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Continuing to Push for Midwifery Continuity of Carer: Research Update

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By Georgia Clancy, AIMS Volunteer

The push for midwifery continuity of care(r) has been a long one. First put into policy via *Changing Childbirth* in 1993,[1] 29 years later we're still figuring out how to make continuity a reality for *all* women in a way that works for providers too. In 2016, the *Better Births* policy offered a renewed commitment to continuity of carer:

to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions. Every woman should have a midwife, who is part of a small team of 4 to 6 midwives, based in the community who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally.[2]

There is already considerable evidence to support the use of continuity of carer, with benefits such as fewer interventions and a higher chance of spontaneous vaginal birth for women,[3] as well as improving confidence, job satisfaction and workforce retention for midwives.[4],[5]

Recently researchers at King's College London (lead by Professor Jane Sandall who is also Head of Midwifery Research for NHS England) have been exploring the implementation of continuity since *Better Births* and trying to identify where further research is still needed. Back in February this year, the team at King's College London held an online update event on their work so far, highlighting three projects.[6]

The POPPIE trial[7] focussed on women who were likely to give birth prematurely receiving continuity from a specialist team of midwives. Despite the team coming up against many of the structural challenges usually associated with implementing MCoC (midwifery continuity of carer), 97% of women who took part in the POPPIE trial said that they would want a similar experience again, highlighting the benefits of personalised care and building a relationship with known midwives.[8] The POPPIE midwives who delivered care also reported the positive impact on autonomy, job satisfaction and support. Of course the midwives who volunteer to take part in a continuity of carer trial, may already favour this way of working and not all midwives may feel the same way. The *Midwives' perspectives of continuity based working in the UK: A cross-sectional survey*[9] found that whilst a third of midwives were willing to work in caseloading and/or team continuity models, barriers to providing this included concerns about changing shift patterns/place of work, night shifts, work-life balance, and the need for different skill sets in different workplace settings. Indeed, in my own research I heard midwives raise concerns about safety if providing continuity required them to work across birthplace settings, as well as the impact on work-life balance.[10] Overall, the POPPIE trial was found to be a feasible model for providing MCoC to a high-risk group.

Project 20[11] was focussed on improving birth outcomes and experiences for women with social risk factors such as low socioeconomic status, black and minority ethnicity, homelessness, victims of abuse, and more. To do this, two models of maternity care for these women were evaluated: a community model in which women were cared for by a team and a hospital model where women had one named midwife.[8, 12] One point highlighted by this team was that continuity is not a 'magic pill' for poor health and social outcomes which require long-term multi-sectoral intervention. That said, the models of care explored here did seem to help as support from known midwives led to increased disclosure of risk factors, reduced anxiety and improved safety (as midwives knew women's medical and social history). These factors seemed to be enhanced in the community model and indeed one member of the team, Victoria Cochrane, highlighted the importance of midwives actually being *in* the community – in community and children's centres – not just GP surgeries and hospitals.

Finally, we heard from the **Lambeth Early Action Partnership (LEAP)**[13] who were testing a community-based caseload MCoC model for women in areas of social disadvantage and ethnic diversity to try and reduce birth inequalities as part of the wider services LEAP offers to local families and children.[14] The study found that the preterm birth rate for women in caseload midwifery was less than half that of women in standard midwifery care (5.1% vs 11.2%) and the number of caesareans was also significantly reduced (24.3% vs 38%). It also showcased the value of local, community-based services that support women and families way beyond the usual six-eight week postnatal period.[15]

Overall it was a fascinating event put on by the team at King's College London which reinforced the

benefits of MCoC and showed that there are ways of making continuity of carer the standard model for *all* women regardless of race, ethnicity, risk-category or postcode. Now that implementation of continuity of carer has begun in England, it will be interesting to see how these studies feed into those plans, and how the implementation will undoubtedly highlight areas where further research is needed.

Author Bio: Georgia Clancy is a research fellow at the University of Warwick. Her research explores women's childbirth preferences, decisions and outcomes in light of NHS England's Better Births policy. Georgia is also a member of the AIMS Campaigns Team.

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[15] Editor's note: Unfortunately, many new mothers will feel they have not received support for anything like the 6-8 weeks.