



My experience of trying to find out how Continuity of Carer implementation is going locally: Like getting blood from a stone

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By Sarah Hawkins

As a birth worker supporting many women and families under the care of three NHS Trusts, it hadn't escaped my notice that not one of them was getting any continuity of carer in line with the vision set out in [Better Births](#)^[1], published in 2016, nor in line with the [Implementing Better Births: Continuity of Carer](#)^[2] guidance (NHS-E, 2017).

The 2017 guidance "set out an expectation that each area will, by October 2017, establish a shared vision and plan to implement Better Births by the end of 2020/21. These plans are expected to show how most women will receive continuity of the person caring for them during pregnancy, birth and postnatally. Local Maternity Systems have been asked to put in place plans to meet local ambitions in this area."

To put this into context, I had clients through 2020 and 2021 - in the midst of the pandemic - who didn't even know who their named midwife was and who never met the same midwife more than once. This left my clients feeling bewildered, and had a particularly negative impact on the wellbeing of women categorised as 'high risk'. It is also my observation that this lack of continuity seemed to create more

work for an already overstretched maternity service. I had increasingly more people coming to me later in pregnancy, desperate and in distress.

I live in Somerset, sandwiched between what used to be five NHS Trusts that are now three. These three Trusts cover a large area, inside and outside the county of Somerset, and include hospital labour wards, many birthing units, as well as community midwife and homebirth teams. I therefore contacted the following three Trusts to gather some information: Royal United Hospitals Bath, Somerset Partnership and University Hospital Bristol.

I decided to reach out to all three for information they held on how well they had delivered a Continuity of Carer model of care during the most recent month (a month when the pandemic was not considered to be at its height). First I looked online for the relevant contact details for the maternity safety champions for each of the Trusts (as mentioned in the NHS Resolution Scheme guidance) and met a dead end on all counts through their respective websites. I then contacted each Trust by phone and asked for that information directly. I was met with confusion and inquisition about who I was and where I was calling from, even though I was asking for information that should be readily apparent and available to members of the public. It took many calls, many incidents of being put through to “someone who can help” and then many emails, leading to many more emails, because eventually I did get the email address of someone in each Trust who I was told “can provide that information”. I then put a simple email together that read: “I am a local resident and I am interested in knowing how well the Trust is doing in terms of Continuity of Carer in maternity services across the Trust. I would like a copy of the latest monthly implementation report as per the NHS Resolution Scheme.”

After 4 months of jumping through hoops, being sent information I had not asked for, and applying for Freedom of Information requests, I still have not got the information I requested. I am at the point where I am convinced that they don't want to share their reports with me - if, in fact, they have them.

What do I know now? I know from my own work supporting families that local women and birthing people are still not receiving continuity of carer. I know that maternity services appear to be getting worse and not better, despite efforts to implement a way of working that was to benefit all and lead to better outcomes. And I know that it is harder to get information than it ever was before.

I feel frustrated and deeply concerned that there seemed to be a reluctance to give me information, and an avoidance and deflection from the one question asked, not just by one Trust but three. I feel despondent and deeply sad that the NHS is failing to provide what it said it would within maternity services, and that it doesn't appear to be trying - or even allowing itself to be held accountable. It feels as though I've been trying to get blood from a stone.

Author Bio: Sarah Hawkins is a Doula, mother and AIMS volunteer who lives in Somerset with her partner, constantly tripping over 2 very small dogs while caring for 4 children including identical twins. Having had two hospital births and a planned freebirth, Sarah is a strong advocate for informed choices in the perinatal period, and for raising awareness of the potential complexities of multiple pregnancy and

birth.

[1] National Maternity review (2016) BETTER BIRTHS - Improving outcomes of maternity services in England: A Five Year Forward View for maternity care www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

[2] NHS (2017) Implementing Better Births: Continuity of Carer www.england.nhs.uk/publication/implementing-better-births-continuity-of-carer/