reality. Organisations are recognised as relationally alive systems made up of the individuals within them (Cooperrider and Fry 2020). Human systems grow in the direction in which they persistently and actively inquire, and if they can envision the future, they can take comfort and courage from being able to see this and thus take action to move there (Hammond 1998).

This research utilises an Appreciative Inquiry philosophy to envision and cultivate a future where midwives are able to work in continuity of care models.

4 RESEARCH QUESTION/AIM(S)

Aim: To explore how midwives employed on a part-time basis can provide midwifery continuity of care services.

4.1 Objectives

1) To explore the experiences of part-time midwives working in continuity of care settings and develop insights into practices which support them.

4.2 Outcome

1) An understanding of the experiences of midwives who have worked part-time in continuity of care settings and personal and organisational strategies which support them.

5 STUDY DESIGN and METHODS of DATA COLLECTION AND DATA ANALYIS

5.1 Appreciative Inquiry

This study will explore the experiences and the organisational and personal strategies developed by part-time midwives working in continuity settings through six semi-structured interviews.

Ethical approval will be sought from Bournemouth University.

The design of this study has been influenced by Appreciative Inquiry, which focuses the research to understand best practices which already exist in comparable healthcare settings. Appreciative Inquiry is a mode of action research which supports transformative organisational change through the co-creation of a shared vision of possibilities (Ludema et al. 2006). This philosophical approach tries to understand the wholeness of complex human experience and seeks to identify possibilities. Where traditional deficit focused organisational change research studies may highlight inadequacies, appreciative inquiry points to answers about how to implement effective and sustainable change (Stavros et al. 2015).

This strength focussed approach has been described as an approach which liberates participants and allows them to unleash a transformational discourse which affirms the forces which are successful, nourishing and sustaining within the organisation (Cooperrider and Srivasta 1987; Ludema et al. 2006). This is pertinent in the context of implementation of midwifery continuity of carer: Recent publications reflect a negative attitude expressed by many within the midwifery profession about the introduction of continuity of care (Hall 2021, Ockenden 2021, McInnes et al 2020).

Appreciative Inquiry is a process in which participants move through stages of identifying what already happens in their personal or professional world, exploring what the future could look like and then, using what has been identified, to begin to design and build innovative new practices (Cooperrider and Whitney 2007). This can be seen as the 4D's of Appreciative Inquiry: Discover, Dream, Design and Destiny. The way in which the process is applied is not prescriptive and should be adapted to the unique setting in which the approach is utilised (Cooperrider and Whitney 2007).

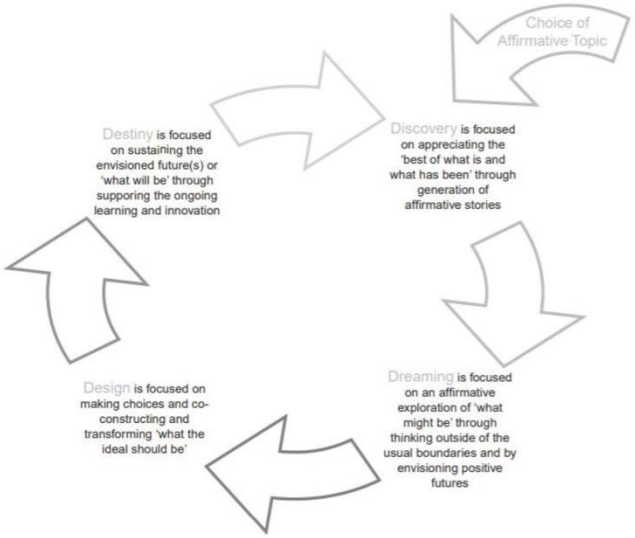


Figure 1*: The 4-D cycle from Carter (2006)*

The topic explored in this research will explore the experiences of midwives in continuity of care settings. The focus on part-time staff has been developed as workforce data reflects that a high proportion of midwives are employed on a part-time basis (Department of Health 2010). There is limited published research which has included the experiences of part-time midwives within continuity of care (Vasilevski et al. 2020).

The manner in which the topic will be presented and shared with participants is that which supports it as an 'affirmative' topic (Cooperrider and Whitney 2007). This is an opportunity to explore the opportunities for part-time staff within a model of midwifery care which provides continuity, to support the identification and development of strategies at a personal and organisational level which support and facilitate part-time midwives to contribute to continuity teams at their highest and most successful potential. Participants may report challenges and difficulties which are known to be associated with working in a continuity model of midwifery care within interview and focus group discussions, this research does not seek to explicitly identify these difficulties, although they will be reported in the research should they arise.

The 4D's of AI have theoretically underpinned the development of the interview guide, which directs the participant to move through a personal appreciative inquiry of their own experience. The chart below illustrates the journey though appreciative inquiry in the interview guide.

4D Phase	Type of AI Question	Questions
Introduction	Establishing rapport and background	Could tell me a little bit about yourself? Tell me about your role in the continuity team? Prompts: What led to you joining the team? What led to you leaving the team? Can you tell me about working part-time in the team and how that works?
Discovery	High Point Experience	Can you tell me about the best experience (an experience which filled you with passion, energy and excitement) you had as a midwife in a continuity setting? Prompts: What were the factors and forces which made it such a great experience? What was it about you, others and the organisation which made it such a great experience for you?
	Valuing	When you feel best about work, what do you value about it?
	Core life-giving factors	Is there anything your organisation or team have done which you feel has been particularly supportive to you?
Dream	Images of a future	If there were no organisational or personal barriers to your vision, what would make being a midwife in a continuity of care setting perfect? Prompts: Tell me about how your role would look? How would the structure of the team look?
Design	Images of the future	What strategies could be put in place to make your vision for midwifery a reality? Prompts: What would be needed at organisational level to make it happen? What would be needed for you at an individual level to let the vision become a reality?
Closing questions		Is there anything else you would like to mention? Is there anything you think is important for me to know about being a part-time continuity midwife?

Figure 2: 4-Ds of AI in the COMPart Study

In the questions relating to the discovery, participants will be asked to share 'the best of what is' (Cooperrider and Whitney 2007) through reflecting on their high point experiences. Questions which facilitate the discovery phase of the research include discussion of participants' best experiences as continuity midwives and what they feel the values and practices of their organisation are when it is at its best.

In the dream stage of this inquiry participants will be asked to imagine how their role would be if barriers were removed to facilitating their dream continuity of care role and maternity service. They will be asked to construct a vision of their dream role as a part-time continuity midwife, considering factors relating to their own lives and to the structure of the organisation in which they would work. Participants will move to a more pragmatic design stage where they consider what would be necessary for the dream to be reality, and consider if any parts of their dream vision could reasonably be implemented in a real-life setting.

The final D, destiny, refers to a post-research stage which examines if any changes have been made from an organisational development perspective. This is beyond the scope of this postgraduate research study. In

Appreciative Inquiries by Carter (2006) and Donald (2012), research participants spontaneously moved to the destiny phase by implementing strategies in their own environment which they could personally affect. Some participants in this study may reach this stage outside of the boundaries of the research because they have spent time reflecting on their own experiences, but this will not be formally reported in the study.

5.2 Data Collection

The COMPart study seeks to explore the experiences of midwives who have previously worked part-time in continuity of care settings. Participants will be recruited for the study using informal professional networks such as an active Facebook group for midwives with an interest in continuity of midwifery care. Six semi-structured individual interviews will be undertaken online using Microsoft Teams. Interviews will be video recorded using the software's inbuilt recording ability. Interviews will be facilitated by the CI who has attended training on undertaking semi-structured interviews. A semi-structured interview guide has been written and included in the appendix. The guide follows an Appreciative Inquiry interview approach in keeping with the methodology (Ludema et al. 2006; Sidebotham et al. 2015).

5.3 Analysis

Analysis of the data will be undertaken by the CI with the support of her supervisors. Thematic analysis, guided by Braun and Clarke (2006, 2021), is a theoretically flexible approach well suited to understanding the themes in the study.

This is a multi-phase process which begins by immersion in the data during the transcription and memoing process. Recordings will be transcribed verbatim by the CI as part of the data immersion process. During the transcription process, data will be de-identified and pseudonymised by the CI. Annotations will be added to the data to reflect meaning such as sarcasm which may otherwise be lost (Byrne 2021). Initial descriptive coding of the data using NVivo software will then be followed by analytical coding. Themes in the data will be developed and refined. Visualisation tools in NVivo may be utilised to draw deeper understanding of the data. Ongoing reflexivity is essential in the research process (Braun and Clarke 2021) to ensure that the influence of the unique lens of the CI is considered when interpreting the themes and to ensure an accurate representation of the data.

As detailed in the Data Management Plan, all access to data will be restricted to the CI and members of the research team. Raw audio/video recordings will be securely stored on the university OneDrive system in a password protected folder until the completion of the academic award, upon which it will be destroyed. During analysis, transcripts and analysis data will be stored within the university OneDrive storage system. On completion of the study, anonymised transcripts of the data will be uploaded to the university's digital repository, BORDaR, for archiving and re-use. This is made explicit in the PIS and PAF forms.

6 STUDY SETTING

The study will recruit participants nationally for online individual qualitative interviews in order to understand the experiences of midwives who have worked part-time in continuity of care settings. This is appropriate to address the research aims by seeking to engage with participants who may have diverse experiences in terms of geography, age, experience.

The recruitment strategy in section 7 will describe the identification of potential participants.

7 SAMPLE AND RECRUITMENT

7.1 Eligibility Criteria, Sampling and Sample Size

The study will interview 6 midwife participants. Participants will be purposively selected to reflect a diverse range of experiences, career stages and geographical locations. It is hoped that interviews with 6 purposively selected participants will add value to the research and meet the aims of the study. This is a reasonable volume of data to be transcribed, analysed, and stored within the limits of a PhD level study.

Inclusion criteria are:

Qualified registered midwife,
Experience of working in NHS funded continuity of midwifery care setting in last 5 years,
Employed on <30h/week basis whilst working in continuity setting,
Able to attend a 1-hour interview on Microsoft Teams.

Exclusion criteria are:

Staff roles other than midwife
Employed on 30h+basis
No experience of working in continuity of care setting in last 5 years

7.3 Recruitment

Participants will be recruited to the project via professional networks and through the sharing of a recruitment poster in social media groups. The recruitment poster will be shared with the admin of the social media group for publication within the group to ensure that the researcher is not approached on a personal social media account. Interested people will be directed to an online participant information sheet and prompted to complete an online form to express their interest. Please see attached recruitment poster.

7.3.1 Sample identification

Potential participants will have seen a recruitment poster on social media. The poster will direct interested participants to contact the research team.

Participants will be directed to complete an online form expressing interest in the study (accessed through QR code or hyperlink from the social media recruitment advert. This data will be collated from Microsoft Forms into a Microsoft excel spreadsheet of monitoring data ensuring that accurate records are kept.

Participants will be offered a £20 Love2shop voucher in recognition of the time and effort of participating in the research. Participants will receive compensation if they begin an interview with the researcher. If participants withdraw before this point, they will not receive compensation. Participants must participate outside of their working hours (this will ensure that they are not at risk of fraudulent double payment for working hours). The act of compensating these participants recognises the experience and value that participants who have worked in this role bring to the research. It was felt to be important that this research

does not reinforce negative practices such as unpaid overtime which is found to contribute to staff burn-out in the NHS. Furthermore, the participants may not presently be employed by the NHS. This is in accordance with guidance produced by the HRA on payments and incentives in research (Health Research Authority 2014).

7.3.2 Consent

The consent process is dynamic and requires good communication skills and knowledge of ethical and regulatory procedures. The PI will be the sole person who receives consent. The PI has completed the 'Introduction to Good Clinical Practice' package which covers Informed Consent taking. All participants will be provided with a copy of the relevant Participant Information Sheet (see attached) and have the opportunity to have any questions regarding participation answered during email correspondence arranging their participation and prior to commencing the interview/focus group. Since all participants are registered midwives, it is not anticipated that any potential participants could lack capacity to give informed consent, however, should the PI suspect the participant lacks capacity, she will thank the participant for their time and politely terminate the interview.

Participants will need to complete an online consent form prior to data collection. They will be sent a link to the consent form via email. The PI will ensure they provide their continued consent at the beginning of their research interview, by asking them to confirm they have read and understood the PIS and that they continue to agree to participate in the study. The PI will document their response on the Microsoft Excel spreadsheet generated by Microsoft Forms from the e-PAF form. All participants will be made aware that they are free to leave the study at any point without having to provide a reason but that depending on the timing, it may not be possible to remove their contribution.

The consent forms- referred to as e-PAF have been developed using Microsoft Forms 365. This secure software is accessible via Microsoft Office 365 using the PI's university user account and is encrypted in line with Sponsor's requirements. The forms involve a set of simple self-assessment questions which check participants understanding as they work through the information. Each statement will need to be answered in order to proceed to the next statement. Participants will select 'yes or 'no' to indicate they agree or do not agree to each statement. If participants select 'no' they are directed to the end of the form, which thanks them for their time and provides instruction for exiting the study, thereby declining to provide their informed consent, links to the summary and full PIS on Microsoft OneDrive and the contact details of the research team. An electronic signature will be collected in the form of an explicit consent declaration at the end of the consent form, confirming whether they agree to participate of not. A 'tick box' option of 'yes, I do consent' or 'no, I do not wish to provide consent' will be used to confirm whether they accept or decline to participate based on the information they have read. This method of obtaining consent is advocated for non-CTIMP studies and is supported by the Health Research Authority (HRA), and the Medicines and Healthcare Products Regulatory Agency (MHRA) (2018). Participants will also select the date they completed the form and provide their name and contact details so the CI can contact them. Participants will then receive a confirmation email from Microsoft Forms 365, with an online link to their consent form. Participants can be sent a hard copy of their consent form if they prefer. The confirmation email will thank them for their response and also has a link to Microsoft's Privacy Statement. The PI will be alerted after each consent form has been completed at her BU email address. Participant's responses will be stored securely on Forms 365. Responses can then be viewed on the Forms platform on OneDrive, and data can be exported into Microsoft Excel for data management purposes. Copies of the consent forms can also be printed from here.

8 ETHICAL AND REGULATORY CONSIDERATIONS

Before the start of the study, approval will be sought from an ethical review board for the study protocol, participant information sheet, informed consent forms, and supporting documents. Amendments that require review by the ethics panel will not be implemented until approval is granted for the amendments. All correspondence with the ethics panel will be retained in the Study Master File at BU.

The Chief Investigator will notify the ethics panel at the end of the study and if the study is ended prematurely, including the reasons for the premature termination. Within one year after the end of the study, the Chief Investigator will submit a final report with the results.

8.1 Assessment and management of risk

This research will receive Sponsorship from BU. The study will be ethically approved by the Sponsor in line with the BU Research Ethics Code of Practice. The study cannot commence until these approvals have been granted. The research will protect the privacy and personal information of participants in the manners discussed within the protocol and the DMP. When research is carried out in a workplace setting there is a potential risk that participants may feel obliged to take part or concerned that their career might be affected if they decline to participate. Any participation in this research will be carried out in a fully informed and consented manner with the opportunity at each interaction for participants to express whether they wish to continue their participation in the study or not.

The PI is a post-graduate research student and a midwife, and has a statutory duty of care to the public. The PI has a professional duty to safeguard the women and children, to practice effectively, safely, honestly, and in accordance with the NMC Code of Professional Practice (2018). The data collection methods are unlikely to pose risks to participants. Any identification of potential harm will be fully risk assessed and promptly managed in accordance with the risk assessment plan. These situations are discussed in turn in with strategies to mitigate against them in the following table.

Potential risk identified	Planned management of risk
Participant: Emotional distress It is possible that participants could experience emotional distress when recalling their experiences, however some may also find the opportunity therapeutic.	If a participant becomes distressed, the PI will comply with the following procedures: 1. Ask the participant if they wish to stop the interview and offer them support. 2. Signpost support services available, such as NHS Counselling services through GP or Occupational Health services; or their PMA team if available in the area. Details of services will be included in the PIS. 3. This should be documented as a serious adverse incident (SAE) in the study SAE logs.
Safeguarding: Concerns including: mental ill-health, child or adult safeguarding, criminal activity, violence	If the PI is concerned about safeguarding issues that could harm the safety of women, children, their families, or the public the participant will be informed that the PI is required by law to share this information. The PI will follow the following procedures in this event: 1. Assess immediate risk to participant (e.g. immediate plans to harm self or others). This is within the scope of the PI's role as a registered midwife;

	2. Inform relevant services such as emergency services where necessary; 3. Contact supervisory team for guidance on how to address the concern. 4. Log the incident as an SAE. Inform the Sponsor of the SAE. The PIS will provide explicit details about the PI's professional obligation to report safety issues that are raised during the study.
Safeguarding: Participant discloses practice which may be unsafe or endanger others	As a practising midwife, the CI has a legal and professional duty of care to ensure the safety of patients and the public (Nursing and Midwifery Council 2018). In the unlikely event that a participant reports unsafe practice of a healthcare professional or support worker the CI will comply with the following procedures: 1. Remind the participant of their own duty to report unsafe practice as a registered midwife; 2. Contact supervisiory team for guidance on how to address the concern 3. Log the incident as an SAE. Inform the Sponsor of the SAE. The PIS will provide explicit details about the PI's professional obligation to report safety issues that are raised during the study.

8.2 Research Ethics Committee (REC) and other Regulatory review & reports

Approval will be sought from the Bournemouth University Research Ethics Committee for the study protocol, PIS, e-PAF forms and other relevant documents e.g. recruitment posters. Amendments that require regulatory review will not be implemented until that review is in place and other mechanisms are in place to implement them at the research site. The PI is responsible for producing an annual progress report as required during the study period. The PI will notify the Sponsor of the end of the study. If the study ends prematurely the PI will notify the Sponsor, including the reasons for the premature termination. Within one year after the end of the study, the PI will submit a final report to the REC detailing the results, including any publications/abstracts

Regulatory Review & Compliance

Before participants can enrol into the study the CI or designee will ensure that appropriate approvals from participating organisations are in place. Specific arrangements on how to gain approval from participating organisations are in place and comply with the relevant guidance. For any amendment to the study, the CI or designee, in agreement with the Sponsor will submit information to the appropriate body in order for them to issue approval for the amendment.

Amendments

If the CI wishes to make an amendment, they will submit an authorised amendment tool for consideration.

8.3 Peer review

This study forms part of the CI's doctoral study at BU and will be submitted in part fulfilment of the qualification of Doctor of Philosophy (PhD). The PI's performance on the PhD programme and the progress of the study has undergone rigorous, high quality peer review by the academic supervisory team, and the

Research Sponsor. The research site match-funds the study in conjunction with BU, as such both organisations are invested in its success and timely completion. The PI attends regular academic supervision meetings to review and monitor the progress of the study and her performance. The PI attends quarterly meetings with the Director of Midwifery at the NHS site for review of progress. The PI has sought review from representatives of the CRN Wessex during the process of research development. As part of the doctoral programme the CI is also formally monitored and peer-reviewed via BU academic processes. The assessments occur at regular stages of the programme as outlined below:

• Probationary Review – The review took place in February 2020 by two independent academic members of the faculty of Health and Social Sciences. The CI outlined the proposed study in light of the evidence and amended substantial elements based on feedback. A risk assessment of health and safety, ethical issues and a future research plan of activities were developed.

• Re-Enrolment Review - At the end of each academic year the progress of the project and the academic development of the CI is reviewed. A training needs analysis is performed and the CI sets objectives and an action plan for the forthcoming academic year.

• Major Review and transfer onto higher degree – The major review exam ensures that the research meets the required academic standards to continue at doctoral level. The Major Review is planned for March 2022

• Final thesis submission – Doctoral examination, expected intention to submit in April 2025.

8.4 Patient & Public Involvement

Whilst it is acknowledged that service users ultimately benefit from the improvements in the practice area; it was not considered appropriate to involve members of the public in a formal PPI process.

The initial proposal for this project was a Participatory Action Research project with a continuity of care team within an NHS organisation. Midwives on this team were involved in the development of the original research proposal. The team was disbanded in 2020 and the project was refocused.

Members of clinical leadership team at the match funding organisation contributed to the refocusing of the research and identification of relevant and acceptable focus. The Director of Midwifery at the match funding organisation assessed the acceptability of the research. Informal peer review by members of the Midwifery Clinical Academic research team was sought.

8.5 Protocol compliance

Protocol deviations can happen at any time. They will be adequately documented onto a protocol deviation form, filed within the ISF, and then reported to the CI and the Research Sponsor within 24 hours of identification. Protocol deviations which are found to frequently recur are not acceptable and could potentially be classified as a serious breach. This will be discussed and forwarded to the Sponsor.

8.6 Data protection and patient confidentiality

All investigators and study site staff must comply with the requirements of GDPR and the Data Protection Act 2018 with regards to the collection, storage, processing, and disclosure of personal information and will uphold the Act's core principles. As outlined in the DMP all data will be collected, handled, maintained, and stored in line with the Act and complies with local Research Sponsor and research site procedures. The CI will implement and maintain compliance with the DMP.

8.7 Indemnity

BU's Public Liability and Professional Indemnity insurance policies provide an indemnity to their employees for their potential liability for harm to participants during the conduct of research. This does not in any way affect an NHS Trust's responsibility for any clinical negligence on the part of its staff (including the Trust's responsibility for BU employees acting in connection with their NHS honorary appointments). BU holds Professional Indemnity insurance to cover the legal liability of the University as Research Sponsor and/or as the employer of staff engaged in the research, for harm to participants arising from the design of the research, where the research protocol was designed by the University. These policies include provision for indemnity in the event of a successful litigious claim for proven non-negligent harm.

8.8 Access to the final study dataset

The PI will have access to the full data set. Any data shared with the supervisory team will be anonymised prior to sharing via BU's Microsoft's OneDrive transfer system. The final dataset will be anonymised, cleaned, and stored within BU's data repository as shared in the PIS.

9 DISSEMINIATION POLICY

9.1 Dissemination policy

Data from the study is owned by BU in line with the student agreement on Intellectual Property Rights. On completion of the study, the data will be analysed and tabulated, and a Final Study Report prepared. The full study report will be shared with funders, sponsors, and participants.

The study protocol, full study report and anonymised participant level dataset will be made publicly available through BU's data repository system BORDaR.

9.2 Authorship eligibility guidelines and any intended use of professional writers

Authorship eligibility will be in line with defined authorship criteria for manuscripts submitted for publication from The International Committee of Medical Journal Editors (International Committee of Medical Journal Editors 2022)

10 REFERENCES

Reference List

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Appendix 3 BU Ethics Application for COMPart Study

Research Ethics Checklist

About Your Checklist	
Ethics ID	40647
Date Created	23/11/2021 15:42:30
Status	Open
Risk	High

Researcher Details	
Name	Katie Gregory
Faculty	Faculty of Health & Social Sciences
Status	Postgraduate Research (MRes, MPhil, PhD, DProf, EngD, EdD)
Course	Postgraduate Research - HSS
Have you received funding to support this research project?	Yes
Is this external funding?	Yes
RED ID	
Please provide the External Funding Body	
Is this internal funding?	
Please list any persons or institutions that you will be conducting joint research with, both internal to BU as well as external collaborators.	Salisbury NHS Foundation Trust

Project Details	
Title	Continuity of midwifery care: Exploring the experiences of midwives employed part-time and understanding strategies which sustain their practice
Start Date of Project	23/09/2019
End Date of Project	06/07/2025
Proposed Start Date of Data Collection	07/02/2022
Supervisor	Lee-Ann Fenge

Summary - no more than 600 words (including detail on background methodology, sample, outcomes, etc.)

This research utilises an appreciative inquiry approach to understand the experiences of midwives working in continuity of care settings on a part-time employment basis. The research seeks to understand the personal, professional and organisational practices which support this model of care and to begin a collaborative process of service transformation. Two phases of research are planned. Phase one will explore the personal and practical experiences of midwives who are employed on a part-time basis in continuity settings across

the UK. Phase two will share themes from the interviews with focus groups involving managers and midwives within the local NHS Trust to explore learning from phase one and how this can support the co-development of the local continuity of care service.

Filter Question: Does your study involve Human Participants?

Participants
Describe the number of participants and specify any inclusion/exclusion criteria to be used
Phase One • Phase One of the study will interview ten midwife participants. Participants will be purposively selected to reflect a diverse range of experiences, career stages and geographical locations. Inclusion criteria are: Qualified midwife, Experience in NHS continuity of midwifery care setting in last 5 years, Employed on <36h basis whilst working in continuity setting, Able to attend a 1-hour interview on Microsoft Teams. **Phase Two** • Two focus groups will be held. The intended sample for the midwifery staff focus group is 6-12. Inclusion criteria are: Qualified midwife at band 5 or 6 (no managerial responsibility). Purposive sampling to reflect diverse experiences will be used if excess numbers apply (career stage, experience in continuity, full and part time, personal circumstances and caring responsibility). The intended sample for the second group is up to 12 midwifery managers. All Band 7 and 8 midwives will be invited to attend. Should excess participants apply, managers with direct responsibility for the continuity teams will be selected. For both focus groups, should in person focus groups not be practicable then the participant numbers will be reduced to 5 participants to support optimal engagement in online focus groups.

Do your participants include minors (under 16)?	No
Are your participants considered adults who are competent to give consent but considered vulnerable?	No
Is a Disclosure and Barring Service (DBS) check required for the research activity?	No

Recruitment
Please provide details on intended recruitment methods, include copies of any advertisements.
Phase One Participants in this phase will be recruited to the project via professional networks and through the sharing of a recruitment poster in social media groups. The recruitment poster will be shared with the admin of the social media group for publication within the group to ensure that the researcher is not approached on a personal social media account. Interested people will be directed to an online participant information sheet and prompted to complete an online form to express their interest. Please see attached recruitment poster. **Phase Two** Recruitment for the focus groups will be via poster displayed in the hospital and distributed by global email to ensure equal opportunity of access for community based staff. Please see attached recruitment poster.

Do you need a Gatekeeper to access your participants?	No

Data Collection Activity	
Will the research involve questionnaire/online survey? If yes, don't forget to attach a copy of the questionnaire/survey or sample of questions.	Yes

How do you intend to distribute the questionnaire?	
online	
If online, do you intend to use a survey company to host and collect responses?	No
Will the research involve interviews? If Yes, don't forget to attach a copy of the interview questions or sample of questions	Yes
Please provide details e.g. where will the interviews take place. Will you be conducting the interviews or someone else?	
Interviews will be undertaken using Microsoft Teams videoconferencing software. All interviews will be conducted by the lead researcher Katie Gregory. Please see attached file for semi-structured interview guide.	
Will the research involve a focus group? If yes, don't forget to attach a copy of the focus group questions or sample of questions.	Yes
Please provide details e.g. where will the focus group take place. Will you be leading the focus group or someone else?	
Focus groups will be facilitated by Katie Gregory. If practicable at the time of data collection, focus groups will be held in person, in a private comfortable room within the local hospital. This echoes the idea that continuity of care is relationship based, and that continuity of care teams rely on the mutual support of colleagues, which is more easily achieved in person. Holding focus groups in-person allows participants to fully engage with one another and to interact with the verbal and non-verbal social cues within the group. This provides a natural flow of group discussion and may enhance data collection. At the time of designing this research, all meetings within the NHS Trust are held on virtual conferencing software such as Microsoft Teams due to the Corona virus pandemic. If these restrictions remain in place during the data collection period then these focus groups will be held on Microsoft Teams software. All staff have access to this software and are expected to be familiar with its use.	
Will the research involve the collection of audio materials?	Yes
Will your research involve the collection of photographic materials?	No
Will your research involve the collection of video materials/film?	No
Will any audio recordings (or non-anonymised transcript), photographs, video recordings or film be used in any outputs or otherwise made publicly available?	No
Will the study involve discussions of sensitive topics (e.g. sexual activity, drug use, criminal activity)?	No
Will any drugs, placebos or other substances (e.g. food substances, vitamins) be administered to the participants?	No
Will the study involve invasive, intrusive or potential harmful procedures of any kind?	No
Could your research induce psychological stress or anxiety, cause harm or have negative consequences for the participants or researchers (beyond the risks encountered in normal life)?	No
Will your research involve prolonged or repetitive testing?	No

Consent

Describe the process that you will be using to obtain valid consent for participation in the research activities. If consent is not to be obtained explain why.
Interested participants will apply to the study through their own free will. All participants will be provided with a copy of the relevant Participant Information Sheet (see attached) and given the opportunity to have any questions regarding participation answered. All participants will be asked to sign a Participant Agreement Form prior to data collection. All participants will be made aware that they are free to leave the study at any point without having to provide a reason but that depending on the timing, it may not be possible to remove their contribution.

Do your participants include adults who lack/may lack capacity to give consent (at any point in the study)?	No
Will it be necessary for participants to take part in your study without their knowledge and consent?	No

Participant Withdrawal

At what point and how will it be possible for participants to exercise their rights to withdraw from the study?

A participant has the right to withdraw from participating in my research at any time without providing an explanation. They do not have to answer every question during an interview. If a participant would like to withdraw from the study when data has been anonymysed it may not be possible to remove their data. Furthermore their participant data such as PAF form will be retained in the study documentation file.

If a participant withdraws from the study, what will be done with their data?

Some participant data such as PAF form will be retained in the study documentation file. Data provided as part of participating in the study such as through interview, would be erased and not included in the study analysis. If a participant would like to withdraw from the study when data has been anonymysed it may not be possible to remove their data.

Participant Compensation

Will participants receive financial compensation (or course credits) for their participation?	No
Will financial or other inducements (other than reasonable expenses) be offered to participants?	No

Research Data

Will identifiable personal information be collected, i.e. at an individualised level in a form that identifies or could enable identification of the participant?	Yes

Please give details of the types of information to be collected, e.g. personal characteristics, education, work role, opinions or experiences

Phase One personal data will include personal characteristics and work role submitted through Microsoft Forms. Participants may also be identified through their interview, transcript or recording. Personal data will also be held on phase two participants through their focus group recording and transcript.

Will the personal data collected include any special category data, or any information about actual or alleged criminal activity or criminal convictions which are not already in the public domain?	No
Will the information be anonymised/de-identified at any stage during the study?	Yes
Will research outputs include any identifiable personal information i.e. data at an individualised level in a form which identifies or could enable identification of the individual?	Yes

If Yes, please give details (e.g. project leaflets, project website, blogs, publicly accessible database, publications)

It may be possible for participants to be identified through pseudonymised data such as quotes in publications. The participant information sheet communicates this possibility and output will be written with the aim of minimising this possibility.

Storage, Access and Disposal of Research Data

During the study, what data relating to the participants will be stored and where?	All participant data and documents will be stored securely in a designated file system on Microsoft OneDrive. Microsoft accounts and OneDrive are accessed securely though the lead researcher's university student account and are governed by Bournemouth University. The study data will be backed up regularly using Microsoft OneDrive platforms and recovery of the user profile is possible through a restore feature. Participant data will include participant demographic information, full name,

	general geographical location. This will be collected through Microsoft Forms and held in an excel file on Microsoft OneDrive. Participants will be allocated a unique identifier under which data pertaining to them will be named. Study documents such as Participant Agreement Forms will be securely held on OneDrive. Phase One interview audiovisual recordings will be made with Microsoft Teams and stored on OneDrive with a file name corresponding to the participant number. Recordings will be permanently erased from the OneDrive when the PhD is completed. Transcripts of recordings will be held on OneDrive. Should phase two focus groups occur online, they will be recorded with Microsoft Teams as above. If focus groups occur in person, they will be digitally audio recorded on a portable recording device. This device will be held securely by the lead researcher and the file will be transferred to the OneDrive system within 48 hours of the recording, and permanently erased from the portable device.
How long will the data relating to participants be stored?	Data relating to participants will be stored for a period of 10 years following completion of the study in accordance with Principle 8 of the Concordat on Open Research Data.
During the study, who will have access to the data relating to participants?	During the study only the lead researcher and project supervisors will have access to data relating to participants.
After the study has finished, what data relating to participants will be stored and where? Please indicate whether data will be retained in identifiable form.	On completion of the study, data will be anonymised and potentially identifiable information redacted. This will then be uploaded to BU's digital repository, BORDaR, for archiving and re-use. This is made explicit in the PIS and PAF forms. Study documents such as PAF forms will be passed to Bournemouth University as the Data Controller.
After the study has finished, how long will data relating to participants be stored?	Data relating to participants will be stored for a period of 10 years following completion of the study in accordance with Principle 8 of the Concordat on Open Research Data.
After the study has finished, who will have access to the data relating to participants?	Study data will be passed to Bournemouth University as the Data Controller, who will keep data secure and restrict access.
Will any identifiable participant data be transferred outside of the European Economic Area (EEA)?	No
How and when will the data relating to participants be deleted/destroyed?	Data relating to participants will be destroyed by the data controller 10 years after completion of the study.
Once your project completes, will any anonymised research data be stored on BU's Online Research Data Repository "BORDaR"?	Yes

Dissemination Plans

How do you intend to report and disseminate the results of the study?	
Peer reviewed journals,Internal Report,Conference presentation,Publication on website,Public Engagement Activities	
Will you inform participants of the results?	Yes
If Yes or No, please give details of how you will inform participants or justify if not doing so	
Participants will be offered the opportunity to receive a copy of the final research report by email on the initial electronic particioant interest form, and again on conclusion of their participation in interview or focus group.	

Final Review

Are there any other ethical considerations relating to your project which have not been covered above?	No

Risk Assessment	
Have you undertaken an appropriate Risk Assessment?	Yes

Filter Question: Does your study require HRA Approval and/or NHS Research Ethics Committee Approvals? HRA Approval Only

Sponsorship	
Do you need to apply for Bournemouth University Sponsorship?	I don't know

Appendix 4 HRA IRAS Ethics Application for COMPart Study

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
The COMPart Study

1. Is your project research?

(•) Yes ( ) No

2. Select one category from the list below:

( ) Ionising Radiation for combined review of clinical trial of an investigational medicinal product

( ) Ionising Radiation and Devices form for combined review of combined trial of an investigational medicinal product and an investigational medical device

( ) Clinical investigation or other study of a medical device

( ) Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice

( ) Basic science study involving procedures with human participants

( ) Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology

(•) Study involving qualitative methods only

( ) Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)

( ) Study limited to working with data (specific project only)

( ) Research tissue bank

( ) Research database

If your work does not fit any of these categories, select the option below:

( ) Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	( ) Yes	(•) No
b) Will you be taking new human tissue samples (or other human biological samples)?	( ) Yes	(•) No
c) Will you be using existing human tissue samples (or other human biological samples)?	( ) Yes	(•) No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

[✓] England

- [x] Scotland
- [x] Wales
- [x] Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

- (•) England
- ( ) Scotland
- ( ) Wales
- ( ) Northern Ireland
- ( ) This study does not involve the NHS

4. Which applications do you require?

- [x] IRAS Form
- [ ] Confidentiality Advisory Group (CAG)
- [ ] Her Majesty's Prison and Probation Service (HMPPS)

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

(•) Yes ( ) No

4b. Please confirm the reason(s) why the project does not require review by a REC within the UK Health Departments Research Ethics Service:

- [ ] Projects limited to the use of samples/data samples provided by a Research Tissue Bank (RTB) with generic ethical approval from a REC, in accordance with the conditions of approval.
- [ ] Projects limited to the use of data provided by a Research Database with generic ethical approval from a REC, in accordance with the conditions of approval.
- [ ] Research limited to use of previously collected, non-identifiable information
- [ ] Research limited to use of previously collected, non-identifiable tissue samples within terms of donor consent
- [ ] Research limited to use of acellular material
- [ ] Research limited to use of the premises or facilities of care organisations (no involvement of patients/service users as participants)
- [x] Research limited to involvement of staff as participants (no involvement of patients/service users as participants)

5. Will any research sites in this study be NHS organisations?

(•) Yes ( ) No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out the research e.g. NHS support costs) for this study provided by a NIHR Biomedical Research Centre (BRC), NIHR Applied Research Collaboration (ARC), NIHR Patient Safety Translational Research Centre (PSTRC), or an NIHR Medtech and In Vitro Diagnostic Co-operative (MIC) in all study sites?

Please see information button for further details.

○ Yes ◉ No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

◉ Yes ○ No

The NIHR Clinical Research Network (CRN) provides researchers with the practical support they need to make clinical studies happen in the NHS in England e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, information from your IRAS submission will automatically be shared with the NIHR CRN. ***Submission of a Portfolio Application Form (PAF) is no longer required.***

6. Do you plan to include any participants who are children?

○ Yes ◉ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ◉ No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
Study is part of a PhD level research project by Katie Gregory, Registered Midwife and Clinical Academic Doctoral Candidate at Bournemouth University

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ◉ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ◉ No

Integrated Research Application System
Application Form for Research involving qualitative methods only

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
The COMPart Study

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Continuity of midwifery care: Exploring the experiences of midwives employed part-time and understanding strategies which sustain their practice

A2-1. Educational projects

Name and contact details of student(s):

Student 1

Title	Forename/Initials	Surname
Ms	K	Gregory

Address	Bournemouth Gateway Building
	St Pauls Lane
	Bournemouth
Post Code	BH88AJ
E-mail	kgregory@bournemouth.ac.uk
Telephone	07927208630
Fax	

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
PhD Studentship: Health and Social Care

Name of educational establishment:
Bournemouth University

Name and contact details of academic supervisor(s):

Academic supervisor 1

Title	Forename/Initials	Surname
Ms	L	Fenge

Address	Bournemouth Gateway Building

	St Pauls Lane
	Bournemouth
Post Code	BH88AJ
E-mail	lfenge@bournemouth.ac.uk
Telephone	
Fax	

Academic supervisor 2

	Title	Forename/Initials	Surname
	Ms	L	Cescutti-Butler
Address	Bournemouth Gateway Building		
	St Pauls Lane		
	Bournemouth		
Post Code	BH88AJ		
E-mail	LCButler@bournemouth.ac.uk		
Telephone			
Fax			

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Ms K Gregory	☑ Ms L Fenge ☐ Ms L Cescutti-Butler

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- ◉ Student
- ○ Academic supervisor
- ○ Other

A3-1. Chief Investigator:

Title Forename/Initials Surname

Post
Qualifications
ORCID ID
Employer
Work Address

Post Code
Work E-mail

* Personal E-mail
Work Telephone
* Personal Telephone/Mobile
Fax

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

Title Forename/Initials Surname

Address

Post Code
E-mail
Telephone
Fax

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):
Sponsor's/protocol number:
Protocol Version:
Protocol Date:
Funder's reference number (enter the reference number or state not applicable):
Project website:

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

◯ Yes ◯ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and

members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

This research utilises an appreciative inquiry (strengths based) approach to understand the experiences of midwives working in continuity of care settings on a part-time employment basis. The research seeks to understand the personal, professional and organisational practices which support this model of care and to begin a collaborative process of service transformation. Two phases of research are planned. Phase one will explore the personal and practical experiences of midwives who are employed on a part-time basis in continuity settings across the UK. Phase two will share themes from the interviews with focus groups involving managers and midwives within the local NHS Trust to explore what could be possible and begin to co-create the local continuity of care service.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Purpose
This research seeks to understand the experiences of midwives who are employed part-time in continuity of care models. This topic has been identified as part of a PhD research project with the broad theme of exploring the experiences of midwives in continuity of care settings. The focus on part-time staff has been developed in response to the researcher's observation of the maternity service in which they work, which reports a high number of part-time staff. Examination of published literature identified limited research which identifies practices to facilitate the inclusion of part-time midwives in continuity services. The purpose of this research is to generate new knowledge to support the implementation of continuity of midwifery care models within healthcare systems. It will also support the CI to achieve a PhD.
Design
The first phase of the study will use qualitative interviews to with midwives who have worked part-time in continuity of care settings to explore their experiences and understand practices which support them in their role. Individual interviews were selected as they provide a dep understanding of the experiences of the participant. It was decided that all interviews would be undertaken using the Microsoft Teams platform to mitigate any risks associated with face-to-face meetings relating to Covid-19. This software platform was identified as secure in association with IT support.
In the second phase of the study, two focus groups will discuss findings from the first phase of the study which will be presented as a vignette. It was recognised that some participants may not have felt comfortable sharing their opinions openly if managers were present in the focus group, so a decision was made to hold two separate focus groups for midwives and midwifery managers. Midwifery managers were included as participants following consultation with midwifery management in the region who identified that the challenges managers faced when implementing continuity of care models were seldom reported in research. At the start of focus groups ground rules will be discussed. They will recognise that focus group participants' contributions are confidential but that this cannot be guaranteed. Focus groups may be held face to face if COVID restrictions allow, however also have the option of being held on a video conferencing platform such as Microsoft Teams. This will be decided based on current advice within the clinical setting at the time of the study.
Recruitment
Participants in phase one will be recruited to the project via professional networks and through the sharing of a recruitment poster (see attached) in social media groups. The recruitment poster will be shared with the admin of the social media group for anonymous publication within the group to ensure that the researcher is not approached on a personal social media account. Interested people will be directed to an online participant information sheet and prompted to complete an online form to express their interest. There is an intended sample of 10 midwives. Participants will be purposively selected to reflect a diverse range of experiences. Inclusion criteria have been developed to ensure that participants have experience suitable for the research.
Recruitment for phase two (focus groups) will be via poster (see attached) displayed within the hospital and distributed by global email to ensure equal opportunity of access for community based staff.
Consent
All participants will be registered midwives and therefore are likely to have the capacity to consent to participating in this research. Participants will be provided with a participant information sheet (see PIS attached) which provides information on purpose and nature of the study, what participation involves, any benefits or risk to them as a participant and highlights that they can leave the research at any point without giving an explanation. All participants will sign a

consent form (see PAF form attached) which documents their consent to participate.
Risks, burdens and benefits
It is possible that participants could become experience emotional distress when recalling their experiences, however some may also find the opportunity therapeutic. If a participant becomes distressed, the CI will comply with the following procedures: Ask the participant if they wish to stop the interview and offer them support. Provide them with details of support services available, such as, NHS Occupational Health services or their PMA team. Details of services will be included in the PIS.
Burdens associated with participating in this research relate primarily to time: phase one participants will be asked to contribute around one hour of their time for this research and will not receive financial compensation. Phase two participants will be able to attend focus groups within their working hours but it is possible that their workload may not be adjusted to reflect their attendance. Phase two participants may incur travel costs if focus groups are held face to face; however the focus groups will be held in their usual place of work and they should claim their travel expenses as normal.
Although individuals may not directly benefit from participating, they will be supporting the development of new knowledge which is hoped to indirectly affect them in the role as a midwife. Some midwives may find the experience of participating in this research enjoyable.
Confidentiality
Identifiable data will be collected as part of this research. Issues relating to personal data have been explored in the writing of the Data Management Plan (see attached) developed through dmponline.com. Data collection will comply with the "Caldicott Principles".

Identifiable data on participants will be securely held in a password protected and encrypted excel spreadsheet. Participants may also be identified through their interview or focus group recording and transcript. Participants will be assigned pseudonyms to protect their identity and file names/transcripts will use pseudonyms. The CI and supervisors will be up-to date with training on confidentiality and will understand their responsibilities regarding this. Only the CI and supervisors will have access to person-identifiable information
At all times the privacy of participants will be protected. However, there are circumstances when the CI will be required to share information with other parties. The following statement will be discussed with all participants as part of the introduction to the interview: "What we will talk about today will be confidential, but there are limits to this confidentiality. For example, if you were to share information about something that could potentially put yourself or someone else at risk of harm, or you share information about the professional practice of a midwife or other healthcare professional that is of concern then this information will need to be shared with specific people at your Trust. If this happened I would discuss this with you before sharing any of this information"
Conflict of interest
I am a registered midwife and as such must comply with the Nursing and Midwifery Council (NMC) Code at all times. This awareness will influence my responsibilities as a CI of this research project.
I am unlikely to experience conflict of interest in this project as my role in both cases is to listen and respond to participants appropriately.
As a clinical academic I am situated as a midwifery professional in the field in which I am studying. This can provide a unique insight into the experiences of the participants. It is important to recognise the diversity of experiences and I will practice reflexivity as a researcher to ensure that I am able to respond appropriately as a researcher and recognise how my own world view affects the research. The discussions in local focus groups may affect my own clinical practice. It is possible that this will influence my facilitation style during the focus groups. This is something I will carry an awareness of through my research. I have attended training on facilitation of focus groups which supports me to facilitate sensitively.
It is possible that information may be shared with me which leads me to believe that someone is at risk of harm or poor clinical practice. As a registered professional I would be duty bound to escalate this to the appropriate clinical team. I would also record this on an incident report sheet in the study documentation.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply*:

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis

- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☑ Qualitative research
- ☐ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

Aim: To explore how midwives employed on a part-time basis can provide midwifery continuity of care services within the NHS.

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

Objectives:

1) To engage with the experiences of part-time midwives working in continuity of care settings;

2) To develop insights into personal and organisational strategies which support midwives in continuity of care settings;

3) To explore how an appreciative inquiry approach may facilitate midwives to move towards a co-designed model of continuity of care.

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

Early review of the literature shows a paucity of pulished information surrounding the implementation of midwifery continuity of care with a focus on midwives who are not full-time. The challenge of moving to a continuity of carer model when a large proportion of staff are part-time has been noted in real-world scenarios.
This research also contributes to a PhD programme and will serve to develop the researcher skills of the CI, Katie Gregory.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

A qualitative design was appropriate as the study aims are to understand the lived experience of participants. The design of this qualitative research has been influenced by the methodology of appreciative inquiry, a strength focussed approach which seeks to highlight best practices which are already working. Use of this approach has been found to support participants to release strongly held negative ideas and envision positive organisational change. It was identified that traditional deficit focussed research might further entrench negative attitudes towards the move to midwifery continuity of carer models by focusing on why the healthcare organisations have previously struggled to implement these models effectively. The influence of appreciative inquiry will underpin all elements of this research. Initial recruitment posters will reflect a positive focus by presenting participation as a opportunity to explore the possibilities for part-time midwives in a continuity of care model. Interview questions have been developed which will encourage participants to reflect on 'the best of their experiences'. In focus groups, participants will be encouraged to explore the possibilities for their organisation. Whilst this philosophical approach encourages an appreciative focus, it supports a holistic understanding of the experiences of participants which may also include some less positive experiences such the challenges and barriers midwives can face.

In the first phase of the research, ten midwife participants will be interviewed by the CI using video conferencing software. This number of participants is anticipated to provide a diverse range of experiences and innovations whilst also reflecting a manageable workload in the associated time frame. Video conferencing software will allow the CI to connect with participants nationally whilst reducing any burden associated with travel and any corona virus pandemic

related risk. Data from video conferencing has been found to be of similar richness to in-person interviews and likely to be acceptable to participants. The use of video conferencing software is common place within maternity services and society in general and participants are likely to have access to smart-phones or laptops through their personal or work device. This phase (including recruitment, interviews, transcription and initial analysis) is expected to be undertaken in a six month time frame. This time frame is a realistic workload for the CI, who works 3 days a week on research, whilst also ensuring that her memories of the interviews remain clear to support analysis. Interviews will be semi-structured using an interview guide which has been developed to support the CI to obtain useful data from interviews and support participants in the focus of appreciative inquiry. Participants will be encouraged to speak about their own experience as a part time continuity midwife and about personal and professional practices and organisational structures which they feel sustain their work as continuity of care midwives. Data from interviews will be transcribed verbatim by the researcher and, when and if required, the use of professional transcription services will be utilised. The researcher will keep reflective journal to aid reflexivity and memos written after interviews in this journal will support analysis. The researcher will be immersed in the data through re-reading of transcripts with audio recording. Data will be thematically analysed using the computer package NVivo.

The researcher will develop vignettes which reflect the themes which are noted in analysis of data from phase one. This will support phase two of the research.

Phase two is expected to be undertaken in a six month time frame. In this phase two focus groups will be held, data will be transcribed and thematically analysed using NVivo software. The focus group discussion will support a co-design process of a midwifery continuity of carer service which is appropriate to the unique needs of local setting. Focus groups were the most appropriate data collection method for this phase as through the sharing of experiences and opinions, participants will begin to understand the viewpoints of others, construct a shared vision of what may be possible to achieve and begin the process of co-creation of a local midwifery continuity model.

Two focus groups will be held: a focus group consisting of midwives and a separate focus group for staff with managerial responsibility. It is hoped that staff will feel open to honest discussion when in a focus group consisting of their peers. Each focus group is expected to be 60-90 mins in duration and 6-12 participants will be invited to attend in person groups (numbers will be reduced to five if online focus groups are held to reflect the associated challenges with online participation). These numbers is expected to be sufficient to meet the objectives of this research. Recruitment for the focus groups will be via poster displayed in the hospital and distributed by global email to ensure equal opportunity of access for community based staff. The focus groups will be audio recorded and transcribed verbatim by the researcher and, when and if required, the use of professional transcription services will be utilised. The researcher will be immersed in the data through simultaneously reading transcripts and listening to the audio recordings. The data will be coded and thematically analysed using NVivo software. At the time of designing this research, all meetings within the NHS Trust are held on virtual conferencing software such as Microsoft Teams due to the Corona virus pandemic. If these restrictions remain in place during the data collection period then these focus groups will be held on Microsoft Teams software. All staff have access to this software and are expected to be familiar with its use. If practicable at the time of data collection, focus groups will be held in person, in a private comfortable room within the local hospital. This echoes the idea that continuity of care is relationship based, and that continuity of care teams rely on the mutual support of colleagues, which is more easily achieved in person. Holding focus groups in-person allows participants to fully engage with one another and to interact with the verbal and non-verbal social cues within the group. This provides a natural flow of group discussion and may enhance data collection. The focus group itself is a tool to begin the process of organisational change: participants can share what is important to their journey and learn from the viewpoints of others.

At the conclusion of phase two, a final research report will be written which will highlight the findings from analysis of both phases and discuss the process and outcomes associated with the focus groups in the local setting. This will be submitted to Bournemouth University, the NHS organisation and the HRA. Further dissemination activities such as writing for academic publication, presentation of findings at conferences and writing of the PhD thesis are anticipated to require a further 12 month time period.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- ☐ Design of the research
- ☐ Management of the research
- ☐ Undertaking the research
- ☐ Analysis of results
- ☐ Dissemination of findings
- ☑ None of the above

Give details of involvement, or if none please justify the absence of involvement.
This research involves staff as participants and as such it was not a requirement to involve the public. Local midwifery managers participated in the research design process which led to the inclusion of a focus group which allowed midwifery managers to participate in the research.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

- [ ] Blood
- [ ] Cancer
- [ ] Cardiovascular
- [ ] Congenital Disorders
- [ ] Dementias and Neurodegenerative Diseases
- [ ] Diabetes
- [ ] Ear
- [ ] Eye
- [x] Generic Health Relevance
- [ ] Infection
- [ ] Inflammatory and Immune System
- [ ] Injuries and Accidents
- [ ] Mental Health
- [ ] Metabolic and Endocrine
- [ ] Musculoskeletal
- [ ] Neurological
- [ ] Oral and Gastrointestinal
- [ ] Paediatrics
- [ ] Renal and Urogenital
- [ ] Reproductive Health and Childbirth
- [ ] Respiratory
- [ ] Skin
- [ ] Stroke

Gender:	Male and female participants
Lower age limit: 18	Years
Upper age limit: 100	Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Phase One participant inclusion criteria:
Qualified midwife
Experience in NHS continuity of midwifery care setting in last 5 years

Employed on <36h basis whilst working in continuity setting
Able to attend a 1-hour interview on Microsoft Teams

Phase Two principle inclusion criteria:
Midwife focus group: Qualified midwife working at Band 5 or 6. Employed by Salisbury NHS Foundation Trust.
Manager focus group: Managerial responsibility for midwifery staff at Salisbury NHS Foundation Trust.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Any participant who does not meet the inclusion criteria.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4

A21. How long do you expect each participant to be in the study in total?

Phase One: Participants will be actively involved in the study for six months from expressing an interest to conclusion of interview process. Participants who elect to recieve a research report will recieve this around 24 months after expressing an interest in participating.
Phase Two: Participants will be actively involved in the study for six months from expressing an interest to conclusion of the focus groups. They will attend one 60-90 minute focus group in this time. Should participants elect to recieve a research report this will be sent by email around 18 months after the start of their involvement.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

It is possible that participants could become experience emotional distress when recalling their experiences, however some may also find the opportunity therapeutic. If a participant becomes distressed, the CI will comply with the following procedures: Ask the participant if they wish to stop the interview and offer them support. Provide them with details of support services available, such as, NHS Occupational Health services or their PMA team. Details of services will be included in the PIS.
Burdens associated with participating in this research relate primarily to time: phase one participants will be asked to contribute around one hour of their time for this research and will not receive financial compensation. Phase two participants will be able to attend focus groups within their working hours but it is possible that their workload may not be adjusted to reflect their attendance. Phase two participants may incur travel costs if focus groups are held face to face; however the focus groups will be held in their usual place of work and they should claim their travel expenses as normal.
Although individuals may not directly benefit from participating, they will be supporting the development of new knowledge which is hoped to indirectly affect them in the role as a midwife. Some midwives may find the experience of participating in this research enjoyable.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

◉ Yes ○ No

If Yes, please give details of procedures in place to deal with these issues:

Although the interviews and focus group discussion will not focus on topics which are considered sensitive, embarassing or upsetting, this research will involve participants reflecting holistically on their experiences. It is possible that participants may experience upset or embarassment when discussing this. The researcher is experienced in discussion of sensitive and upsetting topics in her role as a registered midwife.
There are circumstances when the CI will be required to share information with other parties. The following statement will be discussed with all participants as part of the introduction to the interview: "What we will talk about today will be confidential, but there are limits to this confidentiality. For example, if you were to share information about something that could potentially put yourself or someone else at risk of harm, or you share information about the professional practice of a midwife or other healthcare professional that is of concern then this information will need to be shared with specific people in your Trust. If this happened I would discuss this with you before sharing any of this information". This ensures that participants are aware of this matter. The researcher must act within the NMC code at all times and will act to preserve safety should this be required through the reporting of unsafe practice or danger to participants or others.

A24. What is the potential for benefit to research participants?

Individuals may not directly benefit from participating but they will be supporting the development of new knowledge which is hoped to indirectly affect them in the role as a midwife. Some midwives may find the experience of participating in this research enjoyable.

A26. What are the potential risks for the researchers themselves? *(if any)*

The researcher will not be exposed to any additional risk in the administration of this study when compared to their role as a midwife or in daily life. Day to day risks such as risk associated with travel to the clinical site or incurred through use of electronic devices are not associated with the study itself. The researcher has support from supervisors and peers to manage stress which may be associated with running the research project.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of social care or GP records, or review of medical records. Indicate whether this will be done by the direct care team or by researchers acting under arrangements with the responsible care organisation(s).*

Participants in phase one will be recruited to the project via professional networks and through the sharing of a recruitment poster (see attached) in social media groups. The CI will share the recruitment poster with the admin of the social media group for anonymous publication within the group to ensure that the researcher is not approached on a personal social media account. Interested people will be directed to an online participant information sheet and prompted to complete an online form to express their interest.

Recruitment for phase two (focus groups) will be via poster (see attached) displayed within the hospital and distributed by global email to ensure equal opportunity of access for community based staff.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ◉ No

Please give details below:
Participants will self-identify and express interest in participation.

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

◉ Yes ○ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

Participants in phase one will be recruited to the project via professional networks and through the sharing of a recruitment poster (see attached) in social media groups. The recruitment poster will be shared with the admin of the social media group for anonymous publication within the group to ensure that the researcher is not approached on a personal social media account. Interested people will be directed to an online participant information sheet and prompted to complete an online form to express their interest.
Recruitment for phase two (focus groups) will be via poster (see attached) displayed within the hospital and distributed by global email to ensure equal opportunity of access for community based staff.

A29. How and by whom will potential participants first be approached?

Phase one participants will independently approach the research team by filling in an online expression of interest form.
Phase two participants will be be informed of the research through a poster displayed in the hospital and by global email. Participants will also be aware of the research development through their social interactions in the clinical setting by the CI who also works as a midwife in the NHS Trust. Should additional participants be required, the CI may verbally share information in team handover or during social interaction.

A30-1. Will you obtain informed consent from or on behalf of research participants?

◉ Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

All participants will be registered midwives and therefore are likely to have the capacity to consent to participating in this research. Participants will be provided with a participant information sheet (see PIS attached) which provides information on purpose and nature of the study, what participation involves, any benefits or risk to them as a participant and highlights that they can leave the research at any point without giving an explanation. The research will be discussed verbally between researcher and participant at the start of interaction with participants. This will provide potential participants with the opportunity to understand the nature, significance, implications and risks of the research so that they can make an informed decision about taking part. All participants will digitally sign a consent form (see PAF form attached) which documents their consent to participate.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

◉ Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

Participants will access the participant information sheet when they express an interest in participanting in the study. Should participants have any questions they will have an opportunity to contact the researcher prior to taking part. Participants will have a minimum of 24 hours between expressing an interest in taking part in the study and active participation in an interview or focus group to ensure they have time to reflect on their options.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

All participants will be registered midwives working in the NHS and are therefore expected to have a high level communication skills in English.

A33-2. What arrangements will you make to comply with the principles of the Welsh Language Act in the provision of information to participants in Wales?

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

- ○ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- ○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.
- ○ The participant would continue to be included in the study.
- ○ Not applicable – informed consent will not be sought from any participants in this research.
- ◉ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)? *(Tick as appropriate)*

- ☐ Access to medical records by those outside the direct healthcare team
- ☐ Access to social care records by those outside the direct social care team
- ☐ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☑ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☑ Publication of direct quotations from respondents
- ☑ Publication of data that might allow identification of individuals
- ☑ Use of audio/visual recording devices
- ☑ Storage of personal data on any of the following:
  - ☐ Manual files (includes paper or film)
  - ☐ NHS computers
  - ☐ Social Care Service computers
  - ☐ Home or other personal computers
  - ☑ University computers
  - ☐ Private company computers

☑ Laptop computers

Further details:

A37. Please describe the physical security arrangements for storage of personal data during the study?

A full data management plan has been created and complies with all legal requirements including GDPR.
All participant data and documents will be stored securely in a designated file system on Microsoft OneDrive. Microsoft accounts and OneDrive are accessed securely though the lead researcher's university student account and are governed by Bournemouth University. The study data will be backed up regularly using Microsoft OneDrive platforms and recovery of the user profile is possible through a restore feature. Participant data will include participant demographic information, full name general geographical location. This will be collected through Microsoft Forms and held in an excel file on Microsoft OneDrive. Participants will be allocated a unique identifier under which data pertaining to them will be named. Study documents such as Participant Agreement Forms will be securely held on OneDrive. Phase One interview audiovisual recordings will be made with Microsoft Teams and stored on OneDrive with a file name corresponding to the participant number. Recordings will be permanently erased from the OneDrive when the PhD is completed. Transcripts of recordings will be held on OneDrive. Should phase two focus groups occur online, they will be recorded with Microsoft Teams as above. If focus groups occur in person, they will be digitally audio recorded on a portable recording device. This device will be held securely by the lead researcher and the file will be transferred to the OneDrive system within 48 hours of the recording, and permanently erased from the portable device.

A38. How will you ensure the confidentiality of personal data?*Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

Only the CI and research supervisory team will have access to participant's personal data during the study. If external transcription services are used, this will be subject to university level privacy agreements.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

Data will be analysed by the researcher using the NVivo software package provided by the university. This uses cloud storage compliant with univeristy and GDPR requirements.

A42. Who will have control of and act as the custodian for the data generated by the study?

Title Forename/Initials Surname

Post
Qualifications
Work Address

Post Code
Work Email
Work Telephone
Fax

A43. How long will personal data be stored or accessed after the study has ended?

- ○ Less than 3 months
- ○ 3 – 6 months
- ○ 6 – 12 months
- ○ 12 months – 3 years
- ◉ Over 3 years

If longer than 12 months, please justify:
Data relating to participants will be stored for a period of 10 years following completion of the study in accordance with Principle 8 of the Concordat on Open Research Data.

A44. For how long will you store research data generated by the study?

Years: 10
Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended. *Say where data will be stored, who will have access and the arrangements to ensure security.*

On completion of the study, data will be anonymised and potentially identifiable information redacted. This will then be uploaded to BU's digital repository, BORDaR, for archiving and re-use. This is made explicit in the PIS and PAF forms.
Study documents such as PAF forms will be passed to Bournemouth University as the Data Controller.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

○ Yes ◉ No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ◉ No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ◉ No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ◉ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50-1. Will the research be registered on a public database?

○ Yes ○ No

Please give details, or justify if not registering the research.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

- ☑ Peer reviewed scientific journals
- ☑ Internal report
- ☑ Conference presentation
- ☐ Publication on website
- ☐ Other publication
- ☐ Submission to regulatory authorities
- ☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- ☐ No plans to report or disseminate the results
- ☑ Other (please specify)

PhD Thesis

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

It may be possible for participants to be identified through pseudonymised data such as quotes in publications. The participant information sheet communicates this possibility and output will be written with the aim of minimising this possibility through consideration of the combination of personal data available which may lead to identification of an individual participant.

A53. How and when will you inform participants of the study results?

If there will be no arrangements in place to inform participants please justify this.
Participants will be offered the opportunity to recieve a research report upon completion of the research study. Information about this is available on the Participant Information Sheet and will also be discussed verbally.

5. Scientific and Statistical Review

A54-1. How has the scientific quality of the research been assessed? *Tick as appropriate:*

- ☐ Independent external review
- ☐ Review within a company
- ☐ Review within a multi−centre research group

- [x] Review within the Chief Investigator's institution or host organisation
- [ ] Review within the research team
- [x] Review by educational supervisor
- [ ] Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
This research has been assessed by the researcher's academic supervisory team. The researcher has also presented it at milestone reviews on the academic journey to academics from within the university. This research has also been assessed by the research and development team within the NHS host organisation and by the Director of Midwifery.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 34
Total international sample size (including UK): 34
Total in European Economic Area:

Further details:
There is a maximum of 34 total participants. All will be based in the UK.
In Phase one of the research, ten midwives will be purposively selected. This will ensure that responses reflect a diverse range of experiences and locations which will capture different ways of working in different NHS organisations. In phase two, two focus groups of 6-12 participants will be held. If only online focus groups are held then there will be up to five participants in each focus group. It is not anticipated that excess participants will express an interest in the study, however should it be necessary then participants will be purposively selected to reflect diversity of professional experience, personal circumstances and career stages.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

As this is qualitative research, no formal calculations were required. In phase one, ten participant interviews is hoped to provide variation in response and thus provide useful data without being an overwhelming or repetitive sample size. Focus groups of 6-12 participants provides plenty of stimulus for discussion whilst remaining a size which is easy to facilitate and enable all participants to contribute.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

Data will be thematically analysed by the researcher. This is a flexible mode of analysis which is accessible to a novice researcher. Through the transcription, reading and rereading audio recording, the researcher will be immersed in the data. The transcripts will be opened in the NVivo qualitative software package which will enable an organised and structured approach to analysis. Initial codes will be created to represent patterns and meanings in the data. These codes will be collated and reviewed. These codes may fit together into themes which will be revised until they reflect the meaning behind the data.
The researcher will be supported in qualitative analysis by experienced academic supervisors.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co−applicants, protocol co−authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title	Forename/Initials	Surname
	Ms	L	Cescutti-Butler
Post			
Qualifications			
Employer			
Work Address	Bournemouth Gateway Building St Pauls Lane Bournemouth		
Post Code	BH88AJ		
Telephone			
Fax			
Mobile			
Work Email	LCButler@bournemouth.ac.uk		

	Title	Forename/Initials	Surname
	Ms	L	Fenge
Post			
Qualifications			
Employer			
Work Address	Bournemouth Gateway Building St Pauls Lane Bournemouth		
Post Code	BH88AJ		
Telephone			
Fax			
Mobile			
Work Email	lfenge@bournemouth.ac.uk		

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:
- ○ NHS or HSC care organisation
- ◉ Academic
- ○ Pharmaceutical industry
- ○ Medical device industry
- ○ Local Authority
- ○ Other social care provider (including voluntary sector or private organisation)
- ○ Other

Commercial status: Non-Commercial

If Other, please specify:

Contact person

Name of organisation
Given name
Family name
Address
Town/city
Post code
Country
Telephone
Fax
E-mail

Legal representative for clinical investigation of medical device (studies involving Northern Ireland only)
Clinical Investigations of Medical Devices that take place in Northern Ireland must have a legal representative of the sponsor that is based in Northern Ireland or the EU

Contact person

Name of organisation
Given name
Family name
Address
Town/city
Post code
Country
Telephone
Fax
E-mail

A65. Has external funding for the research been secured?

Please tick at least one check box.

- ☐ Funding secured from one or more funders
- ☐ External funding application to one or more funders in progress
- ☐ No application for external funding will be made

What type of research project is this?

- ○ Standalone project
- ○ Project that is part of a programme grant
- ○ Project that is part of a Centre grant
- ○ Project that is part of a fellowship/ personal award/ research training award
- ○ Other

Other – please state:

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

○ Yes ○ No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

Title Forename/Initials Surname

Organisation
Address

Post Code
Work Email
Telephone
Fax
Mobile

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A68-2. Select Local Clinical Research Network for NHS Organisation identified in A68-1:

-- Not Selected --

For more information, please refer to the question specific guidance.

A69-1. How long do you expect the study to last in the UK?

Planned start date: 04/04/2022
Planned end date: 08/04/2024
Total duration:
Years: 2 Months: 0 Days: 0

A71-1. Is this study?

◉ Single centre
○ Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

- [x] England
- [x] Scotland
- [x] Wales
- [x] Northern Ireland
- [ ] Other countries in European Economic Area

Total UK sites in study

Does this trial involve countries outside the EU?

○ Yes ○ No

A72. Which organisations in the UK will host the research? *Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

- [ ] NHS organisations in England
- [ ] NHS organisations in Wales
- [ ] NHS organisations in Scotland
- [ ] HSC organisations in Northern Ireland
- [ ] GP practices in England
- [ ] GP practices in Wales
- [ ] GP practices in Scotland
- [ ] GP practices in Northern Ireland
- [ ] Joint health and social care agencies (eg community mental health teams)
- [ ] Local authorities
- [ ] Phase 1 trial units
- [ ] Prison establishments
- [ ] Probation areas
- [ ] Independent (private or voluntary sector) organisations
- [ ] Educational establishments
- [ ] Independent research units
- [ ] Other (give details)

Total UK sites in study: 0

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

○ Yes ○ No

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

- ☐ NHS indemnity scheme will apply (NHS sponsors only)
- ☐ Other insurance or indemnity arrangements will apply (give details below)

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

- ☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)
- ☐ Other insurance or indemnity arrangements will apply (give details below)

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

- ☐ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
- ☐ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

○ Yes ○ No ○ Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For further information please refer to guidance.*

Investigator identifier	Research site	Investigator Name

Appendix 5 Recruitment poster for COMPart

Appendix 6 COMPart Participant Information Sheet

Participant Information Sheet

The title of the research project

The COMPart Study: Exploring the experiences of midwives employed part-time and understanding strategies which sustain their practice

We invite you to take part in a research study.

Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part.

This research is being undertaken by Katie Gregory. Katie is a qualified midwife and postgraduate researcher at Bournemouth University.

Who is responsible for the research?

- ✓ This research is being funded by Bournemouth University and NHS Salisbury Foundation Trust.
- ✓ The study team consists of the study lead and an academic supervisory team based at Bournemouth University.
- ✓ Bournemouth University is the organisation with overall responsibility for this study, looking after your information & using it appropriately.

What is the purpose of the project?

- ✓ This research aims to develop an understanding of the experiences of midwives who are employed part-time in NHS continuity of care services. This will enable us to identify practices which support midwives who are employed part-time to work in continuity of care settings.
- ✓ We know that a large proportion of the NHS midwifery workforce is employed on a part-time basis. There is a lack of current evidence about how midwives who are part-time can work in continuity settings.

Who can take part in this study?

- ✓ Midwives who have offered NHS continuity of care services (including antenatal, intrapartum and postnatal care) in the last 5 years, whilst employed on a part-time contract.
- ✓ For the purposes of this research part-time employment means 0.8 FTE or contracted 30 hours week.
- ✓ We are interested in speaking to a range of midwives including those with personal caring responsibilities, those who have returned from retirement and those with health challenges.

Do I have to take part?

- ✓ It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a participant agreement form. We want you to understand what participation involves, before you make a decision on whether to participate.
- ✓ If you or any family member have an on-going relationship with BU or the research team, e.g. as a member of staff, as student or other service user, your decision on whether to take part (or continue to take part) will not affect this relationship in any way.
- ✓ You are free to withdraw from the study at any time up to the point of anonymisation. You do not need to provide a reason and will be supported in your decision by the study team.

What would taking part involve?

- ✓ We would like to explore your experience in a one-to-one interview on Microsoft Teams. This will last approximately one hour. These interviews will be recorded. The video recordings of your activities made during this research will be used only for analysis and the transcription of the recording(s) for illustration in conference presentations and lectures. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings.
- ✓ Interviews will be facilitated by Katie Gregory who is the study lead.

- ✓ This research is an appreciative inquiry. This means that interview questions will inquire into the strengths, good times and positive aspects of your experience. The focus will be on learning from what has worked well for you. This does not mean that you cannot discuss challenges or negative experiences of your role and you are encouraged to talk about your experiences freely.
- ✓ Please contact us if you have any further questions

What are the advantages and possible disadvantages or risks of taking part?

- ✓ There are not anticipated to be any risks in participating in this study, however it is possible you may become emotionally distressed if you recall any emotional experiences.
- ✓ Participants will be offered a £20 Love2shop voucher in recognition of the time and effort of participating in the research. All participants are expected to participate in their own time, outside of working hours. Participants will receive the voucher if they begin their interview with the researcher. If a participant withdraws before this point, they will not receive the voucher.

How will we use information that you provide?

- ✓ Only the lead researcher will know who you are. Your data will be given a pseudonym and you will not be identified in publications in any way.
- ✓ We will keep all information about you safe and secure. This information will include your name and contact details. We will only use this information for the purposes of the research & to check that the research is being done properly.
- ✓ If you consent to being sent a summary of the final research report, your contact information will be accessed to send these to you.
- ✓ Once we have finished the research, we will keep some of the data you provided in your interview in case we need to verify the findings. Video recordings will be deleted when the lead researcher has finished the postgraduate research.

- ✓ The information you provide will be added to Bournemouth University's Online Research Data Repository (BORDaR). This is a central, online location where research data generated by Bournemouth University is stored. This is accessible to the public for reuse which may mean that the data you provide in your interview may also be used to support other research projects in the future. It will not be possible for you to be identified from this data.
- ✓ The research results will be published without any of your personal details being included.

What are your choices about how your information is used?

- ✓ At all times your privacy and confidentiality will be protected, however there may be times when the information you provide needs to be shared with other parties to protect your wellbeing and the wellbeing of others. For example, if you were to share information about something that could potentially put yourself or someone else at risk of harm, or you share information about the professional practice of a midwife or other healthcare professional that is of concern, this information will need to be shared with designated professionals. If this happened Katie Gregory would discuss this with you before sharing any of this information.
- ✓ You are free to stop taking part in the study at any time and do not need to provide a reason. You are also free to withdraw the information you provide in your interview up to the point where this data is anonymised. After the information has been anonymised it is not possible for you to withdraw your interview data. Your information at this point would not be identifiable in any final publications.

How will my information be managed?

Bournemouth University (BU) is the organisation with overall responsibility for this study and the Data Controller of your personal information, which means that we are responsible for looking after your information and using it appropriately. Research is a task that we perform in the public interest, as part of our core function as a university.

Undertaking this research study involves collecting and/or generating information about you. We manage research data strictly in accordance with:

- Ethical requirements; and
- Current data protection laws. These control use of information about identifiable individuals, but do not apply to anonymous research data: "anonymous" means that we have either removed or not collected any pieces of data or links to other data which identify a specific person as the subject or source of a research result.

BU's Research Participant Privacy Notice sets out more information about how we fulfil our responsibilities as a data controller and about your rights as an individual under the data protection legislation. We ask you to read this Notice so that you can fully understand the basis on which we will process your personal information.

Research data will be used only for the purposes of the study or related uses identified in the Privacy Notice or this Information Sheet. To safeguard your rights in relation to your personal information, we will use the minimum personally-identifiable information possible and control access to that data as described below.

Publication

You will not be able to be identified in any external reports or publications about the research without your specific consent. Otherwise your information will only be included in these materials in an pseudonymised form, i.e. you will not be identifiable.

Security and access controls

BU will hold the information we collect about you in hard copy in a secure location and on a BU password protected secure network where held electronically.

Personal information which has not been anonymised will be accessed and used only by appropriate, authorised individuals and when this is necessary for the purposes of the research or another purpose identified in the Privacy Notice. This may include giving access to BU staff or others responsible for monitoring and/or audit of the study, who need to ensure that the research is complying with applicable regulations.

Further use of your information

The information collected about you may be used in an anonymous form to support other research projects in the future and access to it in this form will not be restricted. It will not be possible for you to be identified from this data. To enable this use, anonymised data will be added to BU's online Research Data Repository: this is a central location where data is stored, which is accessible to the public.

Keeping your information if you withdraw from the study

If you withdraw from active participation in the study we will keep information which we have already collected from or about you, if this has on-going relevance or value to the study. This may include your personal identifiable information. As explained above, your legal rights to access, change, delete or move this information are limited as we need to manage your information in specific ways in order for the research to be reliable and accurate. However if you have concerns about how this will affect you personally, you can raise these with the research team when you withdraw from the study.

You can find out more about your rights in relation to your data and how to raise queries or complaints in our Privacy Notice.

Retention of research data

Project governance documentation, including copies of electronically signed **participant agreements**: we keep this documentation for a long period after completion of the research, so that we have records of how we conducted the research and who took part. The only personal information in this documentation will be your name and signature, and we will not be able to link this to any anonymised research results.

Research results:

We will keep your personal information in identifiable form for a period 10 years after completion of the research study. Although published research outputs are anonymised, we need to retain underlying data collected for the study in a non-anonymised form to enable the research to be audited and/or to enable the research findings to be verified.

You can find more specific information about retention periods for personal information in our Privacy Notice.

We keep anonymised research data indefinitely, so that it can be used for other research as described above.

If you have any concerns or complaints about the conduct of this study, please contact the following people at Bournemouth University:

- ✓ Professor Lee-Ann Fenge, Research study supervisor at: LFenge@bournemouth.ac.uk
- ✓ Professor Jane Murphy, Deputy Dean for Research and Professional Practice, Faculty of Health and Social Sciences, Bournemouth University at: researchgovernance@bournemouth.ac.uk

How do I access further support?

- ✓ If you are upset by anything you discuss as a result of taking part in this study & would like further support regarding a workplace issue, please contact your local Professional Midwifery Advocate.
- ✓ A counselling service may be available through your occupational health department or local primary care service.
- ✓ If you need urgent emotional support & advice, please telephone the Samaritans on 116 123 or NHS 111. Available 24 hours a day

Who do I contact for further information?

- ✓ If you are interested in taking part, please contact the research study lead, Katie Gregory at: kgregory@bournemouth.ac.uk

Finally

If you decide to take part, you will be sent a copy of this information sheet and an electronically signed participant agreement form via email to retain for your own records.

Thank you for considering taking part in this research project.

Appendix 7 Theoretical framework to support the understanding of implementing continuity of care.

A Theoretical Framework to support the understanding of implementing continuity of care in midwifery.

Katie Gregory, PGR student, Bournemouth University. 2021

Comparing Normalisation Process Theory (NPT) (May 2009), Consolidated Framework For Implementation Research (CFIR) (Damschroder et al. 2009), Diffusion of Innovations in Service Organisations (DISO) (Greenhalgh et al. 2004) and reflections from Corrigan et al. (2021).
Number in column refers to concept/construct as presented in publication.

	NPT	CFIR	DISO	Corrigan
1. What do team feel are factors driving implementation of CoC? (This may be 'Better Births', strong evidence to support, financial savings in care or in meeting targets)	1	2	3, 7	
2. Who is change agent/ pushing change? Who decided to implement CoC in organisation?	1, 2.1		4, 7, 8	
3. Define the model	1	1	1	
3.1 How is the role different from standard care?	1.1			
3.2 Is the care provided to women different from standard care?	1.2			
3.3 Is this understanding shared by all participants?	1.2			
4. Enrolment	2.2	4	2	
4.1 Reasons for joining the team?			4	
4.1.1 How did you feel in a standard care role?			4	
4.2 Are there particular personal characteristics which suit a CoC midwife specifically as opposed to midwives in general?			4	
5. Resistance from other staff to CoC model			4, 5	
5.1 What do participants view as biggest hurdles for their peers?			4, 5	
5.2 What do participants feel would be the strongest influence on resistant staff?				
6. Team work				
6.1 Do participants feel the team would benefit in involving other staff in CoC- for example MCAs, obstetric teams, health visitors?	2.3			
6.2 What do participants perceive the positives and negatives of NQMs in their teams to be?	2			
6.3 What conditions create optimal team working in CoC team? (see team size, regular meetings, communication via email?)	2			
7. Sustainability of CoC teams				
7.1 What practices might support a CoC midwife finding it tough? What advice would you give to a midwife joining a CoC team?	2			
7.2 Do you feel valued by the organisation for the role you provide?	3.4		2	
7.2.2 Is the financial remuneration seen as fair? Is the time commitment appropriate and sustainable?				
8. Role definition	3		8	
8.1 How do participants view their role definition?				
8.2 How do they feel they are viewed differently to a standard midwife by women?				
8.3 How do other midwife colleagues in standard care view their role? Re Skills, accountability, confidence in the CoC midwife?				
8.4 How do other professionals view CoC midwives? Re Skills, accountability, confidence in the CoC midwife?				
8.5 Are the responsibilities of the CoC midwife clear around who does what aspects of care?				
9. Contextual integration	3.4		4	
9.1 What resources are essential for a sustainable team?				
9.2 What training is useful for CoC midwife?				
9.3 Does it feel that staffing is adequate to cover work? How should a team cover sickness?				
9.4 Existing policies and procedures- do they work within a CoC team?				
9.5 Team specific policies? Are there any and are they appropriate? Are they prescriptive?				
10. Management and leadership		3	3, 8	
10.1 Research shows visible, supportive leadership may benefit CoC teams (Corrigan et al 2020). To what extent do participants agree with this?				
10.2 Should a manager have worked in the model to truly understand the challenges faced?				
10.3 To what extent should managers have control over the work of CoC midwives?				
10.4 What is a good CoC manager?				
10.5 How do the team feel valued by leaders in the organisation?				
11. Monitoring	4		8	
11.1 Are there clear objectives for the team?				
11.2 How do the team receive feedback?				
11.3 What does a successful CoC team look like?				
11.4 How much influence should individuals and teams have on refining the model to suit the people working in it?				