AIMS For a better birth...

How does midwife continuity of care compare with other models of care?

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By Catharine Hart

In this report, Catharine Hart of the AIMS Campaigns Team, tells us about a recent Cochrane study that was asking the same question.

Cochrane review: Midwife continuity of care models versus other models of care for childbearing women (2024)

What is it: A review of 17 randomised controlled trials that compare outcomes for women and babies who received midwife continuity of care with other models of care. This review was first published in 2004 and previously updated in 2016.

Who published it: The Cochrane Library

Publication date: 10 April 2024

Key points: This review compares outcomes for women and babies who had midwife-led continuity of care[1] with other models of care, such as obstetrician-led or shared care.

Please note that this review is looking at midwifery continuity of *care*, rather than continuity of carer.

(See also our AIMS comment below).

The authors define midwifery continuity of care as care that is provided by the same midwife or team of midwives. This can be through caseload midwifery (where women have a primary midwife assigned to them, with a backup midwife) or team midwifery (where a team of midwives share a caseload, usually between 6 and 12 midwives).[2] Within all of these models of care, care is provided in conjunction with medical staff as needed.

This review is a meta-analysis of 17 different studies, looking at a wide range of outcomes for 18,532 women and babies, over a variety of settings spanning five countries (Australia, Canada, China, Ireland and the UK). The majority of studies (12) were based on team midwifery, with 5 looking at caseload midwifery. The authors searched databases for new studies to include since the last update, adding three new studies and removing one study that was previously included. The authors assessed whether each study was at risk of bias and estimated the certainty of each of their findings.

The authors found that women who received midwife continuity of care were more likely to have a spontaneous vaginal birth (70% compared with 66%) and slightly less likely to have a caesarean or instrumental birth, both reduced by 1%, or an episiotomy. It wasn't recorded whether women in the continuity group had fewer caesarean births because of reductions in the number of elective or emergency caesarean sections. The authors also found that continuity models offered cost savings in the antenatal and intrapartum (during labour and birth) periods.

Although women in the continuity group appeared to have a much higher chance of having a known midwife at their birth (63-98%) compared with those under other models of care (0.3-21%), there were wide variations in these figures and much of the evidence was considered to be poor or at risk of bias. The researchers therefore decided that, statistically, there was no strong evidence that women in the continuity group were more likely to have a known midwife at their birth.

Although the risk of adverse events appeared to be similar for women and babies in both groups, the authors state that this is slightly uncertain because of the "risk of bias, inconsistency, and imprecision of some estimates". The authors found that midwifery continuity of care had little or no effect on the chances of preterm birth, induction of labour, admission to neonatal intensive care or having an intact perineum (not tearing) during vaginal birth. The authors found that continuity also seemed to have no effect on the chance of having a postpartum haemorrhage, initiating breastfeeding or having a low birth weight baby, although the evidence around these outcomes is less certain.

The authors felt there wasn't enough evidence to say whether midwifery continuity of care had any

effect on the chance of miscarriage, having a third or fourth degree tear, regional anaesthesia (such as epidural), stillbirth or neonatal death. It is difficult to assess the impact of continuity on rarer outcomes, such as stillbirth, as much larger studies would be needed for reliable results.[3]

AIMS is glad to see that women's experiences were counted as one of the outcomes in this review. The authors acknowledge the problems of trying to measure these experiences quantitatively, so describe them narratively instead. Women who experienced midwife continuity of care reported more positive experiences - including satisfaction with the location of their care, number of visits, relationship with their healthcare provider, choices and decision-making. The authors conclude that, overall, women allocated continuity "showed higher levels and better experiences across measures of trust, safety, quality of care, support, bonding, and physical health postnatally".[4] These results are echoed by other studies which show that women who have continuity of care or carer usually report higher levels of satisfaction with their care.[5]

Several of these results represent a significant change in the evidence around midwifery continuity of care. For example, the previous version of this review found that women with midwifery continuity of care were less likely to experience miscarriage, preterm birth or regional anaesthesia.[6] One of the studies newly added to this review which looked at women with specific risk factors for preterm birth did not show a reduction in preterm birth for women having continuity of care, which changed the conclusions about the effect of continuity of care on preterm birth. One possible limitation of this review is that it included both team midwifery and caseload models, which may have different effects. For example, although the authors found no statistical differences in preterm birth rates between women under caseload or team midwifery within the studies included in this review, results from other studies suggest that caseloading models can reduce preterm birth,[7, 8] The LEAP (Lambeth Early Action Partnership) study, for example, found that women allocated caseload midwifery had less than half the rate of preterm birth (5.1% vs 11.2%), compared with women receiving standard care[7] Of the seventeen studies in this review, the vast majority also only looked at hospital birth settings, with five studies including birth centres and only one including homebirth, so these findings may not apply to settings outside of hospital, especially homebirth. Although the majority of participants were classed as low risk, two of the three newly included studies looked at women with specific risk factors for preterm birth and depression. This could mean the results can't all be generalised to low risk women.

Although the authors note that women with continuity may have "greater agency…. enhanced co-ordination or navigation of care, greater advocacy, timely follow-up of test results, and greater adherence to treatments",[4] they also acknowledge that we don't really know how continuity of midwifery care improves outcomes for women and babies,[9] stating that it is a "complex intervention". It is especially challenging to think about this when the different models of care being studied are not always standardised.[10]

Earlier versions of this review have been called "groundbreaking"[11] for providing solid evidence in support of midwifery continuity models of care. However, randomised controlled trials also have limitations, as discussed more fully on our AIMS webpage Understanding quantitative research evidence.[3]

One of these is that usually only short term outcomes are measured, so we can't know whether continuity of midwifery care affects longer term outcomes. Unfortunately, there was also no data available for some important outcomes, such as whether mothers or babies were healthy after birth or babies were readmitted to hospital, despite the authors initially hoping these outcomes would be included. Some of the outcomes may not give a true indication of the quality of care if taken by themselves. For example, there may be many reasons for variations in caesarean section rates between different units and this measure is no longer recommended to compare the performance of UK hospitals.[12] While AIMS applauds the Cochrane collaboration's aim to "provide accessible, credible information to support informed decision-making",[13] individual women and birthing people may also want to know about other outcomes which are not covered here, such as breastfeeding continuation rates. The Albany caseloading midwifery practice, for example, had much higher rates of breastfeeding continuation than the UK national average.[14]

The authors acknowledge that some of the results were at risk of bias; for example, in a few of the studies people assessing the outcomes were not blinded as to which group the participants were in. In some trials the option of using a midwife led birth centre was only available to those in the continuity group, which could have altered the results, as birth setting can affect many of the outcomes measured[5]

The authors also acknowledge that more research on diverse study populations is very much needed, to improve our understanding of the effects of continuity, especially for those most at risk of the poorest outcomes. Many of the studies excluded high risk or socially disadvantaged women, so the findings may not apply to them. The authors recommend more research is undertaken specifically looking at women with social risk factors or medical complications, especially as they may benefit most from midwifery continuity of care.[15]

Overall, this is an important review which provides reliable evidence to support the continuing implementation of midwifery-led continuity of care models in the UK. Despite the fact that continuity of midwifery care has been a UK policy goal for nearly 10 years[16] and is also recommended by the WHO,[17,18,19] implementation at a wider scale in the UK has so far been fragmented.[20] In 2021, NHS England released guidance to local trusts[21] about delivering full scale UK-wide continuity of carer, with the aim that all women would have a named midwife, providing antenatal, intrapartum and postnatal care under a caseload model. Unfortunately, since then national progress has been patchy, with only 34 teams currently operational (as of May 2024).[22] AIMS supports a staggered implementation of continuity of carer, first being implemented for those most at risk of poorer outcomes, including black and Asian women and those with social disadvantage, as outlined in NHS England's recent Core25Plus5 policy.[23] However, we also continue to campaign for *universal* access to continuity of care for all pregnant women and people and look forward to the day when this is the "standard" model of care in the UK for all, as outlined in our Position Paper on Continuity of Carer. AIMS believes that continuity of carer models are key to a safe, personalised and equitable maternity service, one in which midwives can truly advocate for women and birthing people and get to know and support their individual needs.[20]

AIMS Comment: Please note that this review is referring to midwifery continuity of *care*, rather than

continuity of *carer*. Both models include relational continuity, i.e. women or birthing people within these models should be more likely to receive care from the same smaller group of midwives all of whom they have met,[24] compared to those with standard care. For example, Kingston Hospital states that women with their continuity teams "should ideally be cared for by no more than two midwives from their team".[25] However, unfortunately, there aren't as yet widely agreed definitions of either continuity of midwifery care or carer.[26]

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1 Editor's footnote: Please note the difference between 'care' and 'carer'. When care is provided by anyone from even a small team of midwives (6-12 is usual) the mother may not have been able to develop a trusted relationship with any one of them' it is in relational care that the benefits of continuity are thought to lie.

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