A midwifery team's journey implementing and sustaining continuity of care

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Abstract

The continuity of carer model of care for midwifery is set to roll out exponentially. Yet the setting up and sustaining of midwifery teams primed to deliver this model of care is new to many. Thus, in this article we present a case-study whereby one continuity of carer team was set up in London to enhance the quality of midwifery care. The reflections on the associated challenges, learning, recommendations and sustainability are shared to assist others embarking upon similar journeys. During its first two years of existence, the team was able to achieve high levels of continuity and were able to consistently meet set targets. Quality improvement strategies were embedded throughout. Challenges including data collection techniques and poor communication were also explored. Improved communication, safe staffing levels, continuous evaluation, shared learning, and co-creation will be essential in future quality improvement activities in this area.

Anonymous Manuscript

Introduction

Better Births (National Maternity Review, 2016) is a plan for transforming National Health Service (NHS) maternity care in England into a safer and more personalised maternity system. The re-introduction of Midwifery Continuity of Care (referred to as continuity in this article) is an important part of making women's care personalised and increasing their safety; this will work alongside other components such as the Maternity and Neonatal Safety Improvement Programme (NHS England, 2020) and improved perinatal mental health care. The Department of Health's aim was for the majority of women in the United Kingdom to have access to continuity by 2021 (Department of Health, 2017). This is significant as continuity has the potential to improve outcomes

for both mothers and babies (Sandall *et al.*, 2016) and research indicates that midwives working in a continuity model can more effectively provide women with access to timely information (Symon *et al.*, 2018). In order to reach targets set out by North London Partnerships (NLP) (North London Partners Local Maternity Service, 2019), local maternity services in London have been organising various forms of continuity and many more continuity teams will be needed to sustain this style of midwifery in the future (Lang *et al.*, 2019).

During the pandemic disproportionate numbers of women from "Black, Asian, and Minoritised Ethnic" (BAME) communities experienced neonatal deaths or died in the COVID epidemic (Knight *et al.*, 2021). Thus, new policy directives relating to maternity care were announced to address this. For example, in June 2020, NHS England announced that within the Long Term Plan (North London Partners Local Maternity Service, 2019; Kapur, 2020) women from black and minoritised ethnicities would be prioritised in receiving continuity of midwifery care for antenatal, intrapartum, and postnatal care. Six months later, in December 2020, Public Health England issued a report on tackling inequalities to address access to and engagement with maternity care (Davison, Wiseman and Olander, 2020). As continuity teams have also been identified as being important in addressing such inequalities (Chitongo et al, 2022), a new continuity team was mandated in a large teaching hospital. This article will describe the implementation of this team, and also the associated challenges, learnings, recommendations and sustainability to assist others embarking upon similar journeys.

The start of a continuity team within the maternity service of a large teaching hospital

Caseloading is one way of providing continuity, either antenatally and postnatally or including intrapartum care. Teams provide a named midwife and continuity of care, leading to a safer and better birth experience (Corrigan, Lake and McInnes, 2021). Research suggests that even in countries where the caseloading model is well established (see Jepsen *et al.*, 2016), it remains a

niche way of working which nevertheless attracts midwives of different ages and career stages. Caseloading also fits within the Midwifery Philosophy of Care as the midwifery care provided is holistic and continuous in nature (ICM, 2014). It was with this understanding that the continuity team in question was conceived.

In 2017, an NHS Trust Board Meeting noted that within their Local Maternity System was an area with significant levels of deprivation. The Trust noted that women in that local area were more likely to be older, overweight, or obese and when compared with the national averages. They noted that they were also more likely to experience medical complications in pregnancy such as gestational diabetes and that 32% of residents identified themselves as being from a BAME community.

In November 2018, midwives at the Trust were invited to express their interest in setting up a new continuity team. A senior midwifery post (Band 7) was advertised, and a team leader appointed who had recent experience working as a private midwife in London. In March 2019, the team of midwives took up the challenge to provide continuity of midwifery care for women and their families throughout pregnancy, birth, and the postnatal period, working within a case loading model.

Based on retrospective data, the area around one of the children's centres close to the hospital attributed to 10% of the in-area population of women who had their babies at the hospital. The children's centre was selected to be part of the new initiative for the implementation of the Better Births project. This meant that the midwives had a "mixed risk caseload", including women with universal and additional care needs. Clinics were held there on weekdays for antenatal and postnatal visits. The projected number of women expected to be cared for over the course of a year commencing March 2019 was about 240. This projected number was also the basis of selecting the number of midwives required for the service: six Band 6 midwives with maximum case load of 1:36 over twelve months and one Band 7 team leader with a maximum caseload of 1:24 alongside managerial and leadership duties within the team.

Both the midwives in the team and the matrons (band 8 senior midwives who manage the service at a divisional level) had introductory meetings with the children's centre staff. To prepare the continuity midwives for the role, additional training was offered including: a study day with the London Ambulance Service around managing emergencies in the home environment and shadowing the midwives from the traditional teams who were experienced in homebirths.

A 'Maternity Voices Partnership' was launched to contribute women's voices, to be involved in service planning, and attend external events alongside the midwives to improve services for minoritised groups of women. The new team would be working with and alongside many services and agencies both within the trust and externally, as listed in the table one below.

Table One: List of collaborative agencies that the continuity team would work with

Trust-linked services	External agencies/services
Obstetric consultants and Maternity ward managers	Community-based "Bright Start" Antenatal Task and Finish Group
Perinatal mental health services	Health visitors
Safeguarding team	Local Children's Centres
The established traditional community midwifery team	Council-funded community breastfeeding support team
Neonatal Outreach team	GP surgeries
Fetal Medicine Unit	Other maternity units in the Local Maternity System
	Social Services
	Maternity Voice Partnership

In March 2019, the team started work in the children's centre, taking over the caseload of the community midwife who had been working there providing antenatal continuity to the local women but would not be a part of the new team. Community midwifery leaders (Band 7) mentored and supported the new Continuity team members and shared in provision of on-call support for Home Births. The aim was for at least one midwife in the team to be available throughout the day and night to provide care for women in labour from the caseload. Clinical care was provided at the children's centre, at the women's homes, and at the maternity unit, according to women's choices and needs.

Antenatal care

To reduce delays and to shorten the times between either self-referrals or a referral from a general practitioner and the first antenatal appointment, and to reduce the numbers of women in the geographical area who were being missed until the team saw them postnatally, the matrons worked together with the continuity teams to improve the referral processes. Women were identified based on their postcodes within the specified geographical area; team midwives would filter through the Trust booking referrals system and capture eligible women at the beginning of each week and allocate them to individual midwives based on midwife caseload numbers. The aim was for the named midwife to provide most of the clinical care and be the woman's primary contact for any concerns. Women were also able to send messages or ask questions through an app, by text, or email. A leaflet was given to each woman providing the schedule of visits and information about contacting the team in English with plans to make it available in other languages due to the diverse background of the local population.

Midwives co-ordinated care and made referrals to services such as listed in table one where necessary. They attended multi-agency meetings for women in the borough. Due to the high number of complex safeguarding cases within the geographical area, the continuity team provided an important link between agencies. Midwives were supported by the band 7 Team leader and for care planning in complex cases by the Safeguarding Midwife.

Relationship building and collaboration with health visiting teams and children's centre services

Team members attended and reported back from regular inter-agency meetings and consultations. This improved communication and sharing of vital information to protect vulnerable women in high-risk situations. Working in the children's centre afforded the midwives the chance to be aware of different classes and support services available for parents in the area and to work within the "Bright Start" programme and develop a close working relationship with Health Visiting Teams.

A “journey to parenthood class” given jointly by a health visitor and a midwife trained in the appropriate parent education approach also helps parents to see engagement with health services as a supportive resource.

Women were encouraged to attend the monthly Meet the Midwives sessions which were held in the Children’s Centre. This served to further support relationship building between women, the midwives and the Children’s Centre staff. It also helped to introduce available services within the Children’s Centre to the women who attended. Women attending the meetings could come with their partners and bring their birth preferences and any questions they had. They could also come to more than one session should they choose to and this would serve to increase engagement. The sessions were attended by at least 3-4 of the team’s midwives as this ensured that they had more chance of meeting one of the other midwives who may provide care to them in labour.

On calls and care in labour until discharge

The on-call system was set up to give women telephone access to a midwife team at all times, besides the option of texting their named midwife for non-urgent matters. This was for women to use if they had any concerns during or after pregnancy until discharge. Women could also access a midwife throughout the latent phase of labour for individualised advice and in some cases, had the option to be assessed at home. This was subject to staffing within the team – where there was no team midwife available, phones were diverted to the maternity triage phone line.

Midwives were on-call 2-3 times a week for an 8-hour on-call shift to ensure the service was covered throughout each day and that the team could respond to women and provide referrals, information, support, and care in labour.

The midwives’ working patterns were flexible with a standard shift being eight hours. They managed their own diaries. The day on-call shifts were set hours between 8am and 4pm. The night on-calls were between 4pm and 8am the following morning and were shared between two

midwives, who updated the team regularly on progress in the birth setting. Care was commenced by a team midwife once the women were in established labour until birth. Once women had given birth, the midwife would support them in holding their babies skin to skin, initial infant feeding and routine postnatal observations before transferring them to the ward. Their care until discharge was then handed over to the ward staff.

Upon discharge from the hospital, the hospital discharge summary was sent to the team via e-mail so that the team could arrange postnatal visits at home. Extended postnatal care and referrals to other services (such as community breastfeeding support) were considered before women were discharged from the team to their General Practitioner and health visitor. At least one postnatal visit was to be carried out by the woman's named midwife.

Continuous Quality Improvement

Regular, documented team meetings were set up to review processes and operational procedures and to assess whether the basic resources the team required to function optimally were in place. The meetings also provided a platform to share relevant information about the caseloads of midwives (according to Trust Information Governance policies), to prepare the team for upcoming births and to review any care plans for women with high-risk pregnancies. Furthermore, meetings functioned as a form of regular "peer-review" and opportunity for reflective practice so that learning, and change ideas were shared within the team to continuously improve the service.

Learning from practice issues, the team implemented new ideas for safety and reviewed their use over time. See table two below for suggested improvements.

Table Two: Change ideas implemented by the team and the reasons for the changes.

Change	Reason for change
A revised standardised homebirth checklist	To standardise the expectations of women and midwives
A monthly review of women due to birth including identification of risk factors	Following near misses caused by gaps in care

An offer to leave home birth equipment (without medications) in the home of women with history of previous precipitate labour	In case women are unable to make it to the hospital in time, attending midwives have all necessary equipment to facilitate birth safely
Education around safe sleeping at 'Meet the Midwife' sessions	To maximise all opportunities to provide health education antenatally
'Quality Improvement' project to increase feedback response	Audit of feedback form prompted attempts to reach out to more women in more ways and hear from women who are under-represented
Monthly newsletter	To increase awareness of the team across maternity and share positive experiences

Data and Audit

Data was collected manually on levels of continuity (process measures) and birth outcomes (outcome measures). An audit of electronic data from the pregnancies within the area over the 12-month period before the start of the team was to provide the dataset against which statistics from the first twelve months of the intervention could be compared. However due to there being several gaps in the data, comparison was challenging. The team has instead gathered data to compare to the national averages to use as an analysis of the effectiveness of continuity of care in improving outcomes. The data being collected was based on the findings from a Cochrane Review (Sandall *et al.*, 2016) which explored data collected in relation to women who were not experiencing medical complications.

Statistical data was produced monthly from spreadsheets that captured service provision from referral through to postnatal discharge. These were updated and data are regularly checked by members of the team to ensure accuracy and completeness. This gave information about demographics, obstetric outcomes, levels of continuity, unexpected outcomes and rates of attrition (care discontinued due to reasons such as miscarriage of pregnancy or moving out of area). It also gave the team information about level of risk and safety issues within the caseloads.

The team was able to achieve high levels of continuity the majority of the time and were able to consistently meet set targets. Table three presents the average percentage of continuous midwifery care delivered to women over a one-year period (May 2019-April 2020).

Periods of staff sickness and absences correlated with periods of lower antenatal and intrapartum continuity as can be seen most apparently in the months of September 2019 and January 2020 in table 3.

Table four represents the same data for the next year (2020-2021). In the second year, antenatal continuity figures were lower as the pandemic began to affect staffing: there was a staff reshuffle as vulnerable midwives had to shield. However, the team were still able to attend a high number of labours.

Table five provides a summary of outcomes over the first year. During this time, 39 women of the 112 women who birthed with the team were women from ethnic minority backgrounds.

Table Three: Average Level of Continuity achieved 2019-2020

Month	Average antenatal continuity with named midwife %	Average labour continuity with team %	Average labour continuity with named midwife %	Average postnatal continuity with named midwife %
May	98	100	40	49
June	96	100	40	62
July	90	100	33	55
August	83	100	40	48
September	88	67	17	64
October	92	100	26	54
November	88	100	44	45
December	87	83	42	44
January	86	64	27	34
February	90	92	50	56
March	89	90	10	21
April	94	80	40	48
Overall average %	90	90	34	48

Table Four: Average level of continuity achieved 2020-2021

Month	Average antenatal continuity with named midwife %	Average labour continuity with team %	Average labour continuity with named midwife %	Average postnatal continuity with named midwife %

May	89	93	40	34
June	78	93	53	48
July	74	86	43	36
August	77	78	28	31
September	87	92	42	31
October	81	100	25	44
November	77	100	38	44
December	78	86	14	42
January	77	92	31	46
February	82	100	64	47
March	78	85	15	24
April	81	94	44	42
Overall average %	80	92	36	39

Table Five: Outcomes for 2019-2020

Total births for women under the Continuity Team	**112**
Total births attended by Continuity Team	**101 (90%)**
Total number referred to Continuity Team	**215**
Total number caseloaded by Continuity Team	**197**
Total women who received any care from Team	**56 (including those moved out of area or to private care– not including received discharges)**
Outcomes	
Spontaneous Vaginal Birth	**58 (including those born before arrival at intended place of birth) (51.7%)**
EMCS (Emergency Caesarean Section)	**29 (25.9%)**
ELCS (Elective Caesarean Section)	**12 (10.7%)**
Instrumental (Assisted birth)	**11 (9.8%)**
Episiotomy	**14 (12.5%)**
3rd degree tear	**1 (0.9%)**
Epidural	**31 (31%)**
Breastfeeding at discharge (any breastfeeding)	**77 (69%)**
Demographics from birth data	
Perinatal Mental ill Health identified	**6 (5%)**
Safeguarding required (specific social risk factors)	**10 (9%)**
Black and Ethnic Minorities	**39 (35%)**

Feedback from women and families both formally and informally was vital in improving the service. A feedback form was designed to be given to women before their postnatal transition to Primary Care to enable women to comment anonymously about their care. Women were also able to comment or complain via email or through the Trust-wide patient record electronic systems and

the associated app which was introduced in April 2019. Many women voluntarily provided written feedback explaining what they valued throughout their experience with the team. Plans were made to redesign the feedback form to match the NHS “Friends and Family Test” forms and to include the option of feedback through the Maternity Voices Partnership.

Challenges

Electronic data collection is essential, as is the recognition of poor quality data (National Maternity Review, 2016). Working with the Reporting Team in the Trust to pull data and minimise error, a midwife was assigned to each woman at the first appointment on the electronic system. The number of encounters including telephone appointments could also be seen on the system throughout our data collection. This helped the team to overcome challenges related to previous data collection techniques. However, this occurred after the first year so most of the data collection from the first year involved manual input into Excel spreadsheets which the team found to be time consuming.

Anecdotally, the team was negatively impacted by the lack of a dedicated project manager. A lack of structure and feedback loop to senior management also became an issue when navigating issues such as pay structure –models of pay are now in line with the Agenda for Change pay scales.

Within the team there were developments in the management of expectations; the emotional nature of the work and the fact that the midwives were ‘trail-blazers’/early adopters, meant being heavily invested in the project. This also meant that the team had to adjust their mindsets to accept that some births would be missed, and that on-calls could not always be covered in the event of staff sickness. Learning to ‘let go’ and ‘switch off’ to prevent burn out and emotional fatigue developed over time. Learning to work together as a team, with different backgrounds, experience and expectations was an important element of the team cohesion. For future evaluations it may be useful to capture and explore midwives' experiences. This would make a valuable contribution to emerging research around the efficacy of providing a continuity of carer.

Monthly newsletter

Friction was occasionally experienced between team members, ward managers and hospital-based midwives in the infancy of the team set-up. For example, there was lack of awareness of roles and expectations of the team midwives when they would accompany women receiving continuity of carer to the wards and when ward staff were supposed to contact the team midwives to provide intrapartum care to women receiving continuity of care who were on the antenatal ward for induction of labour. This highlighted the need for the development of trusting relationships and engagement, with both ward managers and ward staff at all levels. McInnes et al (2020) found trusting relationships to be the foundation of continuity of care even at an organisational level and this can be fostered by good leadership. Therefore, the team leader engaged in more of the organisational level meetings to represent the team on a Trust level. The team also agreed that consistent communication and increased presence on the wards would help rectify this issue. Thus a monthly newsletter was developed and sent to all maternity staff by email. This became a useful tool to increase awareness of the team and share the vision, the progress and the challenges faced by the team. This was evidenced anecdotally through the replies received from different members of staff in response to the email circular containing the newsletter congratulating the team and enquiries received from midwives interested in working in the team.

Costs and strategic trade-offs; sustainability

Funding was received from the Local Maternity Service for the recruitment of the band 7 midwife and for the cost of equipment needed to get the team started. The band 6 midwives were recruited internally from other areas of the maternity service. In a review using the NHS Sustainability Model (NHS Institute for Innovation and Improvement, 2018) the team identified that overall, the project had not been disrupted due to individuals leaving. Where there had been periods of staff shortages, care had been adapted by the team to ensure ongoing service to the stakeholders and targets of care were met overall. The team needed to be fully staffed to succeed but could cope

on a short-term basis with one member of the team absent. This however would affect the level of continuity achieved in that period as was reflected in the continuity statistics. New staff members could be rotated into the team if needed with good planning and foresight. The aims and visions were shared with new staff so that they remain working in line with the vision set out by the team as outlined in table six below.

Table Six: Continuity Team Vision, Aims and Objectives

Continuity Team Vision, Aims and Objectives
Vision:
• To provide the women of the area with continuity of carer – a named midwife who they could contact throughout the pregnancy; access to a team of midwives 24/7 in case of emergency or for labour triage
• To provide antenatal, birth and postnatal education so that women felt prepared for early parenthood
• To provide clinical care and information, assessment, screening and health promotion in a kind and professional manner
• To support women and involve them in the planning of their care, tailored to their individual needs.
• To introduce women to relevant community services and to help integrate their care between the hospital and across those community services (holistic patient-centred care).
Aims and Objectives:
- To always be available and accessible to the women in our care.
- To combine clinical knowledge with interpersonal skills and cultural awareness.
- To ensure best practice and promotion of normal midwifery care.
- To reduce the risk of complications to the women in our care.

It has been acknowledged by the team that the initial aims and objectives were vague and this is now being addressed. The team are working towards creating more measurable and clearly defined aims and objectives.

Recommendations

In summary, for the best chance of success we recommend transparent expectations and remuneration for midwives. Managers may need to explore ways of accommodating the recruitment of part-time continuity midwives where possible. This may make it accessible to more midwives and facilitate the set-up of further teams. NHS employers are now required to offer flexible working

conditions (NHS England, 2020). A study in Australia examined women's experiences with part-time caseload midwives and found that this worked equally well for women, with improved work life balance for midwives (Vasilevski et al, 2021).

Realistic and achievable success markers, aims and objectives need to be identified from the beginning; these should be co-produced with communities and other stakeholders. Midwives need a 'base' in which to work from and basic equipment for each midwife such as fetal doppler, sphygmomanometer and laptop. Training support for midwives who have specialised in a particular area needs to be in place to complement existing skills, for example: training in community home births, pool birthing, neonatal resuscitation, and labour ward skills such as Cardiotocograph (CTG) interpretation needs to be in place at the start. Research focusing on implementation strategies identified training needs as an issue to be planned for in advance (Newton *et al.*, 2016; McInnes *et al.*, 2020).

We suggest that further research is required to evaluate local teams and how they meet the expectations of "Better Births" and contribute to the reduction in racial and ethnic health inequalities. Implementation strategies need to consider sustainability, the retention of midwives and women's satisfaction with the services provided (Corrigan, Lake and McInnes, 2021). Any evaluation should measure aspects of risk management and safety as well as midwife satisfaction and burn-out, through an in-depth qualitative study of the midwives' experiences in the new teams.

Conclusions

This article is reflective of a two-year implementation of a midwifery continuity team. Continuity teams will be essential in the delivery of future high quality midwifery care. As such, the challenges, learning, sustainability and recommendations presented here should be useful to those implementing continuity teams of midwifery elsewhere. Overall, communication, continuous evaluation, shared learning and co-production will be essential in future quality improvement activities. It will also be important to evaluate how the midwifery workforce experience this way of

working over time. Lastly, though continuity of care is the gold standard, in light of the recently published Ockenden report (Ockenden, 2020), it is clear that advancing with it can only happen safely within fully staffed units and with fully staffed teams.

Key words:

Continuity of carer; better births; caseload; implementation; midwifery; personalised care

Key points:

Caseloading midwifery enables midwives to provide a personalised service and high rates of continuity

Quality Improvement methods help midwives to work towards sustainability and to document their improvement journey

Communication strategies within the wider maternity team are essential for co-operation and understanding of how the caseloading team operates

Seeking feedback from women who have used the service and making this possible for women who don't speak English is essential for improving the service

Planning and management of implementation needs to consider equipment and training from the outset.

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