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Implementing Better Births: Continuity of Carer

Five Year Forward View

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Acknowledgements

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In particular, NHS England would like to acknowledge the significant contribution made in recent months by the academics, clinicians, and midwifery leaders that participated in NHS England's Continuity of Carer Subgroup, and Expert Reference Group. Without their insight and feedback, this guidance would not have been possible.

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Executive Summary

Background

Better Births, the report of the National Maternity Review, set out a vision for maternity services in England which are safe and personalised; that put the needs of the women, her baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving. At the heart of this vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth.

This continuity of care and relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience; and was the single biggest request of women of their services that was heard during the Review.

Better Births found that some women were receiving this care, and recommended that the NHS in England should roll out continuity of carer to a much greater number of women. Since Better Births was published, Local Maternity Systems have come together across 44 geographies in England, with leadership, governance and the commitment to transform services to meet the expectations of their women and communities.

The “ask” of Local Maternity Systems

The key deliverables for Local Maternity Systems¹ set out an expectation that each area will, by October 2017, establish a shared vision and plan to implement Better Births by the end of

2020/21. These plans are expected to show how most women will receive continuity of the person caring for them during pregnancy, birth and postnatally. Local Maternity Systems have been asked to put in place plans to meet local ambitions in this area. This guidance document is designed to help Local Maternity Systems with further iterations of these plans. It sets out:

- The principles that underpin rollout of continuity of carer
- The high level models available for Local Maternity Systems to choose from
- The detail Local Maternity Systems will need to work out for themselves
- How to set local ambitions and trajectories
- The next steps in making it happen.

Principles

There are four main principles that will need to underpin the provision of continuity of carer models across the country:

1. Provide for consistency of the midwife and/or obstetrician who cares for a woman throughout the antenatal, intrapartum and postnatal periods
2. Include a named midwife who takes on responsibility for co-ordinating a woman’s care throughout the antenatal, intrapartum and postnatal periods

¹ Better Births: Improving outcomes of maternity services in England: A Five Year Forward View for maternity care, page 46



3. Enable the woman to develop an ongoing relationship of trust with her midwife
4. Where possible be implemented in both the hospital and community settings.

Models

There are two main models which meet these principles which Local Maternity Systems will want to consider for implementation locally:

- Team continuity, whereby each woman has an individual midwife, who is responsible for co-ordinating her care, and who works in a team of four to eight, with members of the team acting as backup to each other. This allows for protected time, during which the other members of the team will provide unscheduled care, and the lead midwife will not be called upon. The woman gets to know all the members of the team, so at the time of the birth she has met all of its members.
- Full caseloading, whereby each midwife is allocated a certain number of women (the caseload) and arranges their working life around the needs of the caseload. The backup is provided by a core midwifery team whom the woman is unlikely to have met.

It is likely that full caseloading will be more appropriate for targeted cohorts of women who would particularly benefit from individual continuity (e.g. women with complex medical or social needs).

Neither of these models need to be operated in their pure forms – indeed they may be enhanced by mixing the approaches. For example, greater continuity of the individual carer can be

provided in the team continuity model by midwives organising their own time to make the best use of their availability and arranging scheduled care with the same midwife as much as possible. Similarly, an element of backup can be introduced to the full caseloading model by grouping caseloading midwives together in teams. Both models can operate with a buddy system.

In addition, it will always be necessary for obstetric services, particularly specialist services, to deploy a core midwifery staff on a shift basis, so as to ensure that sufficient numbers of midwives are always available to manage all maternity activity and maintain the core service needs.

Detail to be worked out locally

Developing a detailed model requires working through a number of considerations. These are:

- How to allocate the caseload between teams, for example:
 - Based on geographical areas, with a team of midwives taking all women from a small defined area, and following them through the maternity system.
 - Specialising in caring for specific cohorts of women, whether that be low risk, or those requiring more medically or socially complex care.
- The size and shape of the core midwifery staff, which will need to be available in combination with team midwives to ensure the caseload across the Local Maternity System is covered.
- Size of team. The evidence shows good outcomes for teams of four to eight. Consideration will need to be given to the inclusion of midwives working part time.



- Size of caseload that individuals within teams will manage, which will vary according to case mix.
- Skill mix of each team. This should be appropriate to the case mix. Consideration should be given to the inclusion of specialist roles and Maternity Support Workers.
- How to support and empower teams.
- How midwives will manage their working hours.
- Ensuring that each team has a linked obstetrician (or obstetric team) on whom the midwife can call for advice and to plan obstetric care as appropriate.

Setting an ambition and trajectory

We are asking Local Maternity Systems to build a level of ambition and a timetable for delivery. To calculate a realistic overall level of ambition, Local Maternity Systems will need to balance what the model can theoretically achieve against the level of opportunity to roll it out. The factors which Local Maternity Systems will need to consider are:

- Case mix: some women begin on one pathway and transfer to another (usually more specialised pathway) as their pregnancy progresses, which may mean the involvement of different personnel, such as specialist midwives. Continuity should never become a barrier to the transfer of care where it is required for the safety of a woman and/or her baby.
- Choice: Some women will make an informed choice for care without continuity and continuity must not be a barrier to this choice.

- Availability of midwives: The proportion of the overall midwifery staffing requirement which is in place and able to work in the new model will have a direct impact on the percentage of continuity of carer provided.
- Cost: Given the extent to which factors influencing cost vary, Local Maternity Systems will need to carry out an individual financial analysis based on their own models and circumstances, and assure themselves that they will be able to afford whichever model they choose within their current financial envelope. For example, the following points will need to be considered:
 - Birth to midwife ratios.
 - The minimum level of midwifery staffing required to provide a safe level of cover, 24/7, in all wards in maternity units.
 - Changes in the profile of remuneration to cover the inconvenience to midwives of being on-standby and called out at unsociable times.
 - Geography.

Local Maternity Systems will also need to work out how to phase rollout. It may be easier to start with a relatively small cohort of women as a means of demonstrating the concept locally and developing enthusiasm, followed by rolling it out further within a set timetable. Particular cohorts which some areas are starting with, or considering, include:

- The women who are most likely to benefit. Evidence suggests that women with complex social needs benefit disproportionately in terms of outcomes from continuity of carer.²

² Rayment-Jones, H., Murrells, T., & Sandall, J. (2015). An investigation of the relationship between the caseload model of midwifery for socially disadvantaged women and childbirth outcomes using routine data—a retrospective, observational study. *Midwifery*, 31(4), 409-417.



- A relatively small defined geographical area. This means setting an initial catchment area and delivering a mixed risk service to all women from that area.
- Women on a low risk community midwifery pathway choosing midwifery birth settings. Given that community midwives often already work in teams, it may be an easier operational fit for continuity teams.
- A hospital-based team providing care in collaboration with an obstetric team. This could work in particular with a defined group of women, e.g., women with diabetes.
- Developing an implementation plan which should be incorporated into the local maternity transformation plan, alongside a business case.
- Some midwives may need training to move to the new way of working.

Next steps

The following are key to getting started:

- Engagement: Crucial to the successful design and delivery of local models to implement continuity of carer is co-production with local midwives, and engagement with obstetricians and other health professionals who work within the Local Maternity System. In addition, any model of providing continuity of carer can only be successful if it delivers what women want. It is therefore important that models should be co-produced with service users. Maternity Voices Partnerships will be able to help Local Maternity Systems with this.
- It is important that staff across the Local Maternity System understand how continuity of carer works and how to work in partnership with midwives providing continuity of carer. This means establishing a communications strategy to share these messages. The clinical and operational governance in place across the Local Maternity System will need to be updated to reflect new models of providing care



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Foreword



Better Births set out a clear recommendation that the NHS should roll out continuity of carer to ensure safe care based on a relationship of mutual trust and respect in line with each woman's decisions. This recommendation was not made lightly, but on the basis of a body of evidence that continuity of carer is what women want, improves safety and provides significantly better outcomes.

Implementing continuity of carer is undoubtedly a challenge. It requires a reorganisation of the way NHS maternity services are staffed. However, I can say from direct experience that it is a model that delivers positive results for women, babies and their families, and for midwives and other professionals providing their care. The key to successful implementation is incremental increase of continuity of carer that is manageable.

The evidence shows that when implemented properly, continuity of carer empowers midwives. It enables them to build a relationship with the women they care for, enables them to manage their own working lives and ultimately provides greater job satisfaction.

This guidance does not provide a single national blueprint; rather it aims to help Local Maternity Systems develop a model of continuity of carer that will reflect the needs of local women, their babies and their families. It provides a framework to inform local decisions that are required to build and implement continuity of carer.

This guidance has been produced collaboratively, with midwives, clinicians, leaders, managers, researchers and commissioners who have had experience of leading and working in services providing continuity of carer, and with academics who have contributed to the continuity of carer evidence base. In particular, the contribution from the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists has been invaluable. I would like to thank sincerely all those who have contributed their expertise to the development of this crucial guidance.

Professor Jacqueline Dunkley-Bent OBE,
Head of Maternity, Children and Young people, NHS England,
and National Maternity Safety Champion



Foreword



The Royal College of Midwives has been closely involved in the development of this guidance and believes that it will be helpful to Local Maternity Systems as they work to implement the recommendations of Better Births.

To develop our services so they are based on the principle of continuity of carer throughout a woman's journey is undoubtedly a major ask. However, the evidence shows clearly that continuity of carer is a vital ingredient in

ensuring women and babies receive the very highest standard of maternity care and, given that we are all committed to achieving that, it is critical that we respond positively.

I have seen continuity of carer models that have effectively improved outcomes and experience for women, babies and families. When these models are appropriately resourced and well led they provide well documented benefits not only to mothers but also to midwives' role satisfaction and personal development. The Royal College of Midwives therefore commends this guidance to you and looks forward to working alongside policy makers and local maternity services and systems to support successful implementation of this very important change.

Gill Walton,
Chief Executive, Royal College of Midwives



Foreword



Women have asked for more personalised care during maternity in order to enhance their antenatal, intrapartum and postnatal experiences and therefore, continuity of carer is a key theme of the Better Births report. Evidence has also shown that continuity of carer reduces risks and will make a significant contribution to reducing rates of stillbirth, neonatal death and brain injury during birth by 50% by 2030.

Better Births made a specific recommendation that each midwifery team have a named obstetrician on whom they can call for advice and obstetric care when needed. This is an integral part of providing continuity of carer and one which we at the Royal College of Obstetricians and Gynaecologists support wholeheartedly. This guidance is an important tool for all of us in working towards our goal of making maternity a safe and happy experience for all women.

Professor Lesley Regan, MD DSc,
President of the Royal College of Obstetricians and Gynaecologists



1. Introduction

1.1 National vision, local transformation

In February 2016 Better Births, the report of the National Maternity Review, set out the Five Year Forward View for NHS maternity services in England to become safer and more personal. At the heart of its vision is a recommendation that there should be:

Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.

The recommendation was based on the finding:

Women told the review team that they see too many midwives and doctors over the course of their pregnancy and the birth, and that they do not always know who they are and what their role is. For some women this leads to confusion and they are not able to build up a rapport with healthcare professionals. Relationship or personal continuity over time has been found to have a positive effect on user experience and outcome.³

A national Maternity Transformation Programme has been established to take forward implementation of the Better Births vision. However, the Better Births report recognised that delivering many aspects of the vision would rely primarily on local leadership. This is particularly the case with continuity of carer, which will need to be tailored to meet the needs of

Further sources of information

- [Better Births: Improving outcomes of maternity services in England: A Five Year Forward View for maternity care](#)
- [Implementing Better Births: A resource pack for Local Maternity Systems](#)

local women, babies and their families, and the operational circumstances of each Local Maternity System.

The **key deliverables for Local Maternity Systems⁴** set out an expectation that each area will, by October 2017, establish a shared vision and plan to implement Better Births by the end of 2020/21. These plans are expected to show how most women will receive continuity of the person caring for them during pregnancy, birth and postnatally. Local Maternity Systems have been asked to put in place plans to meet local ambitions in these areas.

This document provides practical guidance about how to go about developing a continuity of carer service model that works for a Local Maternity System, and how to identify an ambition and trajectory for implementation that takes into account local opportunities. It builds on *Implementing Better Births: A resource pack for Local Maternity Systems* which was published in March 2017 to provide practical advice on how to transform local maternity services. It will be useful for Local Maternity Systems as they develop further iterations of their plans.

³ [Better Births: Improving outcomes of maternity services in England: A Five Year Forward View for maternity care](#), page 46

⁴ [Better Births: Improving outcomes of maternity services in England: A Five Year Forward View for maternity care](#), page 46



1.2 Support for local transformation

Each Local Maternity System has a bespoke package of co-ordinated support from NHS England, other national NHS organisations, the maternity Clinical Networks and regional maternity transformation boards. This includes, where requested, specific support on continuity of carer. This package of support for each Local Maternity System will evolve over time and additional requests for support should be made via the regional maternity transformation boards in the first instance.

At the same time, five **Early Adopter Local Maternity Systems** are forging ahead to test continuity of carer models. The learning and solutions from these areas will be shared to help other Local Maternity Systems as soon as they become available. The Early Adopters are:

Birmingham and Solihull United Maternity and Newborn Pathway (BUMP) is working within geographical pilot areas, to provide 80% of these women with continuity of carer through a small team of 6-8 midwives. This is being tested during 2017/18 with a plan to roll this approach out across Birmingham and Solihull in 2018/19.

North West London is testing a full caseloading model across five or six locations. This includes a complex social care caseload, obstetric complex care including multiple pregnancies, and enhancing the antenatal and postnatal experience for women who are “out of area”. Continuity also extends to having a named obstetrician for each team. The development of this continuity approach has been informed by the outcome of a staff engagement exercise where they were able to express their preferences.

Cheshire and Merseyside is piloting small teams of midwives based in the community offering continuity through the antenatal, intrapartum and the postnatal period. This is being tested within one provider catchment area to begin with, before plans to roll out across the Local Maternity System are finalised. Identified obstetricians are also linked to these teams, providing expertise for women who require obstetric input. Women who need more complex care will have a single obstetric team and joint clinical pathways between multiple providers to allow for integration and seamless care. Pilot areas are also testing caseloading within smaller teams of midwives in a “buddy” system to improve the home birth rate across the geography.

North Central London is testing the development of small teams of midwives for specific groups of women. These may include groups with additional social need, women living in border areas where cross boundary working can be tested and women choosing home birth.

Surrey Heartlands are piloting caseloading for specific groups of women, expanding continuity of carer, which is currently limited to include women who are considered disadvantaged and women who are low risk. This includes a dedicated home birthing team working across Surrey Heartlands. With the introduction of a Single Midwifery Team Surrey Heartlands will increase the number of women who only see a small number of midwives during their pregnancy.

These Early Adopters are happy to share information about their plans to help other Local Maternity Systems develop their own approaches. Please contact england.maternitytransformation@nhs.net if you would like contact details.



2. What is continuity of carer and why are we rolling this out?

2.1 What is continuity of carer?

First and foremost continuity of carer means that there is consistency in the midwife or clinical team that provides hands on care for a woman and her baby throughout the three phases of her maternity journey:

- Pregnancy
- Labour
- The postnatal period

Secondly, it enables the co-ordination of a woman's care, so that a named individual takes responsibility for ensuring all the needs of a woman and her baby are met, at the right time and in the right place.

Thirdly, it enables the development of a relationship between the woman and the clinician who cares for her over time.

Better Births recommended that the NHS in England should roll out continuity of carer to a much greater number of women, because this is what women say they want, and because it leads to better outcomes for women and babies, and recommended that the model should be available for both community and hospital midwifery services.

There are different continuity of carer models available (see chapter 3), but all models involve consistency of the midwife or team over the whole pathway. Better Births set a specific expectation that each woman would have "a midwife she knows

at the birth" amongst other requirements.⁵

Although there is not detailed evidence of the degree to which most providers of NHS maternity care currently provide continuity of carer, implementing it at scale is likely to be a change for most. Whilst many NHS maternity providers have made significant progress in improving co-ordination of care through a named midwife, true continuity models are currently limited to small geographical areas, specific cohorts of women (e.g., women with complex social needs) within certain NHS trusts or small, innovative and independent providers of NHS care.

2.2 What women say

The National Maternity Review undertook an extensive programme of engagement to listen to the views of the public, service users, staff and other stakeholders.⁶ On continuity of carer, it concluded:

Women told us how important it was for them to know and form a relationship with the professionals caring for them. They preferred to be cared for by one midwife or a small team of midwives throughout the maternity journey. It was felt that this could provide better support for women, and enable midwives to better meet their needs, identify problems and provide a safer service.⁷

The review held a consultation exercise to seek the views of as many women, health professionals and other stakeholders as

⁵ Better Births: Improving outcomes of maternity services in England: A Five Year Forward View for maternity care, page 46

⁶ Better Births: Improving outcomes of maternity services in England: A Five Year Forward View for maternity care, page 17

⁷ Better Births: Improving outcomes of maternity services in England: A Five Year Forward View for maternity care, page 32



possible. Women were asked: How important is it for you to be supported by the same midwife before, during and after birth?

50% of the 3780 respondents to this question, scored it five out of five for importance, with an additional 23% scoring it four.

The review also held a bespoke consultation exercise for families whose baby died during pregnancy (including miscarriage), labour or soon after birth, and for families who experienced pregnancy complications affecting the health of the mother or baby and/or neonatal admission after birth. This included a similar question. Of the 760 respondents to the question, 66% scored continuity of carer five out of five for importance, with an additional 16% scoring it four.

The National Maternity Review also commissioned a review of the existing research evidence from the National Perinatal Epidemiology Unit at Oxford University. It looked specifically at the evidence of what women say they want and concluded:

The evidence suggests that women have a preference for continuity of midwife, particularly seeing the same midwife during antenatal care and having the same midwife present throughout the labour and birth.⁸

Examples of what women experiencing continuity of carer say⁹

“Following our discharge from hospital, our midwife did all our postnatal appointments – and that was really important again. I have a history of depression from when I was younger, so I was keeping an eye out for feeling more than hormonal – and our relationship meant I was comfortable to talk about it with her. Nothing happened and we coped really well. But having that person who really knew me – all she had to do was ask me how I was feeling and I would have told her the truth. I don’t know if I’d have done that with someone I’d just met, especially if I was feeling vulnerable.”

“The whole experience felt like a real partnership and that is how it should be. I really wish that all women could have the same experience.”

8 Jennifer Hollowell, Alison Chisholm, Yangmei Li, Reem Malouf, [Evidence Review to Support the National Maternity Review 2015 Report 4: A systematic review and narrative synthesis of the quantitative and qualitative literature on women’s birth place preferences and experiences of choosing their intended place of birth in the UK](#), page 37

9 As provided to chairs of Maternity Voices Partnerships.

Examples of what women experiencing continuity of carer say:

"Having one midwife who knew my situation inside out meant I didn't have to explain from the beginning at every single appointment why I was making certain choices."

"She also helped me with breastfeeding. The continuity of carer was so important there – she knew how important it was to me, so she knew she wasn't putting pressure on me talking about it."

"I was lucky enough to see one NHS midwife through my pregnancy, birth and postnatally - with the exception of two appointments where she was unwell and her close colleague covered for her. She was amazing and I would describe the care that we received as exemplary. She supported us fully to make informed choices, and empowered us both to feel confident and comfortable in pregnancy, birth and beyond. I feel that the trust based relationship that we were able to build with her played a huge part in the peaceful, natural birth that I ended up having."

"It's so nice knowing who you're going to see and postnatally feels a lot more personal and reassuring to see a familiar face, especially when you're at your most vulnerable".

2.3 Improving Outcomes

Evidence shows that continuity models improve safety and outcomes. In particular, it shows that women who had midwife-led continuity models of care were:¹⁰

- Seven times more likely to be attended at birth by a known midwife
- 16% less likely to lose their baby and 19% less likely to lose their baby before 24 weeks
- 24% less likely to experience pre-term birth
- 15% less likely to have regional analgesia
- 16% less likely to have an episiotomy.

Implementing continuity of carer is therefore an important tool in meeting our ambition to reduce rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% by 2020 and 50% by 2030.

Although the causal link between continuity of carer and improved outcomes is not fully understood, it is likely that:

- The ongoing relationship built on trust gives the woman the confidence to be open with her midwife and helps the midwife to identify and manage risks.
- The ongoing relationship enables the midwife to provide care with greater empathy,¹¹ provides women with a greater sense of control, and reduces any stress and anxiety felt by the woman.

- Because the midwife is responsible for care co-ordination and liaison with other specialists and the obstetric team, the women gets the level of care that she needs.
- There is less missed care as the midwife is proactive in ensuring missed appointments are rescheduled, acting as a safety net across complex care pathways.

Importantly, it is the relationship through the antenatal, intrapartum and postnatal period which the researchers use to distinguish “midwife-led continuity models of care” from other models. Models which do not fall within this definition may not deliver the benefits described in this research.¹²

Some women may derive a disproportionately greater benefit from continuity of carer. In particular:

- Caseload midwifery appears to confer increased benefit and reduced harmful outcomes for women with complex social factors.¹³
- There may be greater benefits because having an ongoing relationship with a midwife is likely to provide significant support for the emotional wellbeing of a woman undergoing more complex care.

This is likely to have a significant impact on overall outcomes and reduce health inequalities.

10 Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2016 , Issue 4 . Art. No.: CD004667.

11 Walsh, D, and Devane, D, [A Metasynthesis of Midwife-Led Care, Qualitative Health Research](#), March 2012

12 Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2016 , Issue 4 . Art. No.: CD004667.

13 Rayment-Jones, H, Murrells, T, Sandall, J. 2015. An investigation of the relationship between the caseload model of midwifery for socially disadvantaged women and childbirth outcomes using routine data – a retrospective, Observational study, *Midwifery*, Volume 31:4,409–417.



Reflections by midwives at King's College Hospital NHS Foundation Trust on providing continuity of carer

"As a student I spent time with midwives who gave continuity of care, it was from then that I knew that I aspired to work in that way. It was palpable the relationship that was developed between a woman and her midwife which also gave room for her partner and family to become a part of the experience.

And here I am now having worked as a case loading midwife for 15 plus years. I've been constantly aware of the benefits of this relational model of caring for women and their families."

"Having been with the same team for about 10 years, I can happily say from the women's feedback that receiving continuity of care increases their confidence, encourages openness, reliance/attendance, builds bonding and trust. They have also expressed disappointment when not seeing their named midwife.

Personally, I feel exactly the same as the women I care for. Continuity of care enables me to get to know the women's medical, surgical, mental, social and obstetric history very well. This in turn, helps me to plan their care effectively."

"I became a midwife at the age of 40 because I had met caseloading midwives and understood the effects of the work that they do. For me, seeing a family from booking right through to the postnatal period is incredibly rewarding, and I feel really privileged to get to know them well through this time. When the family has additional challenges - and our team specialises in serious mental illness - the rewards are even greater. I also feel that we have had a remarkable number of successes in terms of our families beginning safely and with hope.

I love the fact that I can make promises to women about how they will be cared for in labour, knowing that even if I am away, my trusted sisters in our team will give them understanding and committed care. Close relationships with our team are so important, and we invest lots of time - and tea - in forming firm bonds with the colleagues who will support us through thick and thin."



3. Developing a service model for implementing continuity of carer

3.1 Current models

For the majority of NHS maternity services, routine antenatal and postnatal services are provided within consistent core hours, with urgent and intrapartum care provided on demand. NHS services tend to be built around “units” (obstetric units, midwifery units, etc.), with services staffed and funded to ensure needs of the relevant unit are met. Care is guaranteed by deploying staff on a shift system so that sufficient staff are available within the unit to meet scheduled appointments and demand at all times. In practice this means peaks in activity where staff are very busy – including some times when predicted demand is exceeded and staff are moved from scheduled care to areas where activity has peaked. Peaks in maternity activity can also mean that maternity units may be closed to new arrivals to maintain safety. There may also be times with lower than expected clinical activity.

Within such a model, continuity of carer is rare because the chance of a midwife the woman knows being rostered on at the specific time when she needs unplanned care, for example in labour, is slim.

3.2 Principles for a new model

To provide continuity of carer, a new model of deploying staff is needed, based on midwives being available for ante- and post-natal care, but also being available to provide intrapartum and other urgent care for the women they care for. Mindful of the rationale and the evidence for continuity of carer outlined in the

previous chapter, there are four main principles for the provision of this model. The model should:

1. Provide for consistency of the midwife or obstetrician who cares for a woman throughout the antenatal, intrapartum and postnatal periods
2. Include a named midwife who takes on responsibility for co-ordinating a woman’s care throughout the antenatal, intrapartum and postnatal periods
3. Enable the woman to develop an ongoing relationship of trust with her midwife
4. Where possible be implemented in both the hospital and community settings.

This means in particular that **services that provide continuity over the antenatal and postnatal periods, with the exception of the intrapartum period, cannot be said to deliver continuity of carer.**

3.3 Options for new models

Given historic variation in how care is provided, the impact of physical geography and demographics, and different views of midwives across the country about how they want to provide care for women and their babies, we are not recommending a single model of care for continuity of carer centrally for the whole country. Local Maternity Systems will want to consider the characteristics of the two main models which meet the principles set out above, alongside the considerations which apply.



3.3.1 Team continuity model (midwifery group practice)

Characteristics

- Each woman has an individual midwife, who is responsible for co-ordinating her care.
- Midwives work in teams of four to eight with members of the team acting as backup to each other.
- Each midwife is allocated a certain number of women (the caseload) and arranges her time around the needs of her caseload as far as possible, but also has some protected time, during which the other members of the team will provide unscheduled care, and the lead midwife will not be called upon.
- The woman gets to know all the members of the team, so at the time of the birth she has met all the midwives in the team.

This is the model highlighted in Better Births, which specified a team of four to six midwives, although the research evidence shows that teams of four to eight can achieve the same outcomes.¹⁴

Considerations

This model results in:

- Greater scope for protected time for midwives, which may be appealing to some.
- A significant likelihood of an alternative midwife she knows being available if the woman's own midwife is unavailable.
- An alternative midwife the woman knows for long labours, where the lead midwife may not be able to safely provide care over an extended period of time. A reduced likelihood of a woman being cared for by her own midwife during labour is reduced compared with the full caseloading model.

3.3.2 Full caseloading model

Characteristics

- Each woman has an individual midwife, who is responsible for co-ordinating her care.
- Each midwife is allocated a caseload of women and arranges their working life around the needs of the caseload.
- The backup is provided by a core midwifery team whom the woman is unlikely to have met.

Considerations

- This is the model that provides the greatest chance of continuity of individual carer.
- It suits some midwives. They enjoy the opportunity to build a relationship with their women and enjoy the flexibility of planning their working lives around a different sort of working pattern. For example, by seeking to build work patterns around due dates, they may have periods of time when they are available for women, e.g. three months, but subsequently benefit from a periods time when they are off, e.g., one month.
- Relying on a single midwife means there will be times when the model cannot reliably provide continuity of carer. For example, there will be times a woman goes into labour when her midwife is unavoidably unavailable (e.g., she is sick or already caring for another woman in labour).
- It requires considerable flexibility on the part of the midwife. In particular, it may mean less consistent protected time when the midwife is not available. Some midwives may find it more difficult to juggle other calls on their time and for this reason not all midwives may be able to work in this way.

14 Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2016, Issue 4. Art. No.: CD004667.



- It appears to be more difficult to introduce and sustain on a large-scale basis. If there are not large numbers of midwives able to work on this basis, they are likely to remain a small scale option – either delivered by small independent providers of NHS care (for whom caseloading is their unique selling point) or targeted at cohorts of women who would particularly benefit from individual continuity (e.g., women with complex medical or social needs).

3.3.3 Taking elements from the caseload and team models and using a buddy system

Neither of these models need to be operated in their pure forms – indeed they may be enhanced by mixing the approaches. For example, an element of backup can be introduced to the full caseloading model by grouping caseloading midwives together in teams. Similarly, greater continuity of the individual carer can be provided in the team continuity model by midwives organising their own time to make the best use of their availability and arranging scheduled care with the same midwife as much as possible.

Both models can operate with a buddy system, whereby each woman has a first alternative point of contact within the team. This gives greater certainty to the woman and was recommended in Better Births.

3.4 Hospital care

To achieve continuity of carer at scale, a reorganisation of hospital care around midwifery teams will be required.

Currently, nationally 2% of births take place at home, 2% in a freestanding midwifery unit and 9% in an alongside unit, although there is significant variation across England and it seems likely that these figures could be higher if service capacity were better aligned with women’s choices.¹⁵ Hospital Episode Statistics data from 2012 suggests that around 45% of women at the end of pregnancy would be suited to midwifery care in line with NICE guidance (although this figure is reducing as a result of greater complexity).¹⁶

Given the relatively small proportion of women receiving intrapartum care in the community, providing continuity at scale also requires moving to a continuity team model for hospital-based care. Currently, nationally 37% of women receive intrapartum care on a midwifery pathway within an obstetric unit,¹⁷ 38.7% on an intermediate pathway,¹⁸ and 11.3% on an intensive pathway.

Nevertheless, where areas deploy part or full continuity of carer, consideration should be given to ensuring that sufficient numbers of midwives are always available to manage all maternity activity and maintain the core service needs. It will always be necessary for obstetric services, particularly specialist services, to deploy a core midwifery staff on a shift basis.

15 Better Births, page 19

16 J Sandall, T Murrells, M Dodwell, R Gibson, S Bewley, K Coxon, D Bick, G Cookson, C Warwick, D Hamilton-Fairley, (2014) The efficient use of the maternity workforce and the implications for safety and quality in maternity care: a population-based, cross-sectional study, Vol 2, Issue 38, Health Services and Delivery Research

17 Calculated by subtracting the community birth figure from the percentage of women on the low risk tariff (50% - 13%).

18 2017/18 and 2018/19 National Tariff Payment System, page 53



3.5 Developing a detailed model for each Local Maternity System

Developing a detailed model requires working through a number of decisions. It requires Local Maternity Systems – that is commissioners, providers and service users – to agree an overall model to be commissioned and to set clinical and operational governance to facilitate the model safely and efficiently. But it will also require the detail to be worked out with, and agreed by, individual providers as the employers of midwives, particularly in relation to case mix and working across historically defined boundaries.

3.5.1 Types of caseload

Consideration will need to be given to how to allocate the caseload between teams.

This can be based on geographical areas, with a team of midwives taking all women from a small defined area, and following them through the maternity system. This will include their choice of place of birth, whether that be at home, in a midwifery unit or obstetric unit. This approach will rely on clear clinical pathways, operational guidance, and a good understanding by core midwives of the role of team midwives supporting the care of women in the hospital and community settings. There

may also be a need for standard operating procedures, particularly where continuity teams use freestanding midwifery units or units where they are not employed.

Consideration may also be given to teams of midwives specialising in caring for specific cohorts of women, whether that be low risk, or those requiring more medically or socially complex care. The advantage of specialist teams is that women benefit from the expertise the midwives are able to provide. Caring for a socially complex caseload is rewarding, but can be challenging and the team needs to be adequately resourced and supported in order to be able to provide the highest quality care.

Case study

Imperial College Healthcare NHS Trust

A team of six midwives based at St Mary's Hospital provides continuity of carer to a caseload of women with social risk factors. (In terms of medical care the caseload is mixed risk.) Women are referred by a GP, safeguarding lead or the antenatal clinic in line with criteria developed from NICE guidelines and local demographics. Care is provided at the woman's home or local children's centres. The woman's midwife attends child protection meetings and co-ordinates care between the multidisciplinary team, working closely with social workers and health visitors. Each midwife has a maximum caseload of 35 women and provides intrapartum care.



Providers and commissioners will also need to consider the size and shape of the core midwifery staff, which will need to be available in combination with team midwives to ensure the caseload across the Local Maternity System is covered. This will require careful assurance that ward areas are safe and able to comply with staffing standards, as well as reviewing total staffing requirements, rather than specific teams in isolation. There may be less scope to reduce the number of staff providing ongoing care for inpatients on ante- and postnatal wards, but there should be scope to reduce the number of midwives providing intrapartum care in the core team depending on the percentage of women receiving continuity of carer from midwifery teams. Workforce planning tools will be able to help with this.

3.5.2 Size of team

Consideration will need to be given to size of team. The evidence shows good outcomes for teams of four to eight, and therefore we do not recommend teams larger than this. The larger the team, the more difficult it is for the woman to get to know the whole team and the team to know each other. However, teams of eight may be more successful in ensuring the care is maintained within the team.

Continuity of care, models of midwifery practice at Kings College Hospital

During 2015 community midwifery services at Kings College Hospital (Denmark Hill site) were updated to ensure alignment of teams and caseload practices with community needs. The aim was to target care and resources to the areas of most need and to provide family centred, locally based midwifery services for all low risk women and more seamless care for women needing complex care.

The service provision is now based on a woman's postcode and is structured by dividing the hospital catchment area into 4 geographical quadrants. The community midwifery service is made up of:

- Four Standard community teams
- Four Caseload teams
- In each geographical quadrant there is one standard community team and one caseload team working alongside each other in partnership for that local population
- One Hospital based complex care team
- One Hospital based antenatal team for women resident outside the hospital catchment area
- One Young parents' team for all women under age 19 and their partners

The community redesign of midwifery services on the Denmark Hill site has been established since September 2015. Data is emerging of improved health outcomes for women that have experienced caseload midwifery care. The caseloading teams care for women with mental health or other vulnerabilities and women requesting homebirths. Initial data for the period October 2015 to September 2016, the first year of the realigned community model, suggests that the combined outcomes of the 4 caseloading practices are very positive.

Consideration will need to be given to the inclusion of midwives working part time. Midwives working in this way are estimated to make up about 51% of midwives in England.¹⁹ Issues to consider include:

- Balancing the number of part time and full time midwives between teams
- Making use of job shares to share a caseload between two midwives
- Reducing the size of caseloads appropriately
- How much protected time a part time midwife will require
- Ensuring appropriate skill mix within teams and enabling mentorship.

In practice a large proportion of midwives work 80% or more of a whole time equivalent, which may be easier to accommodate. In New South Wales for example, very part time midwives are sometimes deployed by being allocated to teams to fill gaps, provide essential cover, etc.²⁰

3.5.3 Size of caseload

Consideration will need to be given to the size of caseload that individuals within teams will need to manage. They will need to consider what is safe and realistic for midwives whilst maintaining a good work/life balance, alongside the cost of providing care. The size of a caseload will vary according to case mix. The Birthrate Plus® assessment of staffing requirements for home births and freestanding midwifery units is an average caseload of 1 to 36, which may be best match for a continuity

of carer model, although Local Maternity Systems will need to need to agree a bespoke approach that meets the acuity needs of the population. For example, it may be appropriate to have a lower caseload for teams caring for women with complex needs. A workforce planning tool can help identify requirements, and a good understanding of the case mix of the local population will assist with making judgements.

3.5.4 Skill mix and Maternity Support Workers

There will be a need to ensure that the skill mix of each team is appropriate to the case mix. Consideration should be given to the inclusion of specialist roles and Maternity Support Workers (MSWs).

MSWs have been used to provide care in many NHS services. Their role is variable, and Health Education England (HEE) is working with the Royal College of Midwives, NHS England, NHS Improvement and other stakeholders to consider how their role might be standardised. Currently, they are often deployed to provide care for women and their babies in the postnatal period – and this frees midwifery time for other activities. In some places, such as Birmingham, MSWs are deployed in place of a second midwife attending a home birth.²¹ They have the potential to increase the sustainability of the model if their roles are defined to enable flexibility in the deployment of midwives. However, they are an extra carer with which women will come into contact, so they will need to be appropriately integrated into the midwifery team and become someone the woman knows and is expecting to meet.

¹⁹ Midwifery 2020 Workforce and Workload Final Report, Department of Health.

²⁰ New South Wales Government, [Midwifery Continuity of Carer Model Tool-kit](#)

²¹ Better Births, page 78



3.5.5 Team management and autonomy

Providers will need to consider how to support and empower teams. This may require more focus on leadership and facilitation, through self-managed teams, rather than on direct management. In particular this means a focus on agreed outcomes (e.g., numbers of women cared for; attendance at births) rather than on process (e.g., how they are organising their working day.) This level of autonomous practice, sometimes referred to as occupational autonomy, has been shown to be a key factor in protecting midwives from burnout.²²

Facilitating self-managed teams requires clarity of expectations and acceptance of these by all parties, including:

- Agreement on team caseload, proportion of women who will receive continuity of carer, what happens when a woman transfers out of the caseload, etc.
- Clarity as to when care is handed over to core staff, e.g., how a team midwife maintains continuity of carer, if the woman's labour is induced and who provides cover for breaks
- Adherence to clinical and operational governance e.g., attendance at meetings related to governance, submission of data

contributing to audit, participation in appraisal, provision of A-EQUIP and meetings with the Professional Midwifery Advocate, revalidation and continuing professional development

- Accountability lines and, for example, cover for absence and when can support be expected from the core service.

Providers may want to consider adopting a **hub and spoke** model using some of the principles used by the Buurtzorg district nursing service in the Netherlands.²³ The key element of this model is that each team is a self-determining unit in its own right, supported by a central hub which ensures a robust governance framework around them. The model promotes a sense of inclusiveness and ownership for team members. It builds care around the woman, with midwives acting autonomously to deliver a complete package of care. Teams are responsible for all operational aspects including outcomes and productivity, and members support each other through access to independent 'coaches' rather than managers, when specific expertise or other input is required.

Case study

Nottingham University Hospitals NHS Trust

Under the shared governance model of leadership developed in Nottingham, staff have collective ownership to develop and improve practice, ensuring patients receive safe and confident care. It places staff at the centre of the decision making process and sees managers having a facilitative leadership role. It involves shared decision-making based on the principles of partnership, equity, accountability, and ownership at the point of service. This leadership model empowers all members of the healthcare workforce to have a voice in decision-making, thus encouraging diverse and creative input. In essence, employees feel like they are "part manager" with a personal stake in the success of the organisation.

22 Yoshida Y, Sandall J. Occupational burnout and work factors in community and hospital midwives: a survey analysis. *Midwifery*. 2013;29(8):921-6.

23 <http://www.buurtzorgusa.org/about-us/>



3.5.6 Work patterns and rostering

Providers will need to agree with midwives how they will manage their working hours, and support midwives to design their own work patterns. Consideration will need to be given to how midwives will be able to care for their women (with care needs which are not entirely predictable), whilst ensuring they have a fair work/life balance. In particular this means being clear about the amount of time midwives will be available (on call) to provide care to the women in their caseload, and how much protected time they will have.

The NHS Terms and Conditions of Service Handbook sets out (amongst other terms and conditions) the contractual basis for remunerating midwives for unsocial hours working and overtime, as well as principles for agreeing on-call arrangements locally. It also provides a framework for local NHS Employers to agree variations to standard NHS terms and conditions without disadvantaging employees. Through this it is possible to reach local agreement on annualised hours contracts and to pay for unsocial hours and on-call on a prospective rather than retrospective basis. This offers potential greater certainty to providers and midwives on cost and levels of total remuneration.

Employers will need to consider the following principles:

1. Joint agreement on the precise basis of any approach to reward for continuity based individual midwives in teams should be negotiated with recognised trades unions
2. Total remuneration should be no less than that which relevant on-call, call out worked, unsocial hours and overtime would have provided
3. Arrangements should be reviewed jointly at regular intervals
4. Individual staff should have the right to appeal against remuneration systems
5. Such agreements should not undermine other aspects of Agenda for Change, including working time and equalities.

Consideration will also need to be given to how to manage gaps in core midwifery staff. In a continuity team model, pulling team midwives in to fill gaps destabilises the team and leads directly to the breakdown of continuity of carer for some women. It is therefore to be avoided, and an event that triggers a subsequent review. We recommend finding other solutions, such as use of a flexible workforce.

Case study

Valley Team at Guy's and St Thomas' NHS Foundation Trust

The Valley Team provides team continuity to three to four women per month per midwife in the SW16 post code in London. It cares for a mixed caseload of primiparous and multiparous women with a variety of needs: physical, mental and social.

The team works on a self-rostering basis. Each month midwives work ten days from 9am to 5pm, are available for ten on call periods of 12 hours or 24 hours and have eight days off.



3.5.7 The role of the obstetrician

Better Births made a specific recommendation that each midwifery team have an identified obstetrician who will know the service they provide and on whom they can call for advice.

Local Maternity Systems will need to work with providers to ensure that each team has a linked obstetrician (or obstetric team) available to provide this advisory role and to plan obstetric care as appropriate. A woman may be referred to the linked obstetrician where there is a planned need for obstetric care, in line with NICE antenatal guidance. The linked obstetrician would see her in clinic and advise on management options. However, given the smaller obstetric workforce, the linked obstetrician would not necessarily be the doctor to whom care is transferred when an acute or specialist need occurs. For example, if a woman presents in labour with a breech presentation then the on-call obstetric team would manage the delivery alongside the continuity midwife.

In some cases, where a woman receives ongoing obstetric care, it is also best practice to provide continuity of obstetric care, insofar as possible. Local Maternity Systems may therefore want to consider obstetric staffing models which support this goal. This is most feasible on the basis of a team (or clinic), but it is significantly more challenging considering the size and structure of the obstetric

workforce, and the important role played by specialist doctors. A full continuity model for obstetric care, including intrapartum care, is unlikely to be feasible at scale. However, there is precedent and scope for formation of specialist teams providing antenatal care and planning delivery and postnatal care.

Some specialist teams will already be well-established. For example, most obstetric units will have a multi-professional team responsible for the care of women with diabetes in pregnancy. Tertiary units may have other more specialised teams with named obstetricians for managing complex conditions, such as Lupus. It may be possible for local maternity systems to learn from how these teams are organised and apply this knowledge to the continuity of care model.

Case study

Birmingham Women's and Children's NHS Foundation Trust

Birmingham Women's and Children's are piloting one consultant obstetrician being linked to a community team. This involves the consultant being available to discuss cases by phone. The approach has evaluated well with both midwives and the obstetrician. It has led to avoidance of escalation into clinic and supported confident risk assessment. A full audit is planned later in the year.

Case study

Central Manchester University Hospitals NHS Foundation Trust's Lupus in Pregnancy Clinic

The specialist team within the clinic provides pre-conception advice, routine antenatal care such as blood pressure and urine checks, routine antenatal advice, detailed ultrasound observations of the baby and placenta, monitoring of medication, monitoring of blood tests, monitoring and management of symptoms related to the specific disorder such as 'flare ups'. Surveillance of maternal and fetal health is tailored to individual requirements and a care plan is made for the antenatal period in addition to delivery.²⁴

24 [http://www.cmft.nhs.uk/saint-marys/our-services/maternity-services/our-services-and-clinics/antenatal-care/specialist-maternity-services/lupus-in-pregnancy-\(lips\)-clinic](http://www.cmft.nhs.uk/saint-marys/our-services/maternity-services/our-services-and-clinics/antenatal-care/specialist-maternity-services/lupus-in-pregnancy-(lips)-clinic)



4. Building your level of ambition level and trajectory

4.1 Where do you want to get to?

Once a Local Maternity System has identified the detailed model(s) it will use to implement continuity of carer, to enable delivery planning it will need to build a level of ambition and a timetable for delivery. We believe that combining these local ambitions should enable us to provide continuity of carer for most women nationally.

First of all each Local Maternity System will need to estimate what the local model theoretically can achieve.

In parallel, Local Maternity Systems can work out what the level of opportunity is to roll out the model across the Local Maternity System, taking into account local circumstances by using the following framework below. Where the initial assessment results in a low level of opportunity, Local Maternity Systems may need to consider developing strategies to increase opportunities. Phased implementation may help with this (see section 4.2).

To calculate a realistic overall level of ambition, Local Maternity Systems will need to balance what the model can theoretically achieve against the level of opportunity to roll it out.

4.1.1 Case mix and choice

As set out earlier, women on obstetric or complex care pathways should still receive continuity of carer where possible. However, there are two factors which will reduce the amount of continuity possible:

- Some women begin on one pathway and transfer to another (usually more specialised pathway) as their pregnancy progresses, which may mean the involvement of different personnel, such as specialist midwives. Continuity should never become a barrier to the transfer of care where it is required for the safety of a woman and/or her baby. In particular, neonatal care will be enhanced by the woman giving birth in the hospital in which her newborn baby will be cared for.
- Some women will make an informed choice for care without continuity and continuity must not be a barrier to this choice. For example, a woman may choose antenatal care close to her work, but intrapartum and postnatal care close to her home. The NHS should work behind the scenes to make care seamless.

Local Maternity Systems will need to estimate the proportion of women who fall into both of these categories based on existing patterns of service use.



4.1.2 Availability of midwives

A second issue to consider is the availability of midwifery staff. The proportion of the overall midwifery staffing requirement which is in place and able to work in the new model will have a direct impact on the percentage of continuity of carer provided.

We know that there is significant variation in the ability of trusts to fill vacant posts. Those Local Maternity Systems which do not currently have a full complement of midwives are likely to find similar gaps in a continuity staffing model.

Few midwives have experience of this way of working. Anecdotal evidence suggests that there are some real enthusiasts for continuity models and some who are nervous about the new approach. Continuity models suit some midwives, because it enables them greater freedom to manage their own time, providing that they are able to meet the needs of their clients, and it rewards them by enabling them to build up a relationship with their clients and see the impact of their care over time. Evidence on this is cited by a New South Wales government toolkit.²⁵ Moreover, many midwives find continuity of carer models more flexible than long shifts and regular night working. However, other midwives are concerned about not being able to do exactly as they please when they are available/on call and about juggling other priorities, such as caring for their family. Midwives may benefit from being able to choose between continuity and core teams – and even move between them at different stages in their career.

In practice, midwives are unable to make a decision without detail about the model and exactly what it means for them as individuals. The detail really matters because minor characteristics of the model can have a significant impact on the overall working environment. Therefore, Local Maternity Systems will need to carry out their own engagement with midwives on the basis of the specific model agreed, to develop an understanding of the impact. Empowering midwives to develop the model (in co-production with service users) is likely to result in greater willingness to work within it. Local Maternity Systems should also put in place support for managers who are responsible for leading change.

What midwives say²⁶

“One benefit for us is that you are in control of your caseload and you manage your own diary.”

“In terms of decision-making, I think we are more autonomous working here.”

25 K Sullivan, L Lock and CS Homer, [Factors that contribute to midwives staying in midwifery: a study in one area health service in New South Wales, Australia](#), cited in New South Wales Government, [Midwifery Continuity of Carer Model Tool-kit](#)

26 Collected as part of the Midwifery Continuity of Carer Interactive Guide interviews (Royal College of Midwives, 2017)



What midwives say

"People [midwives] can phone each other any time. We are a close team, and we work well together."

"I used to work in an integrated team. You didn't find out as much about the ladies. There are several examples in which women have disclosed things to me only because they have built up trust in me."

"I don't feel stressed at all over my hours. I think that's because it's caseloading, we know our women. Even if I haven't met her, we've talked about her at meetings, and we share a sheet with the details of each other's women with special needs."

"We have a direct connection with obstetricians, who are based on geographical area, and with Antenatal Day Assessment Unit. Essentially, we have a consultant for our team."

"This model enables us to keep up our skills in all areas, for example I might have one day in a social services meeting, the next in theatre, the next at home. The diversity in experience that we have is exciting."

"Your colleagues are the people who hold you up. They keep you going."

"It takes time to get used to the system, particularly on-calls and having the phone. It takes (time) to get into it...It doesn't stop you living your life."

"There is flexibility with the off-duty as well, and the rest of the team are accommodating. You can plan things for next year as well, we don't have to book loads in advance like others may have to. We work more closely and so there is more understanding of each other, and we can easily arrange swaps."



In addition, some midwives may not have the skills to move to the new way of working. However, this can generally be resolved through training (see section 5.3).

In some parts of England small (independent sector) midwifery practices provide NHS care on the basis of continuity of carer. Local Maternity Systems will want to consider the role that such midwifery practices can play.

4.1.3 Cost

The cost of delivering the local model may have an impact on how widely it can be rolled out.

Given the extent to which factors influencing cost vary, Local Maternity Systems will need to carry out an individual financial analysis based on their own models and circumstances, and assure themselves that they will be able to afford whichever model they choose within their current financial envelope. The key issues Local Maternity Systems will need to consider are:

- Birth to midwife ratios, which will indicate how many midwives are required. Birthrate Plus makes the following recommendations, but local analysis is required to understand whether they would apply in the local continuity model:
 - A ratio of 36 births per whole time equivalent midwife, for home births and freestanding midwifery units, which may be the best match for an all risk continuity team.

Case study

Neighbourhood Midwives

Neighbourhood Midwives are a small independent midwifery practice which have been commissioned by the local NHS to provide complete midwifery care to low risk women living in Waltham Forest. Women are offered the same two midwives (one primary and one secondary) throughout their pregnancy, childbirth and up to six weeks after the birth, and their midwives are available 24 hours a day. They do this by operating in small teams on a self-management hub and spoke model.

- A ratio of 42 births per whole time equivalent midwife for a District General Hospital with greater than 50% of mothers in acuity categories IV and V, which may be the best match for a core midwifery team.
- A ratio of 96 births per whole time equivalent for community services activity only (not involving birth).



- The minimum level of midwifery staffing required to provide a safe level of 24/7 cover in all wards in maternity units, which will be independent of the size of the unit.
- Changes in the profile of remuneration to cover the inconvenience to midwives of being on-standby and called out at unsociable times. Provider trusts can choose to provide compensation for inconvenience on a retrospective basis, but most trusts already deploying midwives on a continuity basis have come to a local agreement on payment on a prospective basis, i.e., by providing a basic uplift to salary. In any case, trusts will need to consider the total income a midwife will receive under the new model, as well as how much midwives earn for the time they work.
- Geography. Delivering services across a remote or more sparsely populated area may require midwives to travel longer distances. This will reduce efficiency per midwife. (Allocations to CCGs have been adjusted to include an allowance for the greater cost of delivering services in the most remote areas.)

A costing and savings analysis will be made through the evaluation of Early Adopter experiences and shared with Local Maternity Systems as soon as it is available.

4.2 Setting a trajectory

Once a Local Maternity System has an overall level of ambition, it will need to work out how to phase it. Rather than starting from a position of no continuity and moving to maximum continuity immediately, it may be easier to start with a relatively small cohort of women as a means of demonstrating the concept locally and developing enthusiasm, followed by rolling it out further within a set timetable. The main strategies for doing this are:

- **Start with the women who are most likely to benefit.** The evidence suggests that women with complex social needs benefit disproportionately in terms of outcomes from continuity of carer.²⁷ These are women who need special care, support or protection because of age, disability, or risk of abuse or neglect and represent 27.8% of births.²⁸ Such women are often included in the complex care category, but they do not necessarily need medical input; rather they often need more support and more time from their midwives. It requires the establishment of midwifery teams specialising in care for women with complex social needs and it is likely to be more resource intensive, because such midwifery teams will need a smaller caseload. However, offering continuity of carer to such women is likely to represent good value for money. This is because these women already need a disproportionate amount of time from traditionally staffed midwifery teams and there will be a disproportionate benefit from improved outcomes. Local Maternity Systems which go down this route

27 Rayment-Jones, H., Murrells, T., & Sandall, J. (2015). An investigation of the relationship between the caseload model of midwifery for socially disadvantaged women and childbirth outcomes using routine data—a retrospective, observational study. *Midwifery*, 31(4), 409-417.

28 NICE Costing statement: Pregnancy and complex social factors (September 2010) – uses ONS data on Live Births to make calculation.



will nevertheless also need a strategy for moving beyond this cohort of women once the model is established.

- **Start with a relatively small defined geographical area.** This means setting an initial catchment area and delivering a mixed risk service to all women from that area, with community-based midwives following the women through the system, including to her choice of place of birth, whether that be at home, in a midwifery unit or obstetric unit. The service can subsequently be expanded to cover neighbouring or new areas within the Local Maternity System.
- **Start with women on a low risk community midwifery pathway choosing midwifery birth settings.** Given that community midwives often already work in teams, it may be an easier operational fit for continuity teams. However, Local Maternity Systems will need a strategy to move beyond this cohort of women and consider continuity of carer for hospital based teams, which potentially requires greater reorganisation of staffing. This will require collaboration and partnership working between the maternity providers and commissioners that make up the Local Maternity System. Local Maternity Systems will need to consider how they provide care to the cohort of women who move into and out of the community midwifery pathway as their pregnancy develops and they make choices about their care (choice of place of birth in particular may be made after choices around antenatal care). Under this model these women are likely to not experience continuity of carer and Local Maternity Systems will need to consider how that is managed.

- **Start with a hospital-based team providing care in collaboration with an obstetric team.** This could work in particular with a defined group of women, e.g., women with diabetes. It will require close working with obstetric colleagues to develop the model. Again, Local Maternity Systems will need a strategy to move beyond this cohort of women and into midwifery settings.

Given that most women do not currently receive continuity of carer with their ante- and postnatal care, some existing services have concentrated on these periods of care first, before planning continuity that extends into the intrapartum period. We do not recommend this approach because such models tend to become custom and practice, whereas rolling out full continuity of carer ultimately requires greater reform to staff deployment.

Local Maternity Systems will need to consider what impact the approach they take might have on health inequalities. Whilst focusing on women with complex social needs is likely to contribute to a reduction in health inequalities, focusing solely on more affluent geographical catchment areas may have the opposite effect. In addition, women who are better engaged and informed could be more likely to seek to access continuity services. This means that Local Maternity Systems will need to actively promote the offer to all sections of the community.



5. Making it happen

5.1 Engagement

As mentioned previously, crucial to the successful design and delivery of local models to implement continuity of carer is co-production with local midwives. Equally important is engagement with obstetricians and other health professionals who work within the Local Maternity System. It is vital that their professional expertise is brought to bear on the design. We therefore recommend that **local midwives, maternity support workers, obstetricians and managers are empowered to co-design the models**. Moreover, in consistency with the occupational autonomy approach (set out in section 3.5.5), commissioners and providers may want to explore overarching models which enable the midwives themselves to plan and develop the detail of how the team operates, with support from the centre.

Any model of providing continuity of carer can only be successful if it delivers what women want. It is therefore important that models should be co-produced with service users. Maternity Voices Partnerships will be able to help Local Maternity Systems with this.

5.2 Implementation planning and business case

Local Maternity Systems will need an implementation plan which should be incorporated into the local maternity transformation plan. It will need to set out:

- How it has been co-produced with staff and service users
- Actions and milestones, with responsible owners

- The ambition and trajectory and how they will be realised in steps
- How the workforce will be deployed and how transition will work
- Training requirements
- Interdependencies with other work streams of the local maternity transformation plan
- How key messages and updates will be communicated to staff, service users and the public
- How the plan will be monitored, assured, and evaluated.

Local maternity systems will need to build in flexibility so that later phases of the plan can incorporate learning derived as continuity of carer is progressively rolled out. Learning from experiences in other Local Maternity Systems, including the Early Adopters, may also inform changes to the plan.

Local Maternity Systems will need to build a business case for implementation which will also form part of the local maternity transformation plan. The business case will need to consider the financial case for change, including overall affordability, transition and recurrent costs, assumptions about savings and how implementing continuity of carer will contribute to the Sustainability and Transformation Plan's financial balance.

5.3 Training

Some midwives may need training to move to the new way of working. For example, some midwives choose to work only on ante- and postnatal care and do not provide intrapartum care.



However, most midwives maintain their intrapartum competency through a rotational rota. The challenges for this group are more likely to be around familiarity with the environment: computer systems, equipment, guidelines around specific conditions etc., particularly if they are asked to support women in busy obstetric units. Maternity providers will need to set out the parameters of what a team midwife will and will not be expected to do and that will dictate what kind of upskilling is required. For example, caring for a woman who chooses an epidural or needs acceleration might require a short familiarisation/refresher course (e.g., a week/two weeks with some theory and some targeted practice), whereas getting up to speed with all of the requirements of a busy labour ward would need a much longer period of updating. Equally some midwives may not feel confident supporting women in a midwifery only environment and will require training in such care. Secondment between teams may be a good way of giving midwives the opportunity to broaden their experience and build their confidence. In any case, Local Maternity Systems and providers will need to conduct a training needs analysis as part of change management processes.

5.4 Communications

It is important that staff across the Local Maternity System understand how continuity of carer works and how to work in partnership with midwives providing continuity of carer. This means establishing a communications strategy to share these messages. The clinical and operational governance in place across the Local Maternity System will need to be updated to reflect new models of providing care.

Local Maternity Systems will also need to ensure that new service models are understood by service users and the general public.

5.5 Monitoring and evaluating continuity of carer

Local maternity systems will need to measure continuity of carer in order to understand how it is being implemented. At the same time, the national Maternity Transformation Programme will need to do the same on a national scale. We plan to do this in two ways:

- By measuring which team provided the midwifery care for each woman at each contact, and how many times it was the allocated team. This will involve a change to the Maternity Services Data Set.
- By asking women what they think. The woman is the ultimate arbiter of whether she felt she had sufficient continuity. We will use the results of the CQC maternity survey, which includes questions on continuity, to form an indicator.

In addition, we need to measure the impact of introducing the continuity of carer so as to manage the risk that it might not deliver the expected benefits within the expected costs. NHS England is developing a benefits realisation package of indicators. It will include costs, savings, changes to outcomes (safety, interventions, user experience, etc.) , and the impact on the midwifery workforce.

Local Maternity Systems and providers will need, in particular, to monitor the impact on midwives locally. This needs to include consideration of whether midwives are able to provide care safely, as well as compliance with employment legislation.



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