AIMS For a better birth...

The search for continuity

AIMS Journal 2014, Vol 26, No 3

Nicky Wesson and Natalie Carter look at some of the issues of continuity in NHS maternity care

This is the story of a highly successful model of midwifery care, hugely popular with parents that was created not once, but twice in the same area and yet despite its success, no longer exists.

Essentially this model is one of continuity, choice and community-based care. Over the last 20 years or so, much work has shown how continuity of care from a midwife improves clinical outcomes,[1,2] both in terms of reduced intervention, and increased satisfaction with the birth experience.[3] As a result, several trusts have implemented pilot schemes incorporating this model of care.

West Middlesex hospital which is based in South West London, was one of the leaders in the field, as it pioneered the DOMINO scheme in the late 1970s. This system (which stood for DOMiciliary IN and Out), supplied community midwives who were on call, initially for women at low risk of complications, expecting a second or third child. These midwives provided women's antenatal care at home, and then went to them when they were in labour, assessed their progress, and then offered them the option of giving birth at home with their assistance, or transferring into hospital with them. The decision about where they had their baby was not made until that point. The same midwives also visited them postnatally.

The model of care was very popular and women expecting a first baby also wanted to be on the DOMINO scheme. It was not possible to provide it for everyone because not all midwives were either able, or wanted to be, on call. This led to criticism of the system being inequitable, and resulted in the head of midwifery at the time, changing it to team midwifery in the early 1990s. This involved small groups of midwives who ran antenatal and postnatal clinics for six defined geographical patches. They also did shifts on the labour ward in the hope of providing some continuity in labour. The DOMINO scheme was closed despite the protests of local parents who campaigned vigorously to retain it, and the homebirth rate dropped to around 1-2%.

More recently, during changes made at West Middlesex in 2009, two recently-qualified midwives, Natalie Carter and Amy Scott proposed a caseloading scheme involving a team of midwives who would hold their own diaries, have their own work mobile phones, and supply antenatal, postnatal and labour care for women who they would book in their own homes. Their aims were to increase the homebirth rate, and to increase the number of normal births not only at home, but in the birth centre and on labour ward. They wanted to reduce the levels of intervention in birth, including that of caesarean section, and

increase the rate of satisfaction felt by women and midwives. The consultant midwife, Pippa Nightingale was in favour of the scheme, and following consultation of working groups across the hospital, including consumer groups, during the summer of 2009, the caseloading team became operational in January 2010.

A team of seven midwives, including Natalie and Amy were recruited initially, eventually reduced to six. The new system was promoted through the maternity website, and had its own email address and phone number, so that women could refer themselves. Midwives were meant to discuss the opportunity with ever y woman at her booking visit and obstetricians could also refer to the team. In fact it was mainly promoted by word-of-mouth, through friends, family, NCT groups and other birthing networks.

Word spread rapidly and very quickly resulted in interest from British, white, well-educated women. To promote equity, each geographical area in the Trust had protected provision for women of different ethnicity who experience showed, were less likely to take up the scheme. Some of these women preferred hospital birth because of their home situation, or regarded homebirth as an inferior system in a high income country (though if they used the scheme were enthusiastic and recommended it to family and friends). Places were saved until any potential woman might be 34 weeks pregnant and if they were not filled, would then be offered to women on the waiting list.

Booking visits, antenatal and postnatal visits were at home (some postnatal visits are in clinics in this area). When a woman believed she was in labour, she was assessed by a midwife at home and she could decide then whether she wanted to go into hospital or have her baby at home. The team was happy to transfer women who wanted it but the numbers of those staying at home, grew steadily. A 20% increase in normal birth was seen within a year. In the time between Jan 2010 and Dec 2012 there were 724 women on the caseload, 165 babies were born at home (23%) and the number of homebirths from a flexible birth plan was 44, that meant 27% of the homebirths were decided in labour. The caseload numbers for April 2013 to December 2013 were 113 total women, 28 planned homebirths, with two of these decided in labour.

Understandably, the scheme was very popular with women who said things like *'the care and information that I received was exceptional', 'I had an incredibly positive experience all the way through', 'this ser vice was brilliant', 'outstanding staff ', 'it made my pregnancy and birth a very positive experience throughout', 'I couldn't have wished, hoped or even paid for better antenatal, birth or postnatal care'.*

There was a discrepancy between the aims of the team and the referrals they received from other members of staff. It became recognised that the caseloading midwives were particularly good at supporting vulnerable women who were socially isolated, had serious depression or who had experienced serious previous birth trauma and they were referred to the team. However, not many of these women wanted low-tech care, preferring elective caesarean section, epidural anaesthesia or consultant-led care. Sometimes such women might be helped to have a normal birth, but the team was not able to predict which they might be.

The scheme was popular with consultants who referred women wanting vaginal birth after caesarean

section (VBAC), frightened first-time mothers and those who had a previous traumatic vaginal delivery. Some midwives were less enthusiastic, regarding the system as inequitable because it was not available to everyone. Some mothers, unable to get a place with the team were very disappointed and unhappy and wrote to complain. As demand grew, eligibility criteria became tighter, and priority was given to women who wanted to give birth at home.

This was a hugely popular scheme, and one which women feared might be lost:*'This was an amazing and very enjoyable pregnancy/labour – please continue to provide this ser vice'*, *'please keep caseload programme going - it's a fantastic ser vice!'*, *'only that you should KEEP this service!'*.

However, the system did come to an end, finishing in December 2013. Several midwives were leaving the team in need of a rest, and recruitment failed to attract more midwives. The increasing numbers of women with complications being referred and the high numbers being cared for had taken its toll. The caseload team is now a dedicated homebirth team.

Given that this was a very successful way of working, with an astonishing success rate – 92% of the women felt it helped them achieve the birth experience that they wanted, 97% rated the caseload midwifery service as excellent, 98% felt supported throughout their experience, 98% found it beneficial to have their care within the home setting, 98% rated their care as excellent, 100% felt that seeing a caseload midwife was more beneficial than seeing several midwives and 100% would recommend the service to others – can we find a way for it to be sustained and available to all women?

This model of continuity is at least as cost-effective as traditional maternity services[2] and often cheaper, given the reduction in interventions such as epidural anaesthesia and caesarean sections, and also the reduction in hospital stays.

What then are the reasons for the seemingly constant failure to sustain this type of care? The two areas of difficulty appear to be – midwives' perceptions of the problems in working this way, such as being on call; and the inadequacy of their training which does not supply them with either the experience or confidence to help women give birth at home, or to have sole responsibility for managing their care.

Recruitment did prove a problem – some midwives who really wanted to do it, felt that they could not do it while they had young children of their own. Some community midwives were happy to do regular shifts including nights, but reported not being able to sleep while they were on call. Many would like to provide continuity of care but are apprehensive about autonomy and accountability. Extraordinarily, a midwife can qualify without ever having attended a homebirth – and the thought of the strain and pressure of being blamed if something goes wrong, is a considerable deterrent. If attending homebirth is not a mandatory part of training, midwives will understandably lack confidence in their ability to assist and make decisions in unfamiliar surroundings.

The ability to remain on call for long periods depends very much on the workload itself. Within this scheme, the number of women booked became too high, due both to the demand and the difficulty in saying 'no' to women. It had been anticipated that the midwives would each have 40 women per year on

their books, in fact they averaged 44. Being on-call for four to five nights a week and 24-hour on-calls, provided a very high level of continuity and satisfaction for both the woman and her midwife, but it was difficult to sustain. It left few opportunities for a midwife to travel out of her area or socialise freely. This compares with other recommendations that var y between a maximum caseload of 28 to 40 women and the independent midwives suggesting no more than 28 women.

Other midwives felt that the team would be pestered by calls from women and that caseloading was incompatible with a normal life. Some women did seem to think that the midwives were on-duty all day and all night, but the vast majority who had established a relationship of trust with their midwife, only called when it was essential.

To succeed in taking birth back from medicine and encouraging a community-based approach with known midwifery care givers, Natalie and others believe that we must find a way to achieve a level of continuity with small teams of like-minded midwives. For any model to be sustainable and available to the majority of women, it must enable midwives to have an adequate work-life balance that gives them time not on-call to be with their own families. Being the sole midwife for a group of women carries a great deal of pressure, not only to 'be there' but also of responsibility. Although it is exceptionally rewarding, it is also exhausting and requires you to give a lot of yourself. Sharing care with midwives, who have the same philosophy and values of birth, helps to shoulder these responsibilities and emotions, while still giving women high quality seamless care. Women still receive continuity but from a few known sources. It is so important that we care for the midwives too.

Midwives who do choose to work in this way require very good support from their managers. Other recommendations that the team suggest for working this way include:

• Have a passion for, and belief and trust in the birth process

• Ensure that you have excellent clinical skills

• Be a good listener

• Be able to be flexible

• Be able to share information concerning safety in a positive and unbiased way

• Be brave

• Be willing – it is hard work

• Be resilient

• Look after yourself and your team

• Be calm

• Be a lateral thinker/think outside the box

• Have a sense of humour

• Be supportive and supported

• Have like-minded colleagues

• Provide consistency of advice

• Ensure that you have ways of re-invigorating your beliefs through conferences, inspirational speakers, courses, visiting a different unit, investigating complementary therapies, reading a book.

Both the DOMINO and caseloading schemes were incredibly successful, but are no longer in operation. The latest evidence-base for practice, both in terms of clinical outcomes and women's satisfaction, is to adapt a model of continuity. We know it works, but we can't sustain it. How do we reach a balance of continuity that supports women but doesn't burn-out the midwife? Small teams are a possible way forward, but much more is required. Midwives must qualify with community-led care and homebirth as their highest skill set, with experience of being on-call, and an ability to assist at homebirth being a mandatory part of their qualification.

If a midwife could not qualify without experience of this degree of autonomy, trusts would be obliged to provide midwifery students with this experience. They would have to ensure that students were familiar with the provision of a competent and confident midwife for women choosing to give birth at home. This is likely to become a priority as the recent draft Intrapartum NICE Guideline recommends, among other things, that all healthy pregnant women should be advised of the benefits of care from a midwife in a free-standing birth centre, and that women expecting a second or subsequent child should be advised of the benefits of birthing at home or in a free-standing birth centre (www.nice.org.uk/nicemedia/live/13511/67645/67645.pdf).

The government and all managers must support this model with the resources required, and midwives must be remunerated appropriately for their commitment and skills. Who else in this world gets up in the middle of the night, for hours on end, night after night to go out and keep life itself safe?

What does it say to the midwife when once again there is no pay rise this year? We don't value you? What does it say to women if we choose not to implement what we know to be the safest and most effective care in maternity services? You and your child are not worth it? Continuity is not a complicated idea, there are ways to make it work if people would just listen and take a leap of faith.

Nicky Wesson and Natalie Carter

Nicky is the author of Home Birth and five pregnancy-related books. She is currently a medical herbalist with a special interest in infertility

Natalie is a midwife working within a home birth team who believes passionately in empowering women to make their own choices for birth, whatever they may be.

STOP PRESS

The new homebirth team is up and running with limited success so far. The bookings are not increasing as quickly as Natalie had hoped but the homebirth rate is above 2%. An encouraging leaflet is going out to every woman inviting her to come and hear about her choices but few women are interested yet. The team is also losing two of its midwives and resources are not always forthcoming

References

1. J Sandall, H Soltani, S Gates, A Shennan, D Devane (2013) Midwifeled continuity models versus other models of care for childbearing women. Cochrane Database Syst Rev, 8 (2013) CD004667. 40-6736(13)61406-3.

2. Tracy SK, Har tz DL, Tracy MB, Allen J et al (2013) Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. Lancet. 382, p. 1723-1732

3. McLachlan HL, Forster DA, Davey MA, Farrell T et al (2012) Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomised controlled trial. BJOG: An International Journal ofObstetrics and Gynaecology 119(11), p.1483-1492

4. Walsh D (1999) An ethnographic study of women's experience of partnership caseload midwifery