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Continuity of carer

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Brenda van der Kooy explores the real barrier to implementation

The new National Maternity Review Report Better Births – Improving outcomes of maternityservices in England[1] identified that continuity of carer is what is required to make a safer, personalised maternity service.

Over twenty years ago Changing Childbirth[2] called for women to have 'Choice, Continuity and Control' and many pilot projects were set up with the hope these would be rolled out across the country. Yet today very few women receive care throughout pregnancy, birth and the post natal period from a known and trusted named midwife working in a small team. So what is the barrier to successfully changing the current fragmented midwifery care provision to a case loading model which provides continuity of carer? The answer is the underlying funding structure.

Burn out, the on-call commitment and difficulties with ongoing recruitment and retention of midwives on case loading teams are the most common reasons cited for the failure of caseload midwifery schemes. However, when examined closely these all stem from lack of funding.

Currently where the few continuity of carer models do exist they are expected to function within budgets based on income generated from the maternity tariff. To achieve this they rely on unrealistic demands put on midwives such as increasing maximum caseload numbers beyond 28-30 women per midwife peryear (full time equivalent posts) plus back up for another 28 – 30 women, failing to remunerate midwives for the on-call commitment case loading inherently involves and requiring them to plug gaps in other areas of the service when required. This results in burnout, discourages other midwives from working in this way and is not mitigated by the increased job satisfaction midwives experience from knowing their caseload of women.

If continuity of carer in the maternity service is to become the norm instead of the exception more money needs to be invested upfront to achieve a sustainable roll out of caseloading models.

However, compounding the whole funding of maternity service issue is the fact that the existing tariff does not cover the actual cost of the current maternity provision. The House of Commons Committee of Public Accounts 2013/14[3] identified that NHS Trust providers of maternity care have to subsidise their maternity services from other more profitable departments within the organisation. This of course is not an option for midwifery only providers, as they don't have other profit making services available to them.

According to another new report Relationships: the pathway to safe, high-quality maternity care, from the Sheila Kitzinger symposium at Green Templeton College, Oxford,[4] current evidence suggests continuity of carer has a cost-neutral effect. In other words, it costs no more to provide than the current fragmented system of maternity care because it saves money from improved outcomes. It acknowledges, however, research is very limited on the financial savings from many other known improved health outcomes that comes from continuity of carer such as reduced preterm births. Where the research does exist, for example, improved breast feeding rates, it is impressive and amounts to millions of pounds of savings annually.[5] So the true situation is that continuity of carer will save the NHS very large sums of money indeed.

So the funding structure requires a shift of resources to invest in midwives to provide continuity of carer to achieve improvements in outcomes for mothers and babies and realise the huge short, medium and long term savings that it will generate. In order to protect scarce financial resources, it will be essential to ensure continuity of carer is measured as an outcome and payment to providers is attached to achieving this. This will provid an incentive for all providers to innovate to develop their own continuity of carer models that work for them and their midwives.

Failing to address the maternity funding structure to enable continuity of carer to be rolled out across the country is no longer an option. It is denying mothers and babies of improved outcomes and birth experience, wasting precious NHS resources and failing to achieve the huge savings from improved health and wellbeing of the future population.

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