



Can continuity work for us?
A resource for midwives

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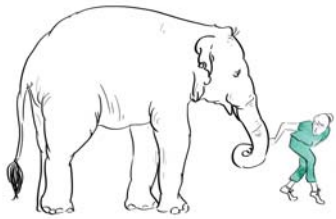
Professor Helen Cheyne

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Exercises



Exercise A
Deflating the
elephants in the room



Exercise B
Looking at
my practice



Exercise C
Thinking about
my practice



Exercise D
Who do you talk
to and how often?



Exercise E
Thinking about
context and need



Exercise F
Making sense of
the practical details



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"This is what I came into midwifery to do"

(MCoC Midwife)

1. Introduction

Midwifery continuity of carer (MCoC) is a concept that has been around for several decades and there are continued efforts being made to understand ways forward for large scale implementation. Maternity services need to be designed in ways that keep women, babies and families at the heart of everything we do.

What we know is that translating the evidence that underlies this model of care into today's maternity service provision is possible. Some organisations have set up one or two MCoC teams, and a small proportion are maintaining more than five. Where there are multiple teams, they support each other as part of a wider team network. These successful MCoC teams care for a sizeable proportion of the women in their geographical area. This has driven the RCM's Better Births Initiative to design an exploratory project looking at practice realities with the renewed focus on implementing MCoC on a larger scale.

Over the last three years we have been supporting conversations and decisions on getting started or scaling up. We have also looked at working arrangements in the urban, rural and remote areas across the UK including home, community and hospital settings.

The collection of practice realities and interactive activities available here is the result of this exploratory work.



How we put this together

A series of expert input and consultation exercises, workshops, webinars and interviews have been used to bring together the research and practice information on implementation. We began with those who had three or more functioning MCoC teams. Most of them were covering the full 168 hours (24/7) including providing intrapartum care, and some were covering around 130 hours depending on their staffing levels. Then we spoke to those working in small teams providing antenatal and/or postnatal continuity. We also got in touch with the teams that provide intrapartum care in the community either in freestanding birth centres/community midwifery units or for home births. Finally, we made a point of getting information from those who left teams either to work in other roles or because they were finding it difficult to continue. We learnt some key lessons about the impact on sustainability.

The main aim of the conversations and data collection was to have a clear understanding of the factors that may facilitate or inhibit the upscaling and sustainability of MCoC across maternity services.

All the initial activities were initiated under the RCM Better Births Initiative in 2015 and the interviews took place between October 2016 and March 2017.

In total, we have held at least six expert and stakeholder sessions (over 200 participants), and interviewed 26 midwives and midwifery leaders. During the development phase of this interactive resource, expert input was sought from Midwifery Professors in the UK.

How to use this resource

We wanted to add to the resources with practical information and share knowledge that sparks ideas, illustrates the core elements and variation in place across the UK. We focused the content on supporting implementation conversations and have made this interactive with a collection of exercises for midwives to use on their own or as part of a group.

You can use the collection of exercises in many ways:

- just for yourself to examine and explore opportunities for implementing and upscaling MCoC models of care in your area;
- share this resource with your team and pick up some of the exercises to do together;
- work through the collection of exercises in a team meeting, at a study day and/or a local gathering;
- use the exercises at strategic or network level discussions.

It is advisable, when possible, to invite your managers and team leaders to provide the managerial perspectives when having these discussions.

Get interactive by clicking on the icons



Go to a section in this resource book



Read the report or publication (online)



Watch a video on the topic (online)



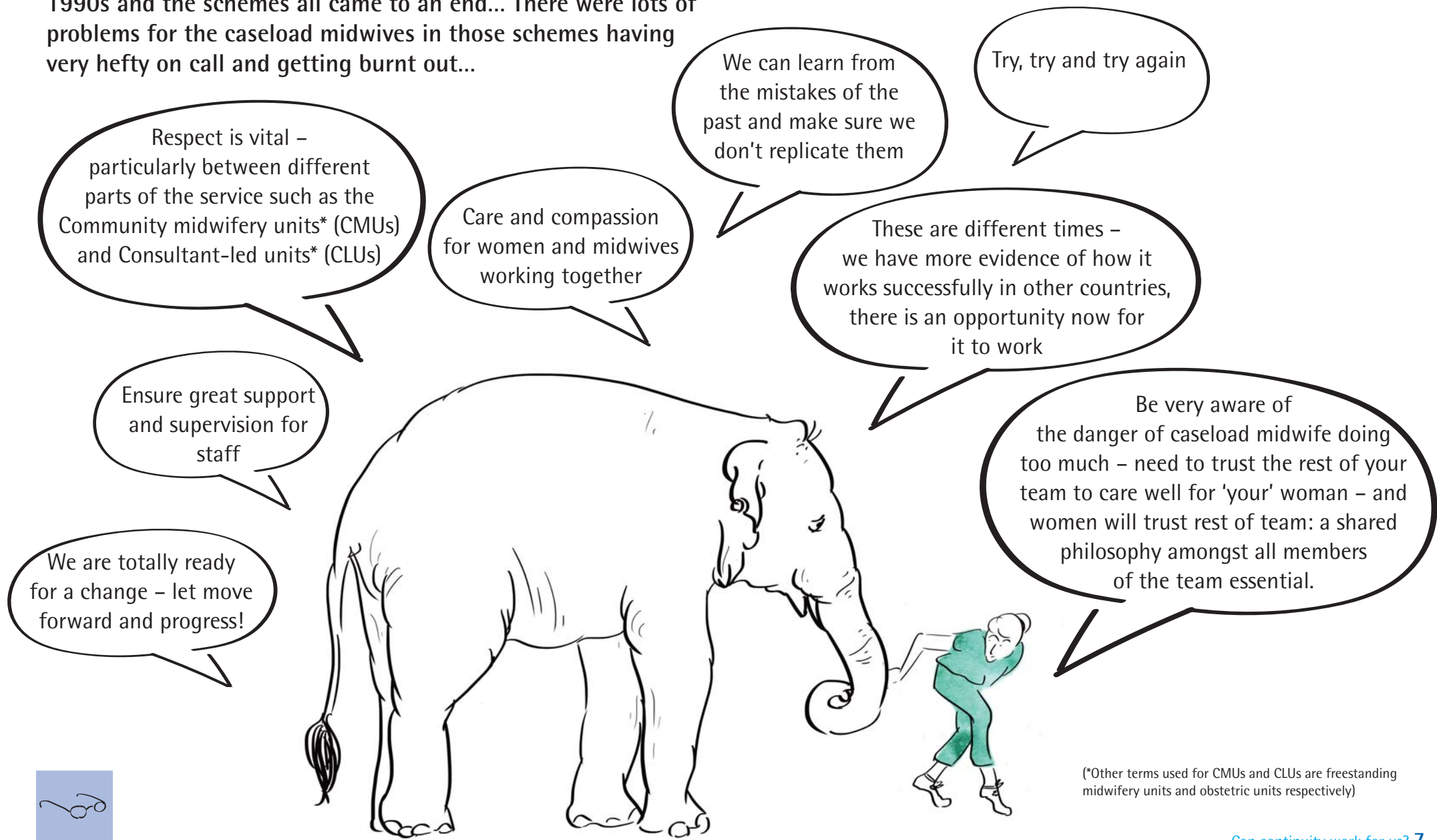
Follow the website link (online)

"The whole idea is that you see women in a multiprofessional way, this is about getting to know what is happening for the mother, what is happening for her family, getting to know her mental health, her obstetric health and setting up a plan in place to support the mum.... very important is the partnership working."



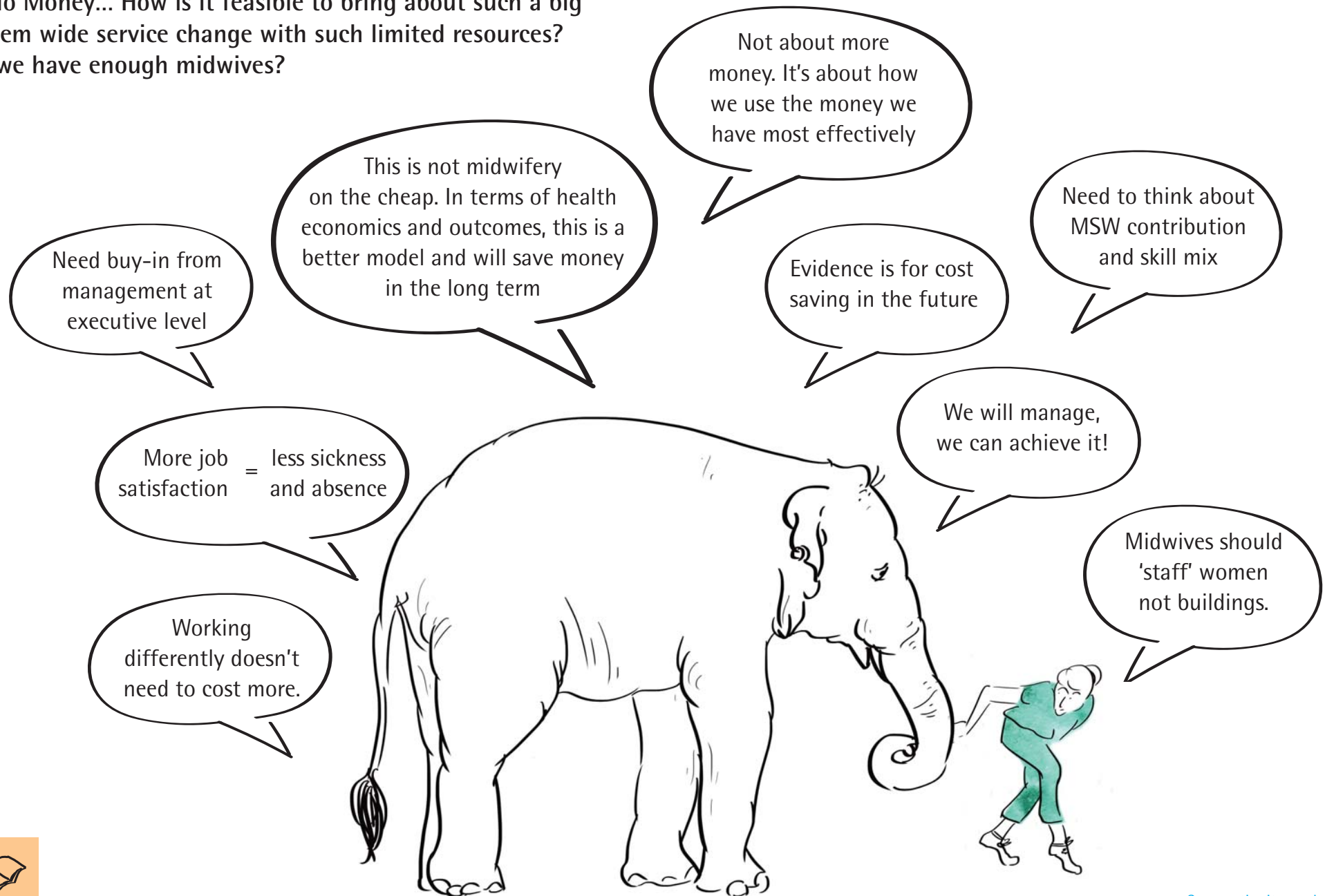
2. Deflating the elephants in the room

1. Tried Before – We tried continuity of carer before in the 1990s and the schemes all came to an end... There were lots of problems for the caseload midwives in those schemes having very hefty on call and getting burnt out...



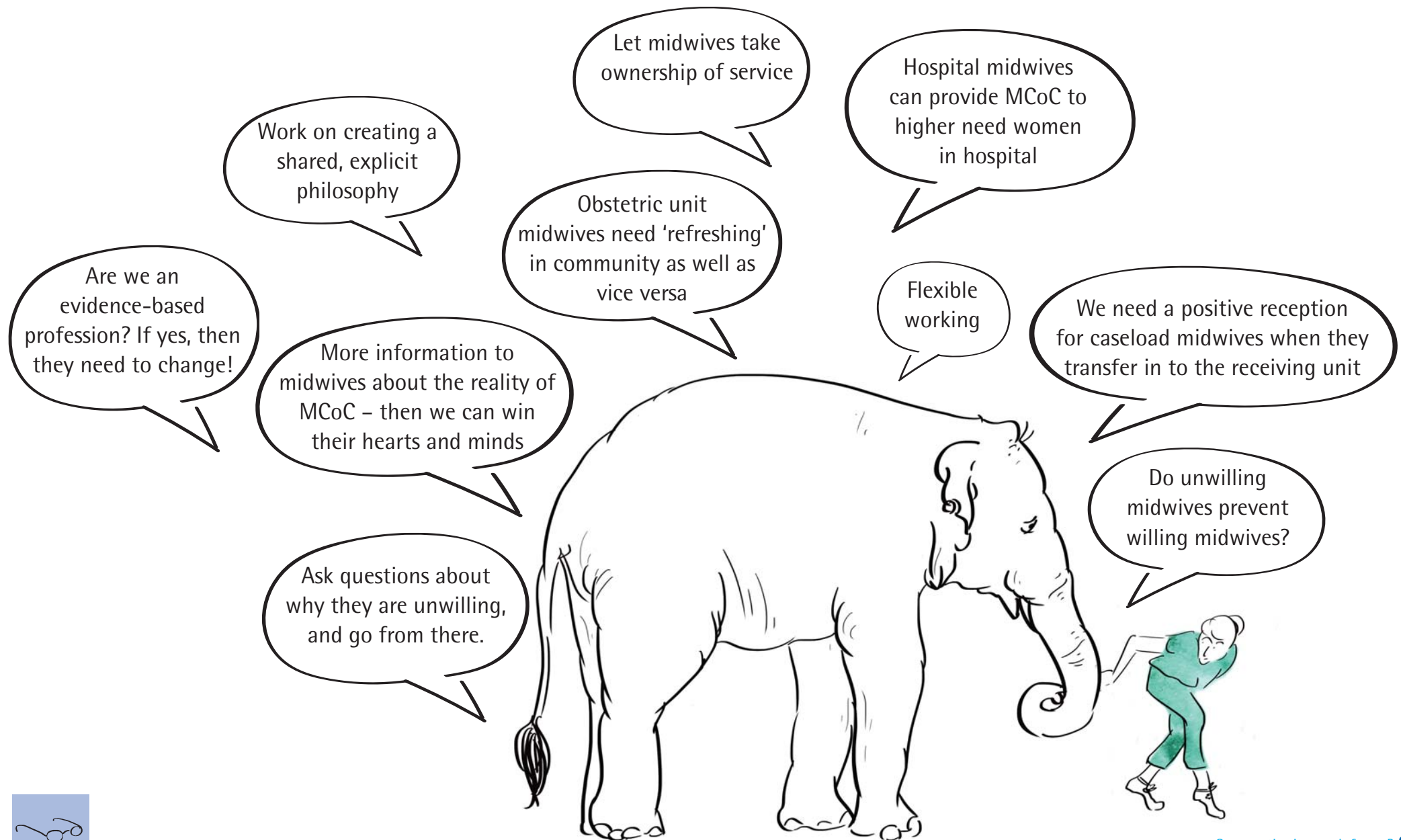
Deflating the elephants in the room

2. No Money... How is it feasible to bring about such a big system wide service change with such limited resources?
Do we have enough midwives?



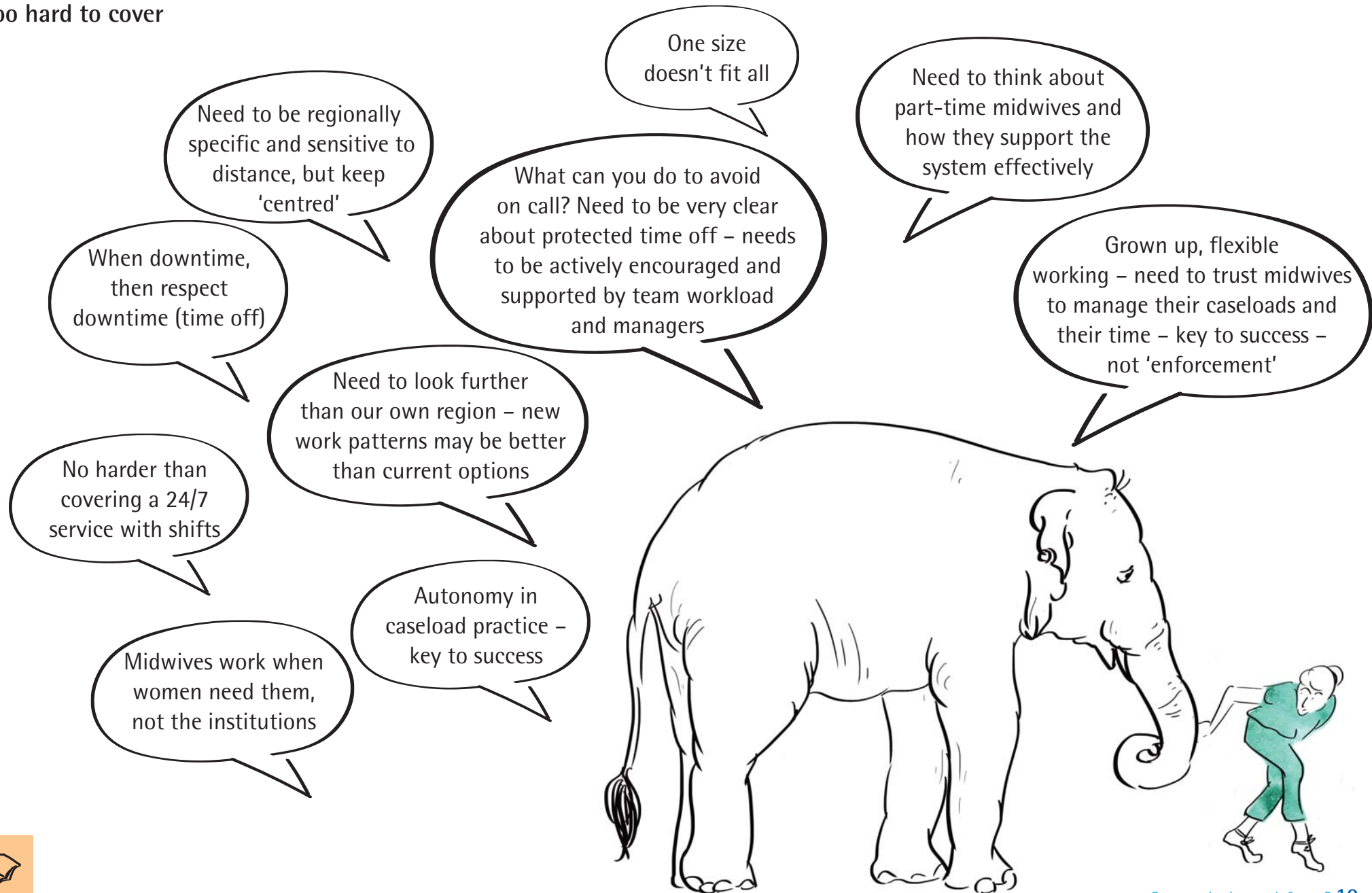
Deflating the elephants in the room

3. Unwilling midwives...



Deflating the elephants in the room

4. Too hard to cover



Walking the elephants out of the room

When we encourage conversations on continuity with a focus on the evidence, current approaches and opportunities, this is what midwives told us:

There are different models of care and continuity. Look at changing off duty to provide better work life balance for midwives.

So glad this is a national venture.

I have been inspired to make this work – extending continuity from caseloading antenatal/postnatal to moving into labour suite with woman if she transfers from CMU or home in labour.

We are all in the same boat.

Huge challenge ahead but looking forward to change.

This is the first discussion I've had around the topic and it's good to hear how others have managed to provide continuity of carer.

Start discussion around challenges. I know acknowledging cannot be 100% continuity of carer will help with staff engagement.

Some good positive messages to allow me to reframe the change in a more do-able light.

I can go back to my team with transparency and honesty and discuss how it will work for us.

That there is no ideal way for everyone but compromise and willingness to work differently is crucial.

There are huge benefits of continuity of carer for women and family and the impact on pregnancy.

Different models of care are needed including shift patterns covering the service 24/7 and following women. I will facilitate discussion with midwives regarding shared responsibility, shared vision and philosophy and self managed teams.



Exercise A

Facilitator's Notes



1 hour



Works best as a group discussion

Deflating the elephants in the room



10mins

1. Using post it notes, ask each person in the group to write down two issues about implementing midwifery continuity of care that are just not being discussed openly right now.



10mins

2. Collect the post-it notes and group up them up on the wall creating around 4 to 5 main themes.



20mins

3. Form small groups or pairs and give them Exercise Sheet A. Get the group to walk around, look at the themes, pick one, write it down, and start quick discussions in pairs or small groups on how they would deflate the elephant with potential solutions or ways forward. Collect the completed sheets and if you have time, give the groups another sheet to pick another topic and repeat their group discussion.



20mins

4. Take a quick glance at the completed sheets and verbally provide a summary to the groups on the main theme and points on deflating the elephant.



This exercise is part of 'Can continuity work for me? A resource to help midwives' (RCM 2017) www.rcm.org.uk/can-continuity-work-for-us

Exercise A

Worksheet 1

Deflating the elephants in the room

Now that you have completed the post it note exercise as a group, you are ready for the next part.



1 hour

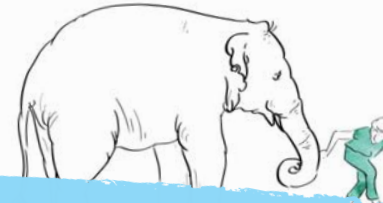
Working in groups, pick an issue from the list and think about how you can deflate the elephant.

Tip

Make this exercise quick and keep the discussions flowing across a number of issues and solutions. You are looking for one-line answers, not an essay.



Find out more information about what other midwives and colleagues said about the elephants in the room: go to *Can continuity work for us? A resource for midwives.*



Issue Title: _____

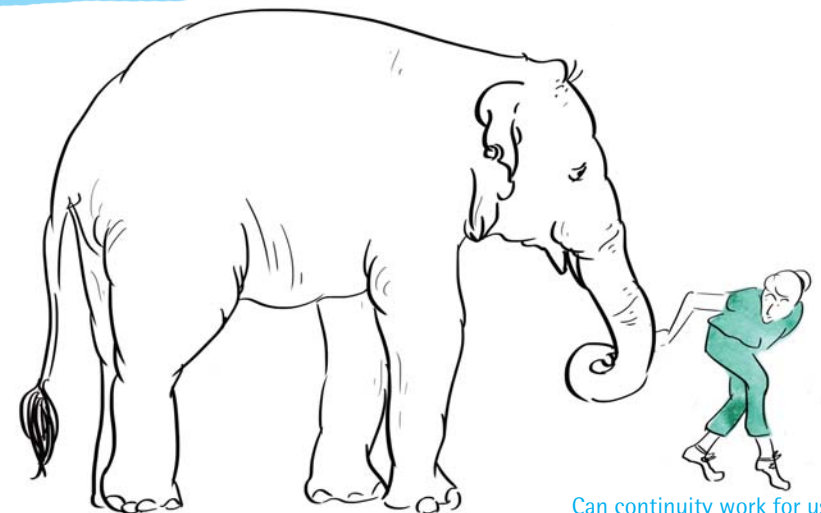
Short Description: _____

Potential solutions or ways forward from the room: _____

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Tip

Make this exercise quick and keep the discussions flowing across a number of issues and solutions. You are looking for one-line answers, not an essay.



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Deflating the elephants in the room

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1 hour

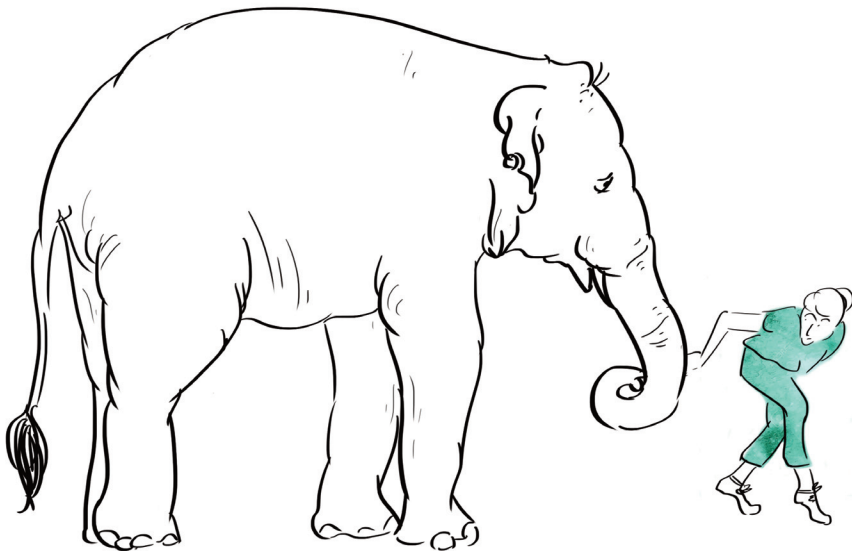
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Issue Title: _____

Short Description: _____

Potential solutions or ways forward from the room: _____

3. Who is in a system for midwifery continuity or carer?



Woman receiving care



Primary midwife

Usual practitioner/named midwife.



Secondary midwife

Working together with the primary midwife, being available and sharing parenting classes etc.



Job share midwives

Two midwives sharing a full caseload or each holding a smaller caseload.



MCoC midwife with buddy system

Usual practitioner/named midwives working in as buddies and sharing the on-calls, drop-ins or other activities.



Core midwives in the acute setting

Working in the hospital setting, inpatients, outpatients, theatres, specialist care and other roles important for the wider maternity care.



MCoC with team/group midwifery


Usual practitioner/named midwives working in a small team/group and sharing the on-calls, drop-ins or other activities. Sometimes they make sure they all have a chance to meet most of the women in the antenatal period, and other times they work within the group as a buddy system. The team/group remains small at around 4 to 8 whole time equivalent (wte) midwives.



Large midwifery teams

Standard care provided where midwives work with larger caseloads not specifically designed for MCoC. They may provide some intrapartum care, but are likely to be on-call infrequently (once a month) and have large clinic-based caseloads.

Buddy systems and team/group midwifery



They all worked differently for managing routine appointments, antenatal classes and being on-call for intrapartum care.

A woman receiving midwifery continuity of carer may receive care from a primary midwife who may also be working in a full-time post through a job share.



In one buddy system, two midwives took turns and shared the care equally throughout the antenatal, labour and birth, and postnatal period. This is what worked best for them. Buddy systems can also have 3 midwives if there is a job share or they wanted to adjust how they cover on-call.



Team/group midwifery set up for providing continuity of carer. Having around 4 to 6 midwives has worked in some areas, others have considered up to 8 midwives adding in full-time posts or including job shares.



Exercise B

Facilitator's Notes



10 minutes as an individual exercise and up to 30 minutes with presentation and discussion



This is an individual exercise

Looking at my practice

You can hand out this exercise as part of a group discussion/workshop.



10mins

1. Start with a short presentation/discussion on key qualities for midwifery practice and how they differ across practice settings.



10mins

2. Hand out the worksheet and give time for each participant to fill it out. Limit the time, but make sure all three of the main sections are completed.



10mins

3. Ask individuals if they would like to share some of their thoughts. Think about the responses to their current work setting during the discussion.

Exercise B

Worksheet 1

Looking at my practice

Many of the midwives we spoke to often referred to the key qualities of their midwifery practice and how it was aligned with their way of working in a midwifery continuity of carer team. Sometimes they focused on relationships (including shared philosophy with colleagues) or on the autonomy and being self-determined.

Have a think about your midwifery practice at the moment and complete this exercise. This one is just for you to reflect.

10 mins

Setting the scene about the way you work

I am mostly based at: _____ working in: _____

What do you find frustrating about the way you are working now?	How would you prefer to be working?	What do you like about the way you are working now?

At present, I ... (please tick one)

☐ work in midwifery continuity of carer team/group/pair

☐ provide some antenatal and/or postnatal continuity as part of my work

☐ attempt to provide some continuity in the way we work

☐ definitely do not provide continuity in the way I work

I have a limited/fairly wide/very wide/full scope of practice (delete as appropriate).

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Tips

This is an individual's exercise for personal reflection. It can just be used as a 10 minute exercise.

Do ask the participants if they are comfortable sharing some of their thoughts.

Do not ask to see the completed sheets.



This exercise is part of 'Can continuity work for me? A resource to help midwives' (RCM 2017) www.rcm.org.uk/can-continuity-work-for-us

Looking at my practice

Many of the midwives we spoke to often referred to the key qualities of their midwifery practice and how it was aligned with their way of working in a midwifery continuity of carer team. Sometimes they focused on relationships (including shared philosophy with colleagues) or on the autonomy and being self-determined.



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Setting the scene about the way you work

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What do you find frustrating about the way you are working now?

How would you prefer to be working?

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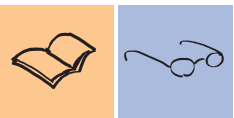
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- ☐ attempt to provide some continuity in the way we work
- ☐ definitely do not provide continuity in the way I work

I have a **limited/fairly wide/very wide/full** scope of practice (delete as appropriate).

"Midwife-led continuity of care confers important benefits and shows no adverse outcomes."

"Policy makers who wish to achieve clinically important improvements in maternity care, particularly around normalising and humanising birth, and preventing preterm birth should consider midwife-led continuity models of care and consider how financing of midwife-led services can be reviewed to support this." (3)



4. The strength of the evidence

Experience of care

There are now a lot of surveys and studies that tell us women want to get to know their midwife. Where women receive midwifery continuity of carer (MCoC) they report higher levels of satisfaction with their pregnancy, birth and early parenting experience (1 and 2).

Improved outcomes

There is strong evidence from a large number of high quality randomised controlled trials, that providing MCoC across antenatal, intrapartum and postnatal care improves a range of key outcomes. There is a reduction in premature birth and fetal loss before 24 weeks, an increase in normal birth and a reduction in a range of medical interventions (3).

So the research evidence demonstrates that MCoC is vital, but is it possible to provide high levels of MCoC in our NHS Systems in the UK?

It is all well and good to have policy ambitions that tells us what care should look like, but the question for strategic leads, midwives and the whole maternity care team, is, how can this be done?

Before you get started, you might find it interesting to have a look at key reports and guidance on implementing relationship based MCoC models:

- This RCM report summarises the research evidence and policy drivers in the UK for midwifery continuity of carer and highlights how continuity of midwifery care contributes to improving quality and safety of maternity care (4)

- The Templeton report draws together some of the latest evidence about implementing continuity models in a very readable way (5).
- New Zealand has over 25 years of experience to draw from as there has been a continuity of carer maternity model for the whole country since 1990. Read more about their way of working in 6.
- The Netherlands, has adopted an interesting new model of district nursing developed over recent years that has helped reduce fragmented care for older people with complex care needs living in the community. It has improved the quality of care received and the job satisfaction of the district nurses. You can read about the Buurtzorg model in reports 7, 8 and 9.



Reporting experiences in England (1)



Reporting experiences in Scotland (2)



Cochrane Systematic Review (3)



RCM Report (4)



Templeton Report (5)



New Zealand Report (6)



Buurtzorg Report (7)



Buurtzorg Report (8)



Buurtzorg Report (9)



A summary of the outcomes from the Cochrane Systematic Review

Associated with several benefits for mothers and babies (3)

- 16% less likely to lose their baby ,
- 19% less likely to lose their baby before 24 weeks,
- 24% less likely to experience pre-term birth,
- 15% less likely to have regional analgesia,
- 10% less likely to have instrumental birth,
- 16% less likely to have an episiotomy,
- 5% more likely to have a spontaneous vaginal birth.
- No difference in caesarean births.
- No adverse effects compared with models of medically-led care and shared care.

The main commonality across the MCoC models is that midwives worked in small teams, intrapartum care was included, and they maximised the opportunity for the women meeting a known midwife during labour.

In the systematic review of 14 trials involving 17,674 women, 10 trials were with team models and 4 with caseloading midwives working in partnership with another midwife or other midwives.

Here are three examples of the models of care from the research:

Buddy system for caseload midwifery

Three geographical areas were covered with 21 whole time equivalent midwives working in 3 practices offering a caseload model of care. Each midwife was attached to 2 or 3 GP practices and cared for 35 to 40 women. Midwives worked in pairs or groups of three (10).

Team of four midwives

They provided antenatal, intrapartum and postnatal care in hospital, and postnatal care in the community for women in a predefined geographical area. The obstetrician saw the women at 36 and 41 weeks as appropriate. 98% of experimental group and 20% of standard group had previously met the midwife attending labour (11).

Midwifery group practice

This was provided in the hospital and community from a named caseload midwife. They were working in a small midwifery group practice with 4 whole time equivalent midwives and providing care throughout antenatal, intrapartum and postnatal periods. The level of continuity was not measured in the study (12).



Cochrane Systematic Review (3)



RCT Study (11)



Templeton Report (5)



RCT Study (12)



RCT Study (10)

"One benefit for us is that you are in control of your caseload and you manage your own diary."

(MCoC Midwife)

5. Autonomy and responsibility

Working in a continuity model of care can be a really big cultural change for midwives who have been used to working in a system with shifts, with set start and finish times, and large teams. It may feel odd for midwives to work in a different way where they are more in control of their own work pattern and schedule. Perhaps this is you? You may be feeling uncertain about how your practice will change as new maternity systems develop around you.

We all need guidance and support to make these transitions and find ways that work sustainably where we are employed. All midwives need to be feel comfortable as they start to work in new ways. For example there will be periods when you are less busy and times when you are very busy. As midwives we appreciate the ebb and flow of maternity service activity and take this for granted as normal. In MCoC models it is crucial that midwives give themselves permission to relax and recover in quieter periods and not feel guilty. This appreciation and acknowledgment needs acceptance at all levels of leadership and management.

A period of orientation is needed for midwives to develop their confidence in working more autonomously. Working in this way is likely to be very different to how you have been working. Midwives working in MCoC teams suggest 3 to 6 months are needed for adjustment. During this adjustment time a new MCoC midwife may need a reduced caseload and an agreed arrangement to work closely with a colleague already established in MCoC teams. The MCoC midwives we interviewed identified that it is helpful to have a 'run in period' with a smaller caseload.

"For people wanting to implement this, I think it is important to start off small with a small caseload. My list is 35 at the moment. I think 16 to start with is good, while everybody finds their feet." (MCoC Midwife)

As midwives we need to identify our educational and developmental needs to ensure we are confident and capable to provide all aspects of care in the settings in which we provide it. This is especially valuable when transitioning to MCoC ways of working. It is imperative time and support is provided for midwives to meet identified educational and training needs as they move into new roles and ways of working.

But we must not forget that enjoying our practice and the way it is organised plays an important part in this for the sustainability of MCoC ways of working. The idea of being more autonomous and self-directed may feel intimidating at first for some of us. However many MCoC midwives we spoke to expressed an increased job satisfaction when they are able to work autonomously and be self-directed:

"Being in charge of your own diary is a bonus." (MCoC Midwife)

"In terms of decision-making, I think we are more autonomous working here." (MCoC Midwife)

"One benefit for us is that you are in control of your caseload and you manage your own diary." (MCoC Midwife)

MCoC midwives need to be central to the establishment of sustainable practice; this has been demonstrated in several studies. Continuity of carer models appear to work best when midwives have the opportunity to be self-determined in how they organise and manage their work and this message came across clearly when speaking with MCoC midwives.

"There is flexibility with the off-duty as well, and the rest of the team are accommodating. You can plan things for next year as well, we don't have to book loads in advance like others may have to. We work more closely and so there is more understanding of each other, and we can easily arrange swaps."

(MCoC Midwife)

6. Shared philosophy and understanding

A shared philosophy amongst a team of midwives providing MCoC is important and ensures consistency of advice and a cohesive approach.

"Because we're constantly handing over to each other, we see how the others work and we learn from each other. We have a team meeting every week, in which we discuss cases, share experiences and debrief. For example, we had a discussion on our approach to discussing fetal movements with women, in which we all shared the advice that we give to women, so that we could agree and make our message uniform. We respect each other, we are friends outside the team, and we offer to do things for each other." (MCoC Midwife)

"We also have an approach to care which is focused on normality." (MCoC Midwife)

Once again, the significance of nurturing relationships is highlighted. Think about the wealth of knowledge that is shared when your colleagues share and discuss practice. Appreciation of differences in approaches enables openness and mutual understanding amongst MCoC midwives who work closely together. The richness of this tacit (unspoken, instinctive and intuitive) and explicit midwifery knowledge comes from working closely together across the continuum of the childbirth experience with women they know.

As this MCoC midwife aptly exclaims:

"We want to be singing from the same hymn sheet, and have a shared ethos." (MCoC Midwife)

"Your colleagues are the people who hold you up. They keep you going." (MCoC Midwife)

"I used to work in an integrated team. You didn't find out as much about the women. There are several examples in which women have disclosed things to me only because they have built up trust in me." (MCoC Midwife)

"..because we can hand over to each other we know what advice was given by our colleague. We always get really good feedback on that." (MCoC Midwife)

"People [midwives] can phone each other any time. We are a close team, and we work well together."

"You definitely have to be a team player, but then I think all midwives need to be."





15 minutes as an individual exercise and up to 35 minutes with presentation and discussion



This is an individual exercise

Thinking about my practice

Some of the midwifery practices experienced by midwives working in continuity of carer teams/groups have been highlighted in the last three sections on the strength of the evidence, autonomy and practice, and shared understanding/philosophy.

You can hand this exercise out as part of taking a step back and reflecting on what is happening today for your participants' midwifery practice.



15mins

1. Spend time highlighting some of the main messages from the sections on strength of the evidence, autonomy and responsibility, and shared understanding/philosophy.



15mins

2. Hand out the worksheet and give time for each participant to fill it out. Limit the time, but make sure the pledge is completed.



15mins

3. Ask a couple of individuals if they would like to share their pledges



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Tips

This exercise is for personal reflection and to be completed individually.

Do ask the participants if they are comfortable sharing some of their thoughts.

Do not ask to see the completed sheets.

Thinking about my practice



15 mins

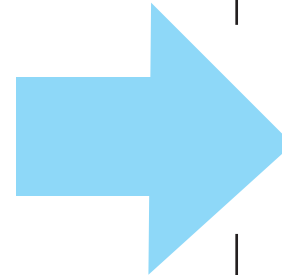
Reflect on what you have read and thought about for midwifery continuity of carer.



Thinking about what you have read and discussed about midwifery continuity of carer, is there one thing that feels overwhelming?



Thinking about what you have read and discussed about midwifery continuity of carer, is there one thing you want to embrace



If you kept moving forward on supporting a continuity of carer system, what happens next?

My little action pledge:

"We're not there to do everything for women but to empower them, and help them to take more control over their own lives."

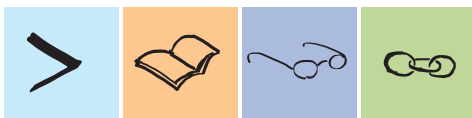
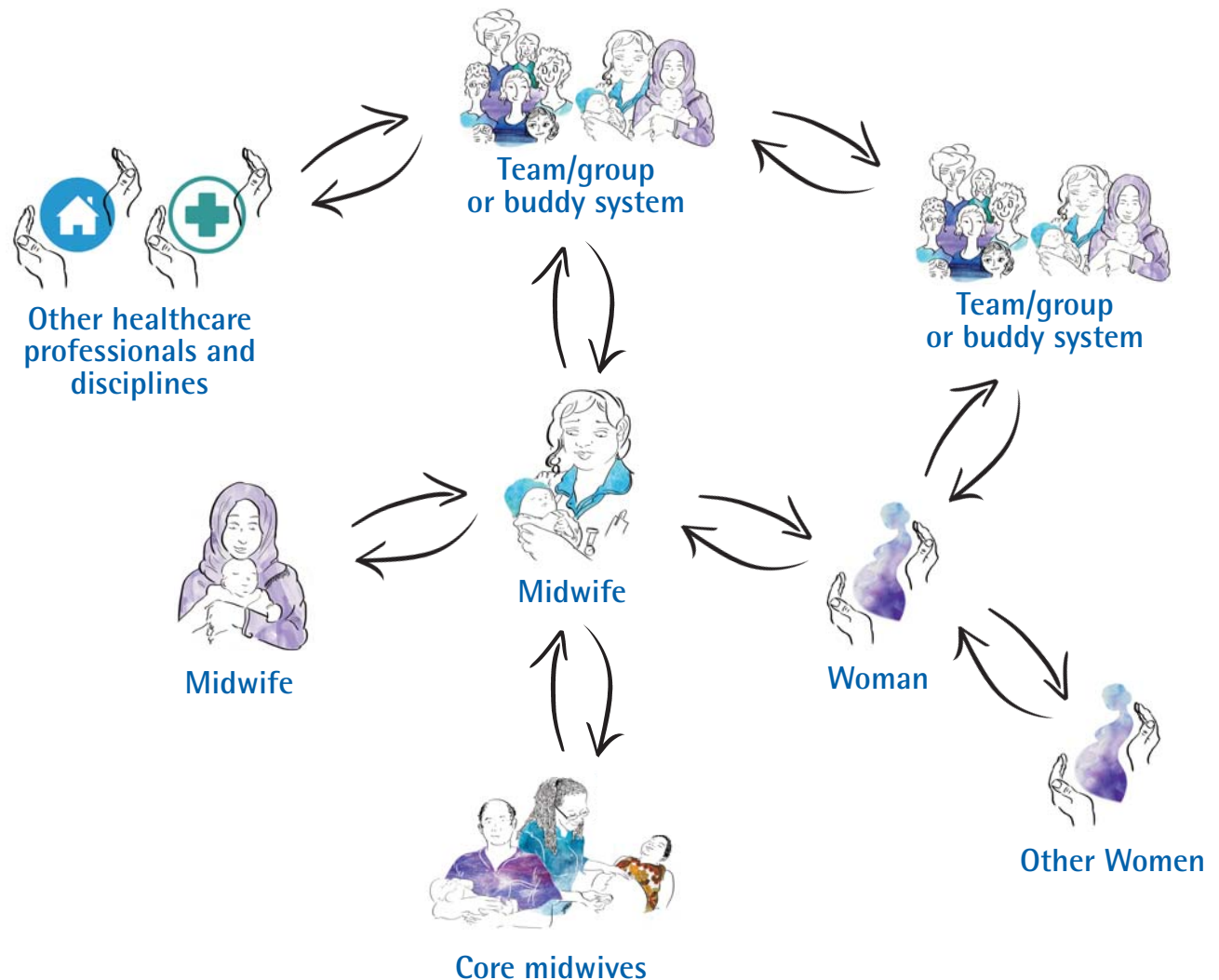
(MCoC Midwife)

7. Relationships

Relationships are clearly central to maternity services and midwifery practice. There is a lot of evidence, both qualitative and quantitative, that highlights the significance of relationships and communication. A whole range of outcomes are improved when a woman is able to get to know her midwife and the midwife is able to get to know the woman through her maternity care.

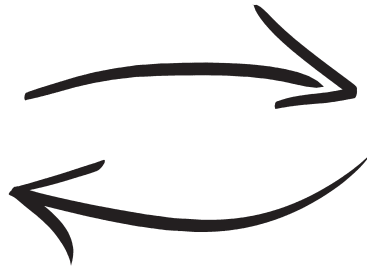
Interestingly this impact is not just for women and their families but has been shown to improve job satisfaction in midwifery practice. Relationships thus contribute to both resilience and sustainability of midwifery practice.

The key relationships that need to be developed to make MCoC work range from the one between the woman and her midwife right through to that between the team and other healthcare professionals and disciplines.





Midwife



Woman

For the women in their own caseload and in their MCoC team/group or buddy system

Enjoying the time to develop a relationship with women and families has repeatedly been shown to enhance midwifery practice. In a survey with midwives currently working in MCoC models in the UK, the importance of this relationship came across very strongly.

"It's nice to see the lady the whole way through. We already have that relationship with the woman. This is much better than in standard care." (MCoC Midwife)

There is emergent evidence that MCoC models enhance safety for women and infants (3). Midwives recognise that providing midwifery continuity of care can improve safety.

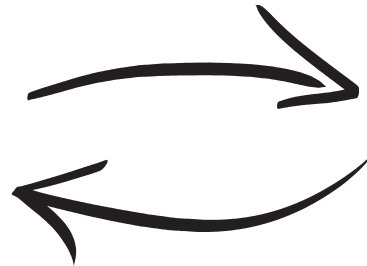
"I used to work in an integrated [large midwifery] team. You didn't find out as much about the women. There are several examples in which women have disclosed things to me only because they have built up trust in me. Things may not be picked up in other models of care and issues can be missed." (MCoC Midwife)

Sometimes midwives express fear that building a relationship with each woman takes too much time, yet this midwife questions this assumption.

"In a fragmented model of care time is limited; you always have limited time to learn about them, whereas I can allow longer appointments. Yet in terms of planning their care, it actually saves time because I already know them." (MCoC Midwife)



Midwife



Midwife

Within members of an MCoC team/group or buddy system

For MCoC to be sustainable midwives working in teams need to develop positive supportive relationships with each other, collegiality is a key ingredient to making this model of care work.

"People [midwives] can phone each other any time. We are a close team, and we work well together." (MCoC Midwife)

"You definitely have to be a team player, but then I think all midwives need to be." (MCoC Midwife)

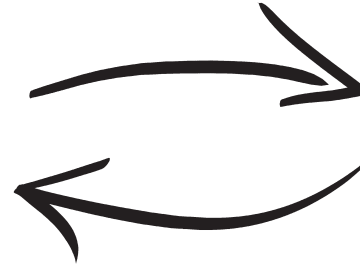
Sharing information and care plans are essential in a fully functioning and sustainable MCoC team.

"But we are aware of each other's women, so if there's a special plan in place we communicate. But although we know about each other's women we may not have met them before. There may be up to 20 or so women who are in our [overall team] caseload whom I haven't met." (MCoC Midwife)

"I don't feel stressed at all over my hours. I think that's because it's caseloading, we know our women. Even if I haven't met her, we've talked about her at meetings, and we share a sheet with the details of each other's women with special needs." (MCoC Midwife)



Team/group or buddy system



Woman

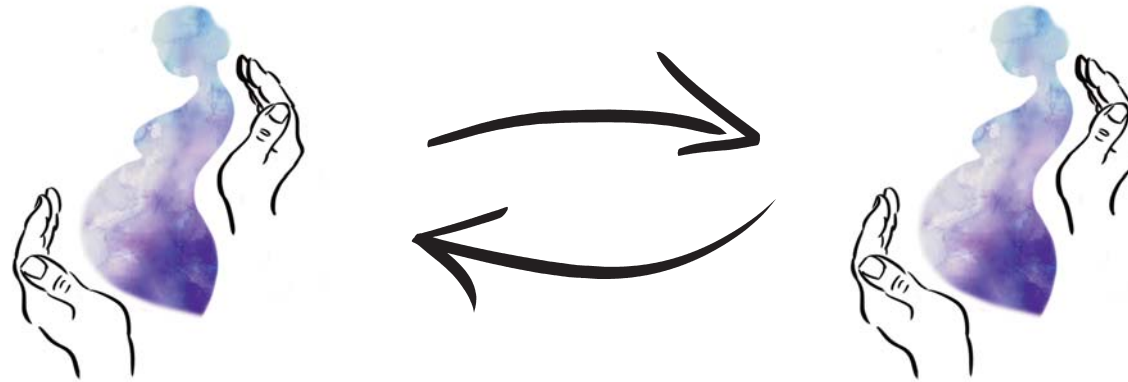
For routine scheduled appointments and on-call care

Although the ideal is that a woman will see and be cared for by the same midwife throughout all her maternity experience, this is not feasible 100% of the time. Therefore communication and opportunity for team members and women to get to know each other is important. Different MCoC teams facilitate this in different ways.

"We hold a password-protected database with all the women that are on our caseload, so we can always check if there are any more complex needs if we have to look after each other's women. Antenatal classes are another way to get to know them. We do two classes, covering quite a broad overview of

topics. The set of two is done every other month, and each class is a two hour session. We invite all the primips who are due in the following two months. That helps with continuity, enabling them to get to know the other midwives." (MCoC Midwife)

"We run a drop-in from 10 to 12 every Thursday, and there are always two midwives present. We use it more if someone can't be seen at a regular antenatal check-up. Very occasionally we see postnatal women there." (MCoC Midwife)



Woman

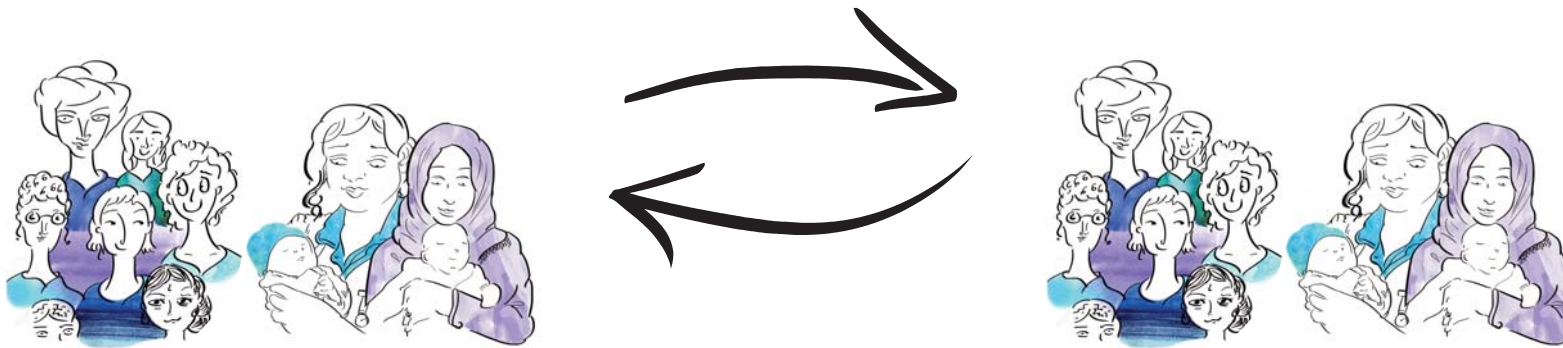
Other Women

For peer support groups/antenatal and postnatal classes

MCoC builds opportunities for women to meet each other on their maternity journey. This is generally through group antenatal and postnatal classes or breastfeeding support groups. These groups are also a useful way for midwives to get feedback from women about what they feel is working well, or not, in the way that care is provided.

What is essential in all of these relationships is the building of reciprocal communication channels which are professional,

respectful and tactful. These communications can be face to face, through information technology and virtual mediums (e.g. video conferencing), phone calls and texts. The key is reciprocity: where there is give and take and mutual support. Therefore how we are supported in our professional relationships is a key aspect of sustainable and resilient MCoC practice that promotes safe, quality, acceptable and accessible maternity care for women and families.



Team/group or buddy system

Team/group or buddy system

With communication between MCoC teams

In a maternity service with several MCoC systems in operation, it is crucial for relationships between teams to also be collegial.

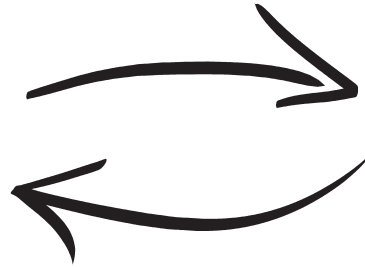
"Relationship with the other teams that do caseloading is important. The coordinators meet at regular intervals. Once a year we have an away day where everyone takes part who works in caseloading. That's how new improved ways of working came about." (MCoC Midwife)

"There is flexibility with the off-duty as well, and the rest of the team are accommodating. You can plan things for next year as well, we don't have to book loads in advance like others may have to. We work more closely and so there is more understanding of each other, and we can easily arrange swaps." (MCoC Midwife)

"because these are small teams if you want to make sure this midwife is there for you, you need to be there for them too." (MCoC Midwife)



Midwife



Core midwives

In the acute care settings

There are many examples where there have been tensions between MCoC teams and hospital core staff and services. Reciprocal communication based on respect of everyone's unique roles is required to make it all work.

"We do get asked to support the core staff as well. For example, I'm on a labour day today and I could be called out by them anytime. It can put extra pressure on you when you may have had been called out every single day recently, or you may have stuff to catch up on. But they just see you as hanging around." (MCoC Midwife)

It works well when arrangements are made to understand each other's workload and when there is reciprocal support.

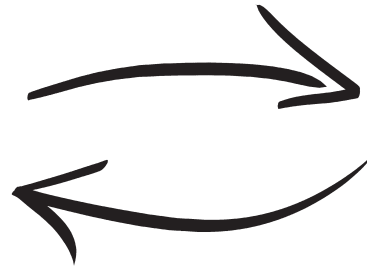
As one Head of Midwifery says:

"Calling caseloading midwives into hospital: we try to do it only when we really have to in order to ensure safety." (MCoC Interviewee)

"The hospital are very good and help us out." (MCoC Midwife)



Team/group and buddy system



Other healthcare professionals and disciplines

Including medical, nursing, allied health professionals in health and social care

These include medical colleagues e.g. GPs, obstetricians, anaesthetists, paediatricians, allied health care providers e.g. health visitors, physiotherapists, and specialist services such as perinatal mental health teams, social services, and medical specialties.

Communication channels with other members of the maternity care team are essential to promote safety and optimal outcomes. It is vital for MCoC midwives not to work in isolation (or feel they work in isolation due to poor relationships with the multiprofessional team).

"We have a direct connection with obstetricians, who are based on geographical area, and with Day Assessment Unit. Essentially, we have a consultant for our team." (MCoC Midwife)

Often MCoC midwives are more involved in the psychosocial aspects of care for some women and communicate with a broad array of other agencies, support teams and professionals.

"...we make more referrals as we talk to women more and they have more trust in us to tell us their problems. We go to our own child protection meetings, whereas integrated midwives usually rely on specialist midwives." (MCoC Midwife)

This may at first seem onerous yet MCoC midwives report having the opportunity to follow a woman through her pregnancy and beyond, and engage with other services is a fulfilling aspect of providing continuity.

"We have a direct connection with obstetricians, who are based on geographical area, and with Day Assessment Unit. Essentially, we have a consultant for our team." (MCoC Midwife)

Often MCoC midwives are more involved in the psychosocial aspects of care and require communication skills with a broad array of other agencies and professionals.

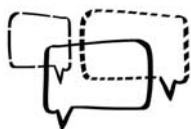
"~we make more referrals as we talk to women more and they have more trust in us to tell us their problems. We go to our own child protection meetings, whereas integrated midwives usually rely on specialist midwives." (MCoC Midwife)

Exercise D

Facilitator's Notes



1 hour



Works best as a group discussion

Who do you talk to and how often

You can hand this exercise out as part of thinking through the types of relationships that exist in current settings and teams.



15mins

1. Spend time highlighting some of the main messages on relationships and thinking about the how these have been formed and why it might be important for MCoC teams/groups. You can also discuss how trust is formed and the difference familiarity with colleagues makes across the different settings.



30mins

2. Form small groups or pairs and ask them to complete Exercise D. Give 5 minutes for each participant to complete the exercise on their own. Encourage the participants to think carefully about (1) how much they knew the individuals the colleagues they were in contact with, (2) how much they could trust them, and (3) whether this is a usual situation for their current day-to-day experiences.

If you are working with a small group, ask them to complete thinking about the care of around 3-4 women using one worksheet per woman.



15mins

3. Ask each group to give feedback and reflect on how this relates to what has been highlighted in the section on relationships.



This exercise is part of 'Can continuity work for me? A resource to help midwives' (RCM 2017) www.rcm.org.uk/can-continuity-work-for-us

Exercise D

Worksheet 1

Who do you talk to and how often?



30 mins

Thinking about the last woman you have cared for, place a dot in the areas where you had communications with colleagues.



Put a dot to show who you talked to.

Reflect back on the exercise, thinking about familiarity and trust for the people you had conversations with.



Other medical/clinical disciplines beyond the maternity team



Broader maternity team



Midwifery colleagues

Midwife



Other health and social care providers



Your role title/short description

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Can continuity work for us? 13

Tip

Make this exercise quick and keep the discussions flowing across all the participants. You are looking for lots of different experiences and reflections on context, trust and familiarity.

Who do you talk to and how often?



30 mins

Thinking about the last woman you have cared for, place a dot in the areas where you had communications with colleagues.



Put a dot to show who you talked to.

Reflect back on the exercise, thinking about familiarity and trust for the people you had conversations with.

Other medical/clinical disciplines beyond the maternity team



Broader maternity team



Other health and social care providers



Midwifery colleagues

Midwife

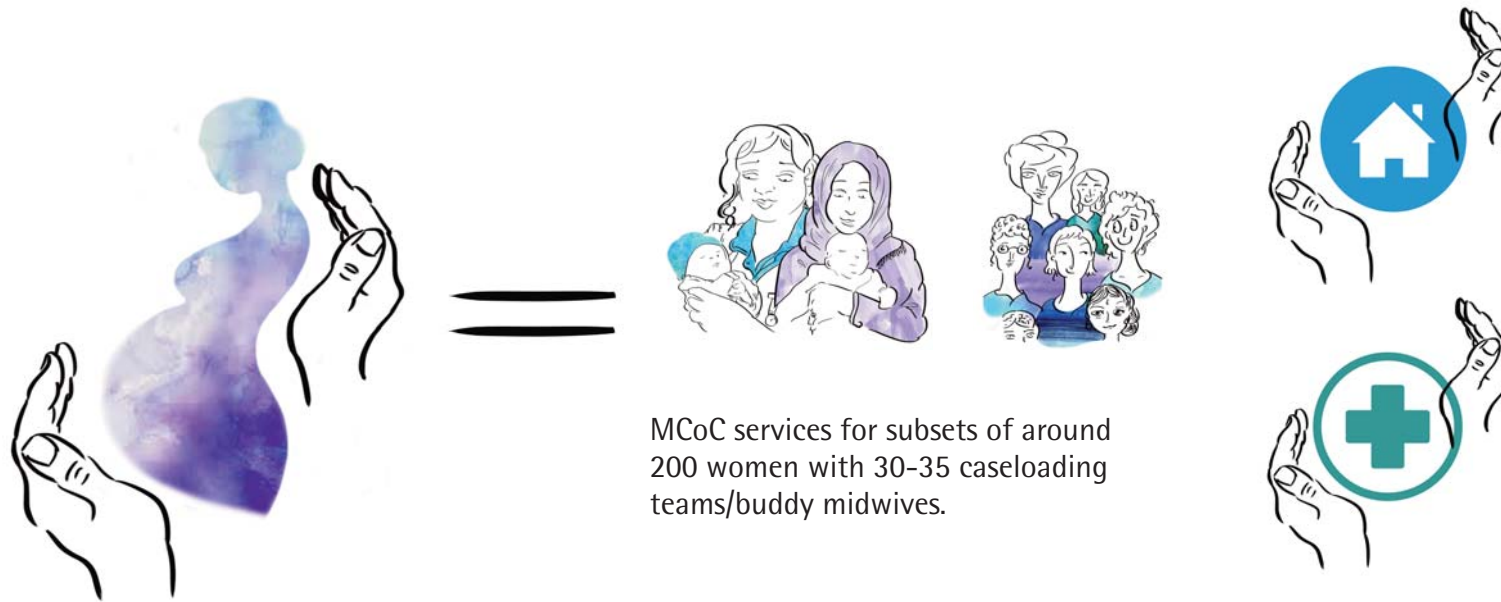


Your role title/short description

"As far as burnout is concerned, we don't do 24/7 cover, the cover is provided by the team."

(MCoC Midwife)

8. Thinking about scaling up midwifery continuity of carer



MCoC services for subsets of around 200 women with 30-35 caseloading teams/buddy midwives.

Most MCoC midwives would be based in and provide routine/scheduled care in the community and follow the woman for intrapartum care.

Some women, because of their health and social needs will have MCoC midwives based in the hospital/acute care setting and also receive all or most of their care in this setting.





Core services with midwives working within inpatients, outpatients, specialist care, leadership, senior strategic and clinical roles.



A small proportion of women, because of their circumstances may not have been allocated to MCoC midwives and may be looked after by the large midwifery team. This may be in the community or hospital for antenatal and/or postnatal care.

McoC for 2000 women

Midwives working in full-time equivalent
Working with a caseload of 35 women per year
per whole time equivalent (wte) midwife.

	No. of midwives (wte) working in McoC	No. of women per team per year	No. of teams for 2000 women per year
 Team	8	280	7
	7	245	8
	6	210	10
 Buddy system	3	105	19
	2	70	29





The teams/groups or buddy systems can be based in the community or the hospital.



Around 55 to 65 midwives
depending on how job sharing is worked,
the geographical coverage and other
service/workforce considerations.

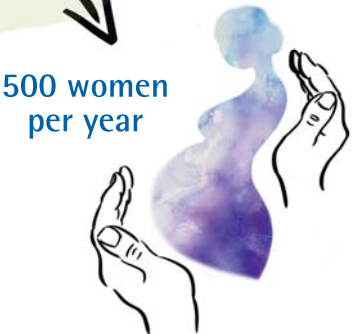
McoC for 500 Women

Midwives working in full-time equivalent
Working with a caseload of 35 women per year
per whole time equivalent (wte) midwife.

	No. of midwives (wte) working in McoC	No. of women per team per year	No. of teams for 500 women per year
 Team	8	280	2
	7	245	2
	6	210	2
 Buddy system	3	105	5
	2	70	7



The teams/groups or buddy systems can be based in the community or the hospital.



Around 14 to 18 midwives
depending on how job sharing is worked,
the geographical coverage and other
service/workforce considerations.

Factors influencing how MCoC can be introduced or scaled up

Decisions about the criteria used to allocate women to midwifery continuity of carer models of care have usually been determined using geographical or medical/social complexities/needs. The number of women requiring the service, manageable workloads, best place of care, and practicalities of managing the referral process at booking have also been factors.

Geographical areas

- Urban: one or two postcode areas may have a large enough caseload for MCoC to be provided, time between home visits may be short, and midwives may be able to work more effectively with communities where engagement levels are usually low.
- Rural or remote: travel distances are likely to be much longer, there may be fewer specialist or voluntary services available for some women, and so these types of care and support may only be provided by midwives.

Medical or social complexities/needs

- Deprivation and social: where women are living in difficult circumstances, midwifery care can be tailored to match their needs, familiarity with supporting organisations and specialist knowledge can facilitate access and enhance the care provided.
- Obstetric, medical, or psychosocial complexity/need: women may require ongoing support from specialist teams and focusing on specific care pathways may enhance the care provided.

Caseloads were usually smaller where midwives were working with a high proportion of women with high levels of complexity. This may be due to a greater frequency or length of appointments as well as the need to coordinate care with other services. Even where care is provided for women based on their medical or social complexities/needs, working across all care settings maintains the breadth of experience for the MCoC midwives.

When we talked to MCoC midwives they said:

"You definitely know when you have too many, if you have no time and your diary is completely full. 40 is more than enough. 25-30 is much more manageable, this enables you to provide the type of care that you should." (MCoC Midwife)

"This model enables us to keep up our skills in all areas, for example I might have one day in a social services meeting, the next in theatre, the next at home. The diversity in experience that we have is exciting." (MCoC Midwife)



Exercise E

Facilitator's Notes



10 minutes as an individual exercise and up to 30 minutes with presentation and discussion



This is an individual exercise

Thinking about context and need

Think about the groups of women cared for in your area and the personal/professional circumstances of the midwives currently working in the area. Use the 3 worksheets to reflect on important areas for consideration.



15mins

1. Spend time highlighting some of the main messages from the section on calculating the numbers and the influential factors for scaling up.



45mins

2. Hand out the three worksheets and give time for each participant to fill it out. Limit the time to 15 minutes per worksheet. It is important to keep this moving for personal reflection only.



10mins

3. Gather feedback on post it notes or flip chart on important points from worksheets 1 and 2 without asking for personal details.



20mins

4. Ask participants to share their responses to worksheet 3 and collate feedback on the context and need identified for women and midwives. Reflect on how this information can be used to inform next steps.



This exercise is part of 'Can continuity work for me? A resource to help midwives' (RCM 2017) www.rcm.org/can-continuity-work-for-us



Tips

This is an individual's exercise for personal reflection. It can just be used as a 10 minute exercise.

Do ask the participants if they are comfortable sharing some of their thoughts.

Only ask for Worksheet 3 to be submitted or discussed in detail.

Thinking about context and need

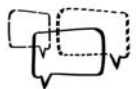
Think about contexts where care is provided

For women

- Demographic factors where you practice now
- Geography: road access, cities and urban/rural/remote areas, language
- Social context: deprivation, high income earners, refugees etc.
- Complexity/needs (e.g. psychosocial, obstetric and medical)

For you as midwife

- Your own demographics like age, caring responsibilities and commitments
- Where you live and work: transport networks, mobile phone reception, and access to car
- Professional context: where have you worked, length of experience, competencies, breadth of professional experience across practice settings
- Social context: income, caring responsibilities, social support, work/life balance
- Complexities/needs: psychosocial, medical, health and social care concerns, resilience



Some of this may be for sharing, but you may want to start by just thinking about this on your own.

Now/Women's context

The context of women in my midwifery care



Now/Midwife's context

My personal and professional context



Thinking about context and need

Think about need for the women and you as a midwife, and then how it might change in the near future.

For women

What are the needs of women in my midwifery care in the current situation?

For midwife

What are your needs professionally and personally in your current circumstances?

About the future

Over the next 3 years, what changes do you anticipate with the above?

Now/Women's needs



Now/Midwife's needs



What the future could bring



Thinking about context and need

When we talked to MCoC midwives they said:

"For people wanting to implement this, I think it is important to start off small with a small caseload. My list is 35 at the moment. I think 16 to start with is good, while everybody finds their feet."

"But we are aware of each other's women, so if there's a special plan in place we communicate. But although we know about each other's women we may not have met them before. There may be up to 20 or so women who are in our caseload whom I haven't met."

Given your thoughts from worksheets 1 and 2, what do you feel could work in your area for MCoC to meet the needs of the women and the midwives.

Option 1

Option 2

Option 3



Some notes and thoughts

"But we are aware of each other's women, so if there's a special plan in place we communicate. But although we know about each other's women we may not have met them before. There may be up to 20 or so women who are in our caseload whom I haven't met."

(MCoC Midwife)

9. Working time and off duty

There was no typical week. The MCoC teams/groups we spoke to had varied approaches to organise their time and share their on-call. Self rostering, swapping, reviewing, asking for cover were all part of how they managed their day-to-day work.



For the buddy system midwives, we heard about a couple of options:

1. The primary midwife provided most of the routine scheduled care, being on-call for the intrapartum care for their own caseload during the day and sharing the out-of-hours period with the secondary midwife. This was sometimes shared with three midwives.
2. Two midwives shared routine scheduled care equally and therefore had a combined caseload. This meant that the women had two named/primary midwives, but would have met both midwives throughout their pregnancy, labour, birth and postnatal care.

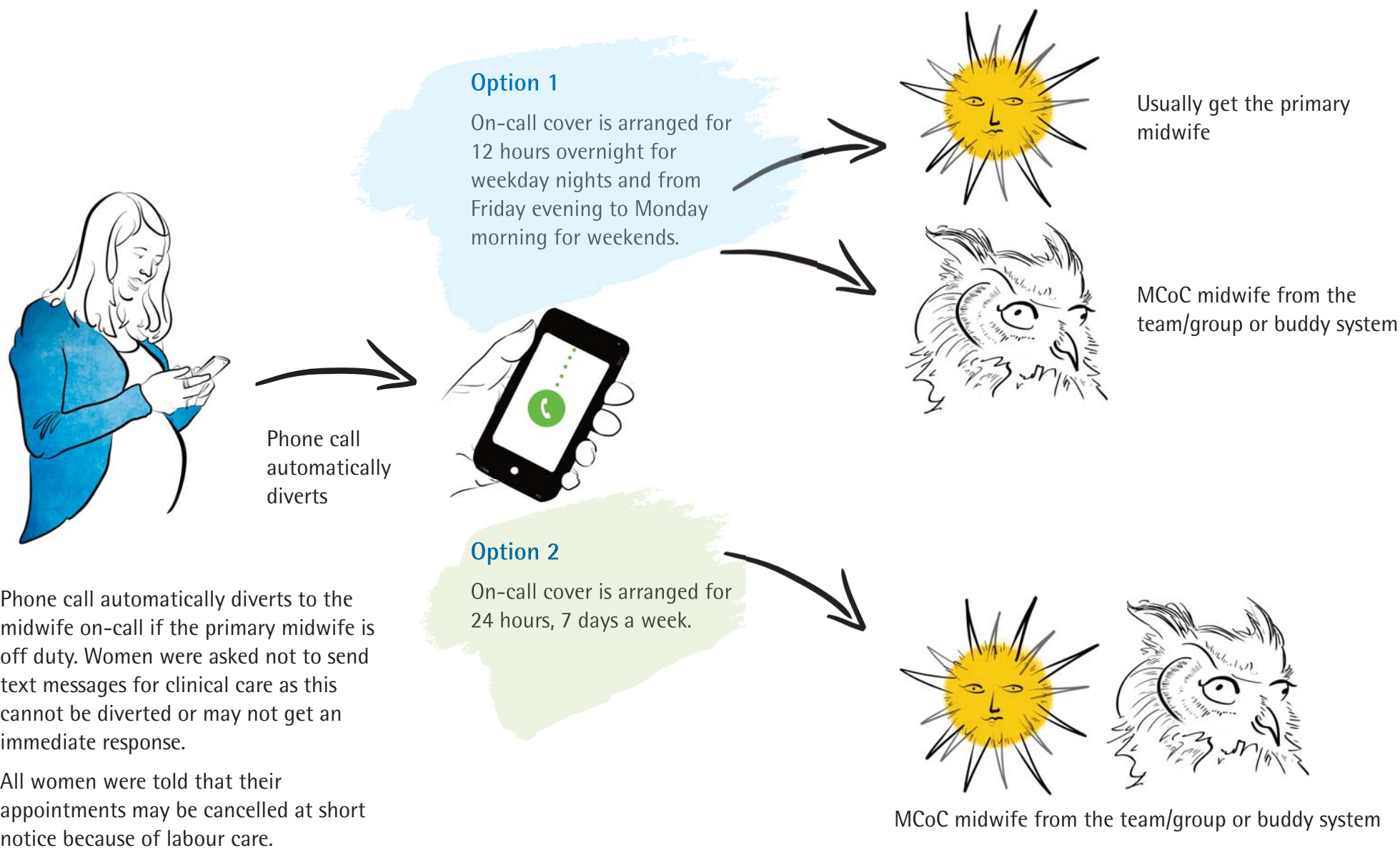
Many MCoC midwives described being able to rearrange appointments with women or ask colleagues to step in at short notice based on how busy it has been.



For the team/group MCoC midwives, there were a few more varieties:

1. The primary midwife covered all the routine scheduled care and shared the on-call both in the day and night time.
2. The primary midwife covered the routine scheduled care and on-call for their caseload during the day and shared the on-call at night and weekends only.
3. The primary midwife adjusted some of their on-call hours based on due dates for their own caseload so that they maximise their chance of being available for intrapartum care. This was managed by allocating women to their caseload based on their due dates (maximum of 3 to 4 women per month).

Different approaches for covering intrapartum care and out of hours contact



On the day before the weekday night on-call



Receive an update on women in labour care

Travel to place of care for handover or stay at home



9am

2pm

6pm

8pm

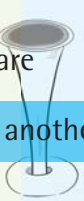
8am 9am

Option 1

Working for usual routine scheduled care

Off duty

On-call covered by another midwife for your caseload



Option 2

Working for usual routine scheduled care and covering on-call for your own caseload



You are first or second on-call for the team/group or buddy midwives



Option 3

Day off

On-call covered by another midwife for your caseload



Some teams handover at 5pm, others at 8pm, and this is flexible in discussion with on-call midwife

On the day after the weekday night on-call

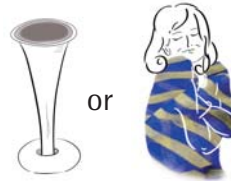


9am

You are first or second on-call for the team/group or buddy midwives

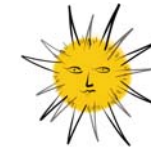


Usual scheduled appointments



Working but no scheduled appointments

Day off



9am

Option 1

Recovery/working day

These would be rescheduled with the women or handed over to colleagues if the night was busy.

Option 2

Recovery/postnatal day

Taken as a recovery day if busy in the night, or review team/group caseloads to schedule appointments on the day for women requiring immediate postnatal care.

Option 3

Recovery/administration day

Taken as a recovery day if busy in the night, or worked as an administration/catch up day for follow up care, referrals and other clinical and non-clinical work.

Option 4

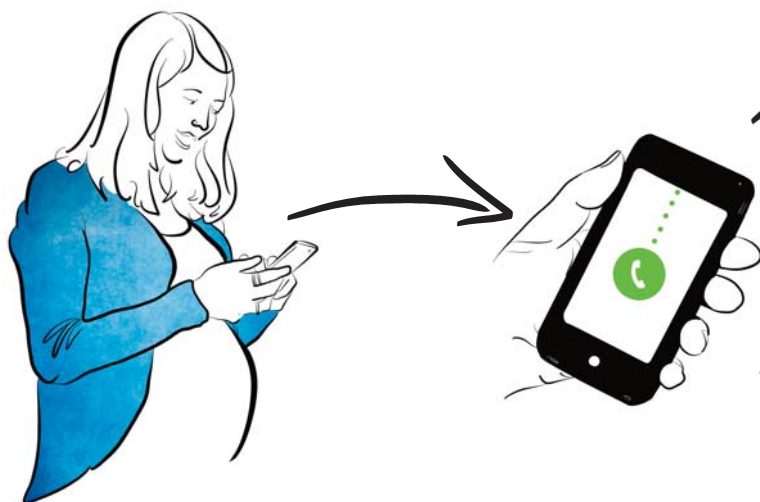
Recovery day

Not working after the night on-call regardless of how busy it was in the night.

The working patterns on the day of the on-call also took into account the need to balance average working hours. This can be to reduce the hours through the recovery day, or add hours due to less busy nights.

Working at weekends

Weekend cover usually started on a Friday evening to Monday morning. This may be 5pm or 8pm depending on the team, but was fairly flexible with discussion between the midwives.



Some MCoC midwives schedule routine care flexibly in the weekday evenings and during the day on Saturdays. This could overlap with being on-call and rescheduling of appointments if called out.

Option 1

This may be shared between 2 midwives for the whole weekend taking turns as first on-call and second on-call. Non-working recovery days were scheduled in the following week following the weekend on-call.

Option 2

This can be worked as 12 hour or 24 hour on-call periods based on the way the team would like to structure the weekends. Recovery days in the following week were scheduled as appropriate to the number of hours covered in the weekend.

Exercise F

Facilitator's Notes



20 minutes as an individual exercise and up to 1.5 hours with presentation and discussion



This is an individual exercise

Making sense of the practical details

You can hand out this exercise as part of a workshop the type of questions midwives might want to consider about the practical details.



15mins

1. Spend some time going through some of the example questions in worksheets 1 and 2 and get participants thinking about what they might want to know about working in MCoC teams/groups or buddy systems..



20mins

2. Form small groups or pairs and ask them to complete worksheet 1. Give 10 minutes for each participant to complete the worksheet 1 on their own. Encourage the participants to share some of their own questions and write down more questions on their own worksheets during the discussion.



20mins

3. Repeat for worksheet 2 giving 10 minutes for each participant to complete worksheet 2 on their own and then 10 minutes for discussion.



35mins

4. Ask each group to provide feedback.



This exercise is part of 'Can continuity work for me? A resource to help midwives' (RCM 2017) www.rcm.org/can-continuity-work-for-us



Tips

Make this exercise quick and keep the discussion flowing across all the participants. You are looking for lots of practical questions on how midwives in a team/group or buddy system will be working together.

Making sense of the practical details

Knowing that midwives in midwifery continuity of carer teams/groups or buddy systems work in a variety of ways, it is important to find out more about how you might be asked to work or how implementation might take place in your area.

Here are some example questions.

Organising my working day

What are my typical working hours for scheduling my routine visits and classes, and what flexibility do I have?

How do I manage all the appointments, for example postnatal visits, if I have been called out the night before?

Figuring out how the on-call works

Is my pay fixed with an enhancement or variable from month to month?

How do I self-roster my on-calls and plan my weekends?

What can I do if I need to swap my on-call at short notice or leave part way through for personal reasons?

What are your questions? Write them here:



Who can help you with these questions? Write them here:



Making sense of the practical details

Here are some more example questions.

The women in my caseload

How will women be allocated to the MCoC team/group or buddy system?

What is the geographical area we need to cover?

What happens if the caseloads are getting too large or too small?

Starting out in a team/group or buddy system

What is the starting caseload for a midwife joining the team/group or buddy system?

What is the induction programme in place and how long will it be for?

What if I need extra support in certain areas to gain more confidence?

Getting to know my team/group or buddy midwives

How often will we meet and where?

How does handover work?

How do I access the notes/information for women in our team/group or buddy system?

Is there a named obstetrician for my team/group or buddy system and what is their role?

If there is more than one MCoC team/group or buddy system, how will we be working together?

What are your questions? Write them here:



Who can help you with these questions? Write them here:



"Because we're constantly handing over to each other, we see how the others work and we learn from each other. We have a team meeting every week, in which we discuss cases, share experiences and debrief... We respect each other, we are friends outside the team, and we offer to do things for each other."

(MCoC Midwife)

References

1. Care Quality Commission (2015). *2015 Survey Of Women's Experience of Maternity Care*. Available at: www.cqc.org.uk/content/maternity-services-survey-2015 [accessed November 2017]
2. Scottish Government (2015). *Having a Baby in Scotland 2015: Maternity Care Survey*. Available at: www.gov.scot/Publications/2015/12/8202 [accessed November 2017]
3. Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2015). *Midwife-led continuity models versus other models of care for childbearing women*. Cochrane Database of Systematic Reviews Issue 9. Art. No.: CD004667. DOI: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004667.pub5/abstract>
4. RCM (2017). *The contribution of continuity of midwifery care to high quality maternity care*. Available at: www.rcm.org.uk/sites/default/files/Continuity%20of%20Care%20A5%2012pp%202107_6.pdf [accessed November 2017]
5. Sandall, J., Coxon, K., Mackintosh, N., Rayment-Jones, H., Locock, L. and Page, L. (writing on behalf of the Sheila Kitzinger symposium) (2016). *Relationships: the pathway to safe, high-quality maternity care*. Report from the Sheila Kitzinger symposium at Green Templeton College October 2015. Green Templeton College, Oxford. Available at: www.gtc.ox.ac.uk/images/stories/academic/skp_report.pdf [accessed November 2017]
6. Grigg, C. P., & Tracy, S.K. (2013). New Zealand's unique maternity system. *Women and Birth* 26 (1):e59-e64. DOI: <http://dx.doi.org/10.1016/j.wombi.2012.09.006>
7. Gray, B.H., Sarnak, D.O. & Burgers, J.S. (2015). *Home Care by Self-Governing Nursing Teams: The Netherlands' Buurtzorg Model, The Commonwealth Fund*. Available at: www.commonwealthfund.org/publications/case-studies/2015/may/home-care-nursing-teams-netherlands [accessed November 2017]
8. Health and Social Care Alliance Scotland (2016). *Report on the Buurtzorg Model of Health and Social Care*. Available at: www.alliance-scotland.org.uk/wp-content/uploads/2017/10/Buurtzorg-Report.pdf [accessed November 2017]
9. RCN (2016). *The Buurtzorg Nederland (home care provider) model: Observations for the United Kingdom (UK)*. Available at: <https://www.rcn.org.uk/about-us/policy-briefings/br-0215>. [accessed November 2017]
10. North Stafford (2000). A randomised study of midwifery caseload care and traditional 'shared-care'. *Midwifery*, 16:295-302. DOI: <http://dx.doi.org/10.1054/midw.2000.0224>
11. Flint C., Poulengeris P., Grant A.M. (1989). The 'Know your midwife' scheme – a randomised trial of continuity of care by a team of midwives. *Midwifery*, 5:11-6. DOI: [http://dx.doi.org/10.1016/S0266-6138\(89\)80059-2](http://dx.doi.org/10.1016/S0266-6138(89)80059-2)
12. Tracy, S.K., Hartz, L.H, Tracy, M.B., Allen, J., Forti, A., Hall, B., White, J., Lainchbury, A., Stapleton, H., Beckmann, M., Bists, A., Homer, C., Fourer, M., Welsh, A., Kildea, S. (2013). Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. *Lancet*, 382(9906):1723-32. DOI: [http://dx.doi.org/10.1016/S0140-6736\(13\)61406-3](http://dx.doi.org/10.1016/S0140-6736(13)61406-3)



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