AIMS For a better birth...

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Exploring continuity of care in maternity and post-natal services, 27 May 2014, David Hume Tower, University of Edinburgh, UK.

The conference's purpose was to consider the *'growing evidence that continuity of care improves maternal and child care outcomes'*, and to look at the implications of this, what it means, how it can be done and how to go forward with it.

Professor Helen Cheyne, Royal College of Midwives Professor of Midwifery and Professor of Maternal and Child Health Research, Nursing, Midwifery and Allied Health Professionals Research Unit, University of Stirling, made a strong star t to the conference with her address, *'Continuity of care: what is it and how can it be delivered?'* Helen described the fragmented and impersonal 'production model' of maternity care which was one of the prompts for the enquiry leading to the Winterton Report in 1992. Helen quoted from and urged all those present to re-read this crucially important report, which among other things recommended a woman-focused service within which the woman would get to know and trust the midwife looking after her during pregnancy, birth and postnatally. The Winter ton Report was followed by Changing Childbirth in 1993 – again promoting continuity of care. There was a strong move towards continuity of care and hopes that this would be embedded in maternity ser vices. Many trials of various shapes and sizes were conducted throughout the rest of the 1990sand were well evaluated. There was however no overall consensus about what continuity means (nor how to sustain it beyond the projects and trials). Helen laid out three ways of defining continuity:

• Informational continuity (all singing from the same hymn sheet)

• Management continuity (everyone offering the same care)

• Relationship continuity

She suggested that continuity is about relationship continuity, and that there is no question that this offers benefits to women and families, but that there are unique challenges to this in maternity ser vices because of the relative unpredictability of birth. She described two possible approaches depending on the level of continuity aimed for, suggesting that team midwifery (where 'teams' are up to 15 midwives or more) works against the possibility of relationship building and continuity.

If the aim is for women to know the midwife looking after them during birth, one potential model is to have teams of 6-8 midwives, based in small geographical areas with a caseload of 40 women each per

year. Each midwife works with a partner midwife and is on call for her caseload women, but both can provide cover for each other. The midwives have no other service commitments and flexible hours, thus having control of their work.

If the aim is to provide continuity for 'planned episodes of care' (antenatal and postnatal), Helen described a different model whereby the woman has a named midwife and up to three other midwives involved in her care. Midwives have a caseload of 38 women each, work with a partner midwife across all clinical areas, have flexible shifts negotiated by the team, a shared philosophy, no on-call duties and some ser vice commitments. These midwives have some control of their workload, but less than the model above.

Helen rightly asserted that we know what continuity is, we know how to do it, we know that it works and we just need to prioritise it and do it!

Eileen Scott, Public Health Adviser, Evidence for Action Team, Public Health Sciences Directorate, NHS Health Scotland, spoke next about *'Continuity of care: The evidence.'*

The focus of Eileen's talk was on addressing inequalities (social risks), as much as physical risks during childbearing. Her premise was that health inequalities are both systematic and avoidable: those with least resources and power have poorest health outcomes and social risks are often compounded by circumstances outside the control of those suffering them, as demonstrated by the Confidential Enquiries into maternal deaths for example.

Social factors included:
- poverty
- mental health challenges
- domestic abuse
- recent migration/language challenges
- substance misuse
- aged under 20

Often these factors go together, so that a woman is likely to suffer several disadvantages. Of course, as Eileen acknowledged, the underlying causes are rooted in poverty, which is systematically constructed and maintained at societal level. However, in terms of maternity ser vices, continuity of care can make a positive contribution, as research by NICE (National Institute for Health and Care Excellence), the NPEU (National

Perinatal Epidemiology Unit) and SEBCHU (Scottish Evidence Based Child Health Unit) over the last decade confirms.

Eileen highlighted the problem women have accessing services and discussed 'cognitive' as well as physical access – for example, women suffering from domestic abuse do not tend to book late, but tend not to disclose their circumstances. This 'cognitive access' is more difficult to look at and measure in a

quantitative focused arena, but is based on relationships. Research shows that women often feel judged and uncomfortable and that staff can be judgemental, lack knowledge of support services and do not understand the issues women face. This is exacerbated by fragmented care. Research also shows very specific benefits of continuity of care, and the increased communication that arises from this, for different groups of women. For example, women suffering from domestic abuse are more likely to talk about this, those suffering from substance misuse are more likely to maintain contact with ser vices, recent migrant women are more likely to access the services they need and remain in contact with ser vices, and for women under the age of 20, continuity of care is one of the only factors that helps women stay in contact with services. As these disadvantages cannot be known beforehand, every woman should have continuity – at least initially.

The final speaker was **Dr Mary Ross-Davie**, Education Projects Manager, Midwifery and Reproductive Health, NHS Education for Scotland, on *'Where next for continuity of carer in Scottish maternity and postnatal care.'* Mary carried out a small sur vey of the 14 Heads of Midwifery in Scotland and of the 10 who replied, 9 said that continuity was a priority for them – though the main focus has been on improving continuity during pregnancy.

Mary suggested that the Cochrane Review on continuity is unequivocal and that we need to shift the continuity focus from care to carer. She also suggested looking at past and current initiatives in Scotland and other parts of the world that have provided or provide continuity and that work for women and midwives, such as the small birth centres in the west of Scotland, a new scheme in Lothian, the Glasgow home birth service provided by two midwives with support from community midwives, the caseloading model in Windsor NHS where the home birth rate is 35%, the One to One Midwives in the Wirral and elsewhere, and the community-based caseloading model in New Zealand.

Mary identified some of the barriers for midwives, which include caseloads being too high (such as in the Netherlands and elsewhere), many midwives working part-time and the perception that it is not feasible. For example, although the One to One scheme initiated by Lesley Page in West London was well evaluated, it did not spread – partly because imposed financial constraints led to it being seen as a luxury for well-off women and partly because midwives looking at it from the outside saw the midwives providing it as 'heroic' and going 'beyond the call of duty' in ways they felt would be unmanageable for them. Mary suggested promoting the benefits of continuity, such as regaining the status and role midwives once had, working in local catchment areas, basing care in the community and finding 'champions'.

Mary concluded by calling for more care in the community and integrating health and social care, with midwives co-located with other staff. She laid out the questions and challenges: how to upscale sustainably, such as star ting small/local or having a national strategy, making small shifts in ante and postnatal care or radically restructuring. She also rightly stressed that midwives need to feel that there are benefits for them, that they are well resourced and supported, that there is flexibility in the workforce, that they are confident in community settings and that they are enabled to manage their own

time with adequate time off (a particular challenge for those in management who find it difficult to relinquish control). She also suggested that women need to demand it and that a tipping point needs to be reached, where continuity is seen as the 'new normality'.

Lively debate ensued! This focused on the integration of services, how to work with the voluntary sector, working well with health visitors and other services, increasing the numbers of midwives, looking at continuity in the context of long-term wellbeing and cost effectiveness. Helen Cheyne discussed her report Having a Baby in Scotland 2013: Women's Experiences of Maternity Care (www.nmahp-ru.ac.uk/files/2014/01/Maternity-sur vey-final-repor t-2014.pdf), which will be able to link women's experiences to outcomes, providing more evidence about the benefits of continuity.

As any reader of a certain age can imagine, this was both a frustrating and heartening conference. It was frustrating to see yet again the limits of our collective memory of even very recent history – all those midwives who worked so hard to promote, provide and evaluate continuity through endless pilot studies and schemes in the 1980s and 1990s must want to throw in the towel – and Helen Cheyne emphasised the need to avoid reinventing the wheel. It was heartening to hear relationship continuity throughout pregnancy, birth and the postnatal period moving from what could only be described as a 'dirty word' in Scotland to being talked about positively. Both Helen and Mar y were crystal clear – we know what it is, we know how to provide it, the evidence supports it, we need to get on and do it! This would be a very welcome sea change – and in my humble opinion, in answer to Mar y's questions, we need to have a radical restructuring at national level. Scotland is small and cohesive enough to do this and we have tried the small scale and tried the 'small steps' approach. Neither work at embedding continuity in maternity ser vices and all too often these small schemes depend on key individuals and fold when the individuals move on, even when they have been well evaluated.

Nadine Edwards

Editor's note: Contrary to popular belief, qualitative research shows repeatedly that caseloading midwives are able to sustain this if they are well supported. It also shows that they enjoy working with women they know, and feel that they can provide a safer and better service to the women and families in their care.