

Increasing the number of women who receive continuity of midwife care: *A best practice toolkit*

Aim

To increase the number of women accessing continuity of midwife care in London.

This toolkit has been produced as part of the London Maternity Strategic Clinical Network's strategy to identify areas of good practice for implementation across all maternity units in the capital, ensuring equally good outcomes for all pregnant women and their babies.

This toolkit presents the evidence that continuity of midwife care improves maternal and infant outcomes, improves maternal experience of care and uses resources more effectively.

It also reinforces Department of Health policy and the NHS Mandate that *"every woman has a named midwife who is responsible for ensuring she has personalised, one-to-one care throughout pregnancy, childbirth and during the postnatal period, including additional support for those who have a maternal health concern"*¹.

Current National Institute for Health and Care Excellence (NICE) antenatal² and postnatal quality care standards both state women should have a named midwife.

In the postnatal period, this person is referred to as a named healthcare professional³. This should be available to all women including those of social complexity⁴.

The toolkit is intended to cover all pregnant and childbearing women in all maternity units across London.

Background and rationale

A woman who receives care from a known midwife is more likely to:

- » Have a vaginal birth.
- » Have fewer interventions during birth.
- » Have a more positive experience of labour and birth.
- » Successfully breastfeed her baby.
- » Cost the health system less.

A woman who receives care from a known midwife is less likely to:

- » Experience preterm birth.
- » Lose their baby before 24 weeks' gestation.

This applies to low and mixed risk populations of women⁵.

Other studies have found that women who carry social complexity and find services hard to access in particular value continuity⁶ and increased advocacy and care co-ordination⁷. Women also experienced increased agency and control, and more empathic care⁸.

Comments from mothers

The below comments are direct quotes, received from the Family and Friends Test at Guy's and St Thomas' NHS Foundation Trust.

"Fantastic midwife team. Have had an appointment to meet all the midwives but also having an assigned midwife to do home visits is so appreciated. Given me a lot of confidence as this is my first pregnancy and continuous contact during past weeks is excellent."

"Like flexibility of home visits and comfortable by consistency of midwife so don't have to repeat medical history/situation which makes visits more efficient."

"The care I have received from the valley team midwives has been excellent. Completely different to the care I received three years ago with my first. I feel very well looked after and feel as though they really got to know me and my baby as always saw the same person. All women should have this level of maternity care."

There appears to be a cost-saving effect for midwife-led continuity of care as compared to other care models, in which the estimated mean cost saving for each maternity episode is £12.38.

However, the level of implementation of continuity of midwife care and the number of women who have a named midwife who cares for them throughout their pregnancy and birth is unknown. In the last national survey of 23,000 women's experiences of maternity care in England in 2013, 34 per cent of women saw the same midwife every time during pregnancy, and 27 per cent during the postnatal period.

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In 2010, 25 per cent of women had previously met the staff who cared for them during their labour and birth. Women who saw the same midwife were more likely to have all their questions answered, given enough time, felt listened to, and felt involved with their care⁹.

Increasing continuity of midwife care has been identified as a priority for maternity services and the Strategic Clinical Network. For example, south west London commissioners have already stated their expectation that women with uncomplicated care should have no more than two midwives providing antenatal and postnatal care within a community setting.

Definition

Midwife continuity of care (MCOC) models provide midwifery care by one named midwife or a small group of midwives for each woman. This may be throughout pregnancy, birth and postnatal periods or for defined periods, such as during the antenatal or postnatal periods.

This continuity of care allows each woman to get to know her midwife/small group of midwives. This contrasts with shared care models, where responsibility is shared between different healthcare professionals and women may not know their care providers or previously have met the person who will be caring for them in labour.

Examples of models

Antenatal continuity

Women are booked by a named midwife who will see them for the majority of their antenatal care, with back up provided by a 'buddy' midwife. This model is particularly useful for 'out of area' women, that is, those who return to another community area for postnatal care.

Antenatal and postnatal continuity

Women are seen in the community for booking and scheduled antenatal care by a named midwife or buddy. The same midwives provide postnatal care for the woman following the intrapartum period. This model may be orientated around GP surgeries or children's centres for care delivery

Team midwifery care

Antenatal, intrapartum and postnatal care is provided by a small team of midwives (typically six to eight, though team size may vary) in collaboration with doctors in the event of identified risk factors. Intrapartum care may be provided in a hospital, midwifery led unit or the woman's home.

Midwifery group practice case load care

Antenatal, intrapartum and postnatal care are provided by a named midwife, with secondary backup midwife/midwives providing out of hours cover, along with assistance and collaboration with doctors in the event of identified risk factors.

Auditable standards

In the Cochrane review, levels of continuity (measured by the percentage of women who were attended during birth by a known carer) varied between 63 and 98 per cent⁵.

The CQC 2010 and 2013 national surveys established baseline data¹⁰:

- » Proportion of women who saw the named midwife/back up midwife every time during pregnancy - *34 per cent*.
- » Proportion of women who were attended during birth by a known midwife - *25 per cent*.
- » Proportion of women who saw the named midwife/back up midwife every time during the postnatal period - *27 per cent*.

Using the measures stated above identifies the percentage of women in a service that have continuity of care in:

- » Pregnancy and labour and birth.
- » Pregnancy, labour and birth and the postpartum period.

Regular audits will benchmark women's experience of continuity of care and quality of care.

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Key factors for successful implementation

All models

- » A woman and her individual needs should be central to model design and should be the focus of any business case.
- » There should be robust engagement with the midwives who will be providing the care, as they may be able to offer practical solutions to implementation challenges.
- » IT and clerical systems should support the aim that the majority of midwifery care is provided by a named midwife, and should consider this from a woman's first point of contact or referral to services. Investment in this should be considered part of the programme of change.
- » A back up midwife (or midwives) whom the woman has met on more than one occasion during her pregnancy is always available.
- » Women should have access to phone numbers which allow them to communicate easily with their named midwife.
- » MCOCs should use the same clinical guidelines, protocols and decision making frameworks as the rest of the maternity service to ensure consistency, continuity of care and best practice.
- » An interdisciplinary collaborative approach means midwifery care continues to be provided by the named midwife, even when complications arise.
- » Midwives should have an agreed midwifery philosophy of care, vision for the model and ways of working together.
- » Targeting MCOCs towards those with specific needs or priority groups in the local community (eg pregnant teenagers, women with increased social needs or who find services hard to access) can help support implementation by addressing health inequalities.
- » It may be preferable to introduce new models in a staged fashion to ensure that all systems are functioning, and there are no unexpected obstacles.
- » Midwives may require educational input to reskill them into independent decision making if they have been working in a hospital model.

Teams and case load models

- » The named midwife provides care from early in pregnancy (usually booking visit) through labour and birth, up to two weeks postnatal.
- » One-to-one care for labour and birth is provided by the named or back up midwife.
- » There is sufficient investment for all midwives to have 7-day a week access to birth equipment, phones, pagers, IT systems.

Sustainability

It is essential that any model being designed is woman centred, however, should also meet the needs of both the midwives and the service. The following points have been identified as central to promoting sustainability of a MCOC model¹⁰.

All models

- » Management support for the model is critical to drive through change and maintain it in the face of challenges.
- » There should be a midwife team leader with sufficient time allocated to fulfil that role.
- » Managers should ensure there are opportunities for professional development, reflection and debriefing.
- » Clinical supervision should support good decision making and enable the maintenance of professional relationships with women, avoiding the development of co-dependency.
- » Ongoing formal and informal communication is crucial, including regularly scheduled team meetings.
- » There should be clear reporting lines and escalation processes to line managers and obstetricians.
- » To encourage multi-disciplinary working, there should be specific relationships with named medical staff in place as appropriate.
- » Succession planning should be continuously reviewed to allow good handover between midwives. This may include the use of preceptor midwives on rotation to different clinical areas.
- » All models of care should be subject to audit of key outcomes and women's experience.

Teams and case loads models

- » The optimal size of a team (6-8 whole time equivalent) allows midwives sufficient protected time away from working and on-call demands. Anecdotal evidence suggests that

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teams smaller than six have a high risk of burnout and may experience difficulty covering all aspects of care.

- » The size of the case load should not exceed 35-42 women a year per each whole time equivalent midwife. Case loads should be smaller when there are known complexities in care.
- » Allowing midwives the opportunity to self-manage their working week can further develop skills for successful implementation and adaption to on-call. This may include how teams manage on-call working, a typical working day and time off. HR systems and processes should work with this aim rather than restrict the potential for flexible working.
- » Midwives with experience of community working and significant clinical experience are likely to be important in establishing good working practices, and decision making. This should not preclude less experienced midwives from joining teams, but skill mix should be considered in terms of support for these midwives.
- » Early enthusiasm for team and case load working may lead to less rigorous approaches to protected time off; this should be addressed specifically and early during implementation, as there may be a risk for burn out.

Midwives have identified key factors for achieving optimal work experiences within MCOC models. These are not only about successful relationships with the women they care for, but also the relationships they have with their peers, medical colleagues and managers¹¹:

- » The ability for midwives to develop meaningful professional relationships with women through continuity of care.
- » Supportive relationships at work and at home.
- » Positive working relationships and occupational autonomy allowing midwives the ability to organise their working lives with maximum flexibility through negotiation.

This includes:

- Positive and supportive relationships with midwifery colleagues in MCOC models.
- Collaborative relationships with medical colleagues and midwifery peers at the hospital.
- Managers who facilitate professional development, interpersonal confidence and skills, assistance with debriefing and reflection.

Appendices

Practical case studies to support this toolkit are available in the appendices:

- » Appendix 1 - Guy's and St Thomas' NHS Foundation Trust | *Continuity of care models for pregnant women with medical and psychological conditions.*
- » Appendix 2 - Imperial College Healthcare NHS Trust | *Achieving antenatal and postnatal continuity.*
- » Appendix 3 - King's College Hospital NHS Foundation Trust | *Case loading midwifery care.*
- » Appendix 4 - Royal Free London NHS Foundation Trust | *Antenatal and postnatal continuity for complex women.*

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Guy’s and St Thomas’ NHS Foundation Trust

Continuity of care models for pregnant women with medical and psychological conditions

Providing women with continuity of care from a small team of midwives has ensured high risk women have a multidisciplinary care plan. This improves access to specialist care whilst promoting normal birth, preventing unnecessary appointments, readmissions and the likelihood of pre-term birth.

Outline of service

A risk assessment of all maternity referrals is completed prior to the booking appointment. If a medical or psychological condition is referenced in the referral form, a woman is allocated to the high risk case load midwifery team.

There are two midwifery teams (Thames and Tower), and both are hospital based. Each team has seven midwives (six band 6 and one band 7). Between them, they care for approximately 700 women per year. The booking midwife is responsible for coordinating the antenatal and postnatal care, liaising with the relevant specialists. The aim for the case loading team is to provide as much intrapartum care as possible. At busy times, care can be provided by a midwife either on the obstetric or midwifery led birth centre. Antenatal appointments are one stop, multidisciplinary consultations. The Thames team cares for women with blood disorders, diabetes, cardiac, lupus, cancer, skin and gastrointestinal conditions, such as Crohn’s disease. The Tower team cares for women with renal, fetal cardiac, mental health, sickle cell disorders and multiple pregnancies.

Key messages for success

Challenges	Enabler
Reorganising existing midwifery staffing to establish the case loading midwifery teams.	<ul style="list-style-type: none"> » Clear and engaging recruitment process (eg job descriptions outlining role and responsibilities and internal meetings with staff to discuss and share the benefits of the case loading team model for high risk women). » Value based recruitment – a strong commitment to each other and to providing the best possible care to women with high risk conditions. » Engaging broader stakeholders, such as commissioners and maternity service liaison committee. » Creative use of existing vacancies to redesign the service provision.
Organising the rotas.	<ul style="list-style-type: none"> » Identify timings of specialist clinics and ward rounds and organise case loading team member to attend. » Rotas are organised in such a way that a midwife is able to visit any woman who is an inpatient or outpatient and can lead parent education for high risk women.
Wellbeing of team and retention.	<ul style="list-style-type: none"> » Annual away day, including a programme of consultant led discussions. » Encouraged to access other developmental opportunities, such as examination of the new born, supervisor of midwife course and trust-based leadership courses. » Timely and meaningful appraisals. » Weekly team meetings. » Ensuring the team have office space.
Maintaining skills and ensuring appropriate development of staff (eg exposure to normality).	<ul style="list-style-type: none"> » Established an annual development programme specific to high risk case load midwifery team. » Joint statutory mandatory training programme to ensure broader skills kept up to date. » Weekly multidisciplinary meetings with relevant specialist consultants.

Guy's and St Thomas' NHS Foundation Trust

Continuity of care models for pregnant women with medical and psychological conditions

Model in detail

How is the model funded?

There was no new funding required for staffing for this project. Staff posts came from the reorganisation of existing posts from our obstetric and midwife led birth centres.

How often do women see their named midwife?

Team continuity is the focus of this model of care however, antenatal care is provided by the same midwife approximately 65 per cent of the time. Continuity of care varies more in intrapartum (where it can drop to 30 per cent due to the current size of the case load) and postnatal, depending on complexity of care and geography. A review and prioritisation are being conducted for both teams, for a list of conditions to achieve a much better continuity of care ratio antenatally through to labour and immediate postnatal care.

Antenatal care for all women in high risk teams is provided in the hospital based antenatal clinic. A proportion of the women looked after are from outside the local catchment area. Postnatal continuity is best for women who live in the area however, all women are seen on the wards for immediate postnatal care.

How do women contact their midwife?

Each team holds one group mobile phone, and this is factored into the rota.

Is there any outcome data?

The teams were established in 2007 following a research evaluation of case loading midwifery by King's College London and GSTT. Each year data is collected on process metrics such as access, continuity and compliance with care plan completion. All women have an agreed multidisciplinary care plan in their notes, and there is timely referral to the high risk team. Very good outcomes are achieved generally for high risk women however evidence is being gathered continually. A research project to evaluate the health outcomes benefits of the Thames and Tower teams is being explored.

Contact

Mitra Bakhtiari

Midwifery Matron/Community/Hospital Clinics/Supervisor of midwives

Guy's and St Thomas' NHS Foundation Trust

Mitra.Bakhtiari@gstt.nhs.uk

Imperial College Healthcare NHS Trust

Achieving antenatal and postnatal continuity

Within one year 82 per cent of women’s antenatal and postnatal appointments were with the named midwife or buddy within the specified teams.

Outline of service

The geographical patch for community midwifery for Imperial has been divided into 7 areas and in each area there is a team of 8 whole time equivalent midwives. One midwife in the team will book a woman for her pregnancy care and plan to see her throughout her pregnancy. After the birth the same midwife will see the woman for postnatal care. When this named midwife is not available she will have a specific ‘buddy’ midwife who will take over care. Intrapartum homebirth care is offered by the team but not by a specific midwife. Intrapartum hospital care is not covered by the team.

Key messages for success

Challenges	Enabler
<ul style="list-style-type: none"> » Capturing activity in the community. » Ensuring continuity of care between community and hospital (ie avoiding risk from ‘lost or missing’ information between points of care delivery). » Midwives spending time travelling between hospital and community areas collecting and delivering paperwork and specimens or duplicating appointment paperwork. 	<ul style="list-style-type: none"> » Review of IT systems and diary management: Midwives were provided with IT devices to allow remote access to hospital systems so no time lag in information held in any area. This was supplemented by Courier services to community clinics.
Midwives working for long periods in hospital model may find decision making in the community difficult.	<ul style="list-style-type: none"> » Training sessions before starting in the community on autonomous decision making, team building and homebirth skills.
Recruitment and retention of suitably skilled midwives.	<ul style="list-style-type: none"> » Midwives who were already working in community and antenatal clinic were the source of staffing for this project. Stopping all hospital midwifery led clinics of women who live in the geographical patch freed up some resource and converting the workload in the community into this model freed up the rest. » Midwives undergoing preceptorship are rotated into these teams, which offer the midwives experience and expose them to ways of working they may not have considered before.
Moving care into the community and away from hospital.	<ul style="list-style-type: none"> » Creating links with Children’s Centres allowed delivery of care across the community.
Ensuring continuity of care actually happens.	<ul style="list-style-type: none"> » Midwives manage their own workload and diaries, this allows them to flex to meet the needs of the women. On a typical day the midwife will work 9am – 5pm but may flex around start and finish times. She will be required to be on-call 5 times per month.

Imperial College Healthcare NHS Trust Achieving antenatal and postnatal continuity

Model in detail

How is the model funded?

There was no new funding required for staffing for this project. Staff posts came from re-organisation of existing posts in the community and antenatal clinic. Staffing is arranged in each team in the following way: 2 whole time equivalent (wte) band 7 midwives. One who manages the team on an operational level and one who is the lead for vulnerable women and complex needs. There are five wte band 6 midwives and two midwifery support workers at band 3.

The teams also support the case loading team midwives with their home births as well as attending any that arise from their own women and so each team has one midwife on-call per night.

Money was required for the investment in IT and required a business case to be approved by the Trust board.

How do women access the service?

Women may be referred by their GP or self-refer into the service. Referrals are received centrally at the Trust and then sent on to the appropriate team for them to arrange the booking. The appropriate team is the one in the same area as the woman lives. It is not linked to who the woman's GP is.

Where are women seen?

Appointments are at the local children's centres. Women may be seen at home in the postnatal period but will also be offered clinic appointments.

How often do women see their named midwife?

The KPI that the service has set for itself for this is 90 per cent of appointments the woman has in the antenatal and postnatal period should be with the named midwife or buddy. The structure has been in place for about a year and currently they are achieving 82 per cent in these specific teams.

What happens when women develop complications?

Each team has a named obstetrician that they refer women to. This supports clear communication and multi-disciplinary working.

How do women contact their midwife?

The woman has the mobile phone number of her midwife.

Is there any outcome data?

The Friends and family test score has changed from 38 pre-implementation to 83.

Contact

Pippa Nightingale

Head of Midwifery

Queen Charlotte's and Chelsea Hospital and St Mary's Hospital

Pippa.Nightingale@imperial.nhs.uk

King’s College Hospital NHS Foundation Trust

Case loading midwifery care

Achieving 18 per cent caesarean section rate, 30 per cent homebirth rate and 88 per cent exclusive breastfeeding at six weeks.

Outline of service

The Lanes Midwifery Practice is a group of six midwives who provide continuity of care from booking to up to 28 days postnatally, including attending the woman for her birth regardless of location. Women access the service by being booked at the GP where the service is based. The team have a 1:36 midwife to woman ratio.

Key messages for success

Challenges	Enabler
Obtaining the funding to start the service.	<ul style="list-style-type: none"> » Engagement with a local GP practice who were keen to have midwives providing this service for their women meant that there was an opportunity to share the start-up costs of the project. The surgery funded equipment and provided premises for the midwives – office and clinical room. The rest of the funding was obtained by using vacancies in the general community and engaging the commissioners in the project who were willing to fund some additional midwifery places (approximately two).
Midwives working for long periods in hospital model may find decision making in the community difficult.	<ul style="list-style-type: none"> » Midwives have enhanced induction, attending study days on topics such as homebirth and water birth, and spend considerable time working with other members of the team at the start, especially being supported with on-call. This has demonstrated that experience is not necessarily required but an interest in normality and home birth is essential. » The team recruit and interview their own midwives from within the existing staffing which encourages team working and realistic expectations in candidates.
Recruitment and retention of suitably skilled midwives is a constant challenge partly due to the perception of the demands of the on-call requirement.	<ul style="list-style-type: none"> » The teams retain control over their working week not working set hours and create their own rota. This helps offset the demands of on-call. » Midwives undergoing preceptorship have been rotated into these teams, which offered the midwives experience and expose them to ways of working they may not have considered before. (This has stopped for unrelated reasons). » Midwives are not expected to work all day and be on-call and potentially up all night. Overnight on-call is split between two midwives.
Midwives need community bases to see women.	<ul style="list-style-type: none"> » The midwives have an office at the GP which enhances the delivery of care in the community.
Other staff’s perception of this being an elite service where midwives have different conditions of work undermines team working.	<ul style="list-style-type: none"> » The team is managed by the community matron and the team support as required the general community on-call rota encouraging sense of team working. » Midwives who have worked in the team previously spread the team ethos and knowledge when working elsewhere.

King's College Hospital NHS Foundation Trust Case loading midwifery care

Model in detail

How is the model funded?

There was some new funding required for staffing for this project. Some posts came from re-organisation of existing posts in the community and some from working closely with PCT/commissioners on the project, as above. Staffing is arranged in each team in the following way: Six whole time equivalent (WTE) midwives, one of whom is a band 7 who manages the team on an operational level and provides clinical leadership. There are five WTE band 6 midwives and one part-time midwifery support worker at band 3. The teams also support the other case loading team midwives and wider community with their home births as required. Each midwife is on-call three times per week and so each team member needs to carry a full set of birth equipment at all times.

How do women access the service?

Women may be referred by the GPs at the surgery at the team's base or self-refer into the service but must be booked with the link GP practice. There can be problems of capacity as the midwives can only book three women per month and local women are known to change their GP to access the midwives' service. If the number of women exceeds capacity of the team they attend an antenatal clinic in the local area.

Where are women seen?

Appointments are at the office which is at the GP surgery or at home.

How often do women see their named midwife?

Women see their named midwife at booking and for the majority of their antenatal visits. The midwives have a partner that will see the woman for one to two visits in the antenatal period and efforts are made to introduce the woman to the rest of the team to increase the chances of her having met the midwife who attends her birth.

What happens when women develop complications?

The team has a named obstetrician to whom they refer women. This is set up with an open-door communication policy, so they can email and ring about cases as needed. This supports clear communication and multi-disciplinary working and prevents inefficient use of clinic appointments.

How do women contact their midwife?

The woman has the mobile phone number of her midwife and can use it to speak to a midwife from the team 24 hours a day.

Is there any outcome data?

Ninety-two per cent of women were attended by Lanes midwives and 51 per cent of women had their named midwife for some or all of their labour. Thirty-six per cent of women were high risk at booking, and 50 per cent at labour onset.

Homebirth rate: 30 per cent; LSCS rate: 18 per cent; instrumental birth rate: 17 per cent; attempted VBAC rate: 87 per cent; labour in water rate: 26 per cent; induction of labour rate: 14 per cent; epidural rate: 20 per cent.

Contact

Tracey MacCormack
Matron for Community and Antenatal Services
King's Denmark Hill site
Tracey.maccormack@nhs.net

Royal Free London NHS Foundation Trust

Antenatal and postnatal continuity for complex women

Improving outcomes for complex women – increasing birth weight, reducing neonatal complications and improving women’s engagement with services.

Outline of service

The Unity team is a small team of midwives who provide antenatal and postnatal case load care to women with complex needs who are booked with the Royal Free London (Hampstead site). Care is led by a named midwife with a buddy, and the team is clinically led by the named midwife for safeguarding. Intrapartum hospital care is not covered by the team.

Key messages for success

Challenges	Enabler
Forty per cent of women using the service are from outside the geographical area of the hospital: co-ordination of care is therefore extremely complicated across different boroughs.	<ul style="list-style-type: none"> » Midwives carrying their own diaries and organising their own clinics and workloads is an essential aspect to support continuity and therefore ensure that midwives who know women well can co-ordinate and liaise with relevant agencies. » The clinical leadership of the named midwife means that there is also continued representation and support even when the named midwife is away.
This is a highly complex group of women who require skilled and knowledgeable midwives.	<ul style="list-style-type: none"> » Midwives have an enhanced induction into the team attending study days on topics such domestic violence. They also spend considerable time working with the clinical lead for the service at the start of their placement with the team. This has demonstrated that experience is not necessarily required but an interest in working with this client group is essential.
Because the group is not resourced to provide Intrapartum care ensuring the correct care plan is delivered at the birth and women are picked up by the team postnatally has been difficult.	<ul style="list-style-type: none"> » Introduction of a universally applied checking process for admissions to labour ward ensured women and care plans were not ‘missed’. It also ensured the team were notified of their women having given birth and could offer support to the hospital staff. » The team use a ‘red folder’ on labour ward to communicate essential information. » The team visit the maternity wards daily to assist with communication, support staff and women and a smooth transition back into the community.
This is a group of women who find it difficult to engage with services.	<ul style="list-style-type: none"> » Creating links with Children’s Centres allows midwives to run their own clinics in them which are close to the woman’s community.
Other staff’s perception of this being an elite service where midwives have different conditions of work undermines team working.	<ul style="list-style-type: none"> » Unity team is managed by the community matron and the midwives participate in the general community on-call rota encouraging sense of team working. » Midwives who have worked in the team previously spread the team ethos and knowledge when working elsewhere.

Royal Free London NHS Foundation Trust Antenatal and postnatal continuity for complex women

Model in detail

How is the model funded?

There was no new funding required for staffing for this project. Staff posts came from re-organisation of an existing case load project in the community. This had been geographically based and although targeted at the same group of women had led to struggles with access and boundaries. The Unity team is organised in the following way:

3.6 whole time equivalent midwives. 1 is a band 7 who leads the team operationally and the rest band 6's. Each carry a case load of 35 – 40 women per year. They also have a band 8A clinical lead who is also the named midwife for safeguarding, who carries a case load of 30 women per year. The team also support the community team midwives with their home births and so are on-call periodically.

How do women access the service?

Women may be referred by their GP or self-refer into the service. Referrals are received centrally at the Trust and then sent on to the team for them to arrange the booking. Women may also be picked up at booking and referred onto the team.

Where are women seen?

Appointments are generally at the local Children's Centre, which is seen as critical for success of the service. Women may be seen at home occasionally in the antenatal period if this will assist in engagement.

How often do women see their named midwife?

Continuity is described as very good but figures are not available for this to date.

What happens when women develop complications?

As all women have a degree of complexity in their pregnancy multi-disciplinary working is critical and so is supported by fortnightly MDT meetings.

How do women contact their midwife?

The woman has the mobile phone number of her midwife and her buddy.

Is there any outcome data?

There has been a noticeable improvement in the degree of engagement from women with services and less evidence of chaotic behaviour. In addition there is an anecdotal trend towards babies having increasing birth weight and less severe withdrawal symptoms where substance abuse is an issue. There are plans to audit these outcomes formally and undertake an evaluation with the women who use the service.

Contact

Jude Bayly
Safeguarding Midwife
Royal Free Hampstead NHS Trust
jude.bayly@nhs.net