Is to see me to know me? Are midwives prepared for continuity models?

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Introduction

This paper aims to outline the evidence base for continuity of carer models and describe the importance of understanding what continuity of carer means to women. We consider the implication to midwives in practice and how we worked through the issues with staff to develop a pilot project for staged implementation of a continuity of care model.

Maternity services are keen to develop their facilities to ensure that women and their families are looked after in such a way as to maximise their satisfaction and achieve positive outcomes. There is often debate amongst teams regarding the provision of greater continuity of carer and models of care to enable women to have a known midwife look after them throughout pregnancy, birth and the postnatal period, whilst ensuring a good work–life balance for staff. This is a challenge for many maternity services in the UK.
Powys model

Powys maternity services are somewhat unique in being wholly midwife-led. Care is provided within the community or from one of the six free-standing midwife-led units and two midwife-led day assessment units. There is no district general hospital in the county. The midwives are the lead carers for all women (about 1200 per year).

Women classified as high-risk at booking, or who develop complications during pregnancy, are still cared for by the midwife but are also referred to a consultant obstetrician in neighbouring facilities. The health board covers 25% of the landmass of Wales, 100 miles from one end to the other and is split into two teams, north and south.

The evidence

Sandall et al (2016b:2) described the philosophy underpinning midwife-led continuity of care models:

‘The philosophy behind midwife-led continuity models is normality, continuity of care and being cared for by a known and trusted midwife.’

The authors go on:

‘midwife-led continuity is based on a premise that pregnancy and birth are normal life events.....the model of care includes continuity of care, monitoring the physical, psychological, spiritual and social wellbeing of the woman and family.’ Sandall et al (2016b:3)

These definitions seem appropriate and in agreement with the philosophy of Powys maternity services.

There is currently much debate in midwifery literature about the benefits of continuity of carer. The benefits are presented by Sandall et al (2016b) in their updated Cochrane Review, *Midwife-led continuity models versus other models of care*. They found that women who received midwife-led continuity models of care were more likely to experience a spontaneous birth without intervention and to be cared for by a known midwife; there was no noted difference in adverse outcomes. The reviewers suggested that the noted benefits were most likely associated to the process of midwife-led care itself rather than birth environment as many of the studies reviewed had taken place in obstetric units. Tracy et al (2013) highlighted the benefits to women of caseloading schemes compared to standard midwifery care. No difference was noted in caesarean section rates, neonatal Apgar scores or preterm birth. Caseload midwifery was noted to reduce women’s use of pharmacological pain relief, be related to a reduced incidence of induction of labour, and increase the chance of a spontaneous physiological birth. The study also noted a reduction in the incidence of postpartum haemorrhage and an increase in breastfeeding rates at both six weeks and six months, and overall concluded that caseloading models were a cost-effective way of providing midwifery care.

The benefits of caseloading midwifery were also highlighted by Dahlen (2016), although the author does emphasise a need for further research into the benefits specifically for younger mothers. A large study in Australia (the COSMOS trial) exploring caseloading models of care found that women’s satisfaction with care was increased when continuity of carer was implemented (Forster et al 2016).

Developing trusting relationships is a core theme in the midwifery literature on continuity. Hunter et al (2008) suggest that good-quality, caring relationships are a key feature of maternity care and should be contemplated when developing maternity care systems, as without consideration of relationship issues, initiatives to keep childbirth normal may be ineffective. In MacLellan’s (2011) discourse analysis exploring the ‘art’ of midwifery, human relationships were identified as the core thread leading to a feeling of control, confidence and satisfaction for women. MacLellan (2011) describes presence, guardianship, intuition, confidence and courage as key themes, highlighting the importance of trusting relationships gained through delivering high-quality care that features reciprocity, equality, openness, compassion and kindness. Dahlberg & Aune (2013) studied 23 women in the Netherlands and found that relational continuity gave midwives the opportunity to provide holistic care resulting in empowerment for the woman and her family. They also linked positive outcomes experienced by women to the development of trust within the relationship with a midwife.

A positive birth experience was associated with the connection that women formed with the midwife; Dahlberg & Aune (2013) suggest that this connection is based on trust, mutuality and respect. One approach to facilitating trusting relationships is caseload midwifery. McCourt & Stevens (2009:17-35), in their chapter ‘Relationhip and reciprocity in caseload midwifery’, specify the importance of midwives and women getting to know each other in a reciprocal relationship to engendering a sense of mutual trust. Women in Williams et al’s (2010) study of the value of continuity of care and caseloading in Australia also described the relationship between women and the midwife in terms of a friendship built on trust, with the women valuing the support offered by the caseload scheme. Huber & Sandall (2006) discussed the value of continuity of carer for the development of trust and supporting women with breastfeeding. They described several characteristics of continuity of carer as a model for building trust within the relationship: the bridging of life worlds, space to develop self-confidence, development of supportive relationships, and joint expectations leading to greater technical expertise and confidence. McCourt & Stevens (2009) wrote about their two research studies exploring organisation of care, specifically case holding midwifery and its effect on the emotional work of midwives and women. In their studies, the benefits of women getting to
know midwives as ‘real people’ were highlighted by midwives who described feeling valued as an individual person and not just a ‘cog in the wheel’. The midwives also described the benefits of getting to know women through continuity of care schemes which meant they did not have to consistently start over and could develop an understanding of the woman. In the report Front line care (The Prime Minister’s Commission 2010) the commission again calls for every woman to have a named midwife to provide her support and care for pregnancy and birth.

For many women today their main relationships within maternity services are with midwives. Timmis (2010), in her opinion piece about caseload midwifery, described the improved safety, effectiveness and satisfaction experienced by women who were cared for by midwives providing continuity of care. Continuity is associated by Timmis (2010) with higher levels of trust, enabling women to feel confident and able to discuss sensitive issues and their values. MacLellan’s (2011) discourse analysis of the art of midwifery described four fundamental midwifery skills identified in the literature: presence, guardianship, intuition and confidence. The author suggested that women value more than the midwife’s mere presence, but what was important was the trust resulting from knowing and understanding a woman intuitively.

When considering the evidence around continuity of carer there would appear to be two main arguments: a) continuity of carer and knowing your midwife at the birth is beneficial to women and babies and should be the aim for good-quality maternity services, and b) the focus of all maternity care should be of a general good quality, but continuity of carer schemes are too difficult to implement and sustain for midwives.

a) Midwife-led care and continuity schemes contribute to improving quality and safety in midwifery care at no extra cost to services (Sandall et al 2016b). Sandall also reported that women who receive continuity of care from a midwife are more likely to report positive experiences, have improved clinical outcomes and better coordination of care for women with a complex pregnancy.

Relational continuity allows trust to build and evolve within the midwife-mother relationship. Trust serves to empower women and midwives as a team and has been shown to increase confidence in the birth process. The women report feeling like an individual rather than just part of the crowd, and personal closeness to the midwife resulted in greater psychological trust which reduced the level of unpredictability and fear of childbirth for the woman (Dahlberg & Aune 2013). However, Green et al (1998) warned that simply meeting a midwife was not the same as ‘getting to know’ the midwife, therefore getting to know them antenatally to build trust for the birth is very important. Health outcomes are noted to improve where a positive relationship is formed. Phillips-Salimi et al (2012) described a positive relationship as one that involves a connection between midwife and mother. They defined connectedness as: intimacy, belonging, caring, empathy, respect and trust. Supportive relationships developed through continuity of care schemes have been shown to be highly valued by women and increase levels of satisfaction with care (Williams et al 2010). However, when considering the literature available it should be acknowledged that studies related to satisfaction with having a known carer are inconclusive. Women who have experienced continuity and a known midwife generally report that it is important and that they were satisfied with the model of care; studies involving women who have never experienced continuity and a known midwife for birth also generally report satisfaction and a lack of importance for continuity models of care.

b) Sandall et al (2016a) state that the evidence available does not show any significant differences between one-to-one caseloading and team midwifery where women receive care from a small team. Team midwifery may be easier to implement and sustain than one-to-one caseloading. It was suggested that to create a sustainable model, support is needed from senior management, midwives need to be recruited who are committed to the model and those not committed to the model be redeployed to other areas of midwifery. Midwives would need to be able to exercise autonomy, have well-developed links with consultants, midwives and supervisors, be in control of their own diaries and be committed to working in partnership with the woman. This makes implementing a new model for continuity difficult in existing systems where current staff may not be committed and it is difficult to redeploy and recruit. Midwives are concerned about burnout and unrealistic expectations that will impact on their work–life balance. Bowers et al (2015) describe the challenges of community midwives providing continuity during the postnatal period when visits are planned based on specific needs and when considering reduction in travel for community staff. They suggest that continuity in the truest sense would be challenging without a radical change to community midwives working hours and flexibility. Dagustun (2013) wrote of the challenges for providing continuity through caseloading due to midwives’ working practices and their willingness to provide 24/7 cover. This may cause friction where midwives have been forced to work differently. She emphasised that even from the woman’s perspective, continuity of carer works well when a midwife and mother have a good relationship. However, being stuck with one midwife could also be a disadvantage if the midwife and mother did not develop a good relationship, or if the midwife was not able to demonstrate empathy and caring.

**Strategic direction**

The Welsh government is currently reviewing its maternity strategy (Welsh Government 2011) with an
emphasis on improving antenatal and intrapartum continuity for all women, and an expectation that all health boards will look at ways to improve intrapartum continuity. The decision to develop continuity is an outcome of the Your birth - we care survey, undertaken by the consultant midwives in Wales (Welsh Government 2017), in which women identified that knowing their midwife was important to them and that the norm across Wales was to see many midwives.

The recent Better births review (NHS England 2016) recognised the importance of personalised midwifery care and has set continuity of care as a standard for all maternity units in England. The standard set by the maternity review is that women will receive care from small teams of midwives (4–6 midwives) throughout their entire pregnancy, birth and postnatal period (NHS England 2016). From our audit we know that on the whole Powys already meets this standard for antenatal and postnatal care but does not provide this to all women for birth.

A redesign of services in Scotland (The Scottish Government 2017:51) has recommended that:

‘Every woman will have continuity of carer from a primary midwife who will provide the majority of their antenatal, intrapartum and postnatal care and midwives will normally have a caseload of approximately 35 women at any one time. Where women require the input of an obstetrician in addition to midwifery care, they should have continuity of obstetrician and obstetric team throughout their antenatal and postnatal care. Midwifery and obstetric teams should be aligned around a caseload of women and should be co-located for the provision of community and hospital-based services. Early adopter NHS Boards should be identified to lead the change in practice. Implementation should ensure appropriate education, training and development and realignment of resources is achieved, recognising the potential for additional resources to be required during implementation’.

**Powys response**

As a result, Powys Maternity Services set up a task and finish group to explore the options for care provision. As a first step to this process an audit was carried out on 50 sets of notes to obtain a baseline figure for the level of continuity currently received. The management team agreed a best practice standard that each woman would ideally be allocated a named midwife responsible for completing the booking and the birth plan as a minimum and that women on average should not see more than three different Powys midwives in total. It was considered ideal if women who birth in Powys were cared for by a midwife they had met but felt unlikely that this would currently be achieved.

The standard of having a named midwife completing the booking and the birth plan as a minimum was looked at. The majority of women (46/50) were booked by their named midwife, however, not all women were booked by their named midwife (four) and some women (14) did not have a birth plan with the named midwife.

In terms of antenatal care, the numbers of Powys midwives seen by women ranged from 1–6 in total giving an average number of three. This was in line with the standard set for most women though several women did see more than three midwives (ten). In the postnatal period the number of Powys midwives seen ranged from 1–5 with the average number seen again within the standard of three. The audit did not look at whether the midwives seen postnataally were different to those seen antenatally which would have impacted on the total number of midwives seen across the care pathway. Of the women who birthed in Powys, just over half the women were cared for by a midwife they knew (this was predominantly women who had had a baby before and had met midwives in a previous pregnancy as well).

In preparation for our first continuity of care task and finish group, a SurveyMonkey questionnaire was carried out via the Bump talk (user group) Facebook page to gather initial information from women and their families about their experience of knowing their midwife and how important this concept was for them. We had 64 responses over the three-day period that the survey was ‘live’.

According to Powys’ policy all women are allocated a named midwife who is responsible for coordinating that woman’s care throughout her pregnancy and the postnatal period. Respondents were asked whether they knew who their named midwife was. The majority, 85%, said that they knew who their named midwife was by name. However, 12% of respondents said that they did not know or had not been allocated a specific individual midwife. The majority of respondents felt that having a known midwife was important. The majority felt it was important to have a known carer providing their postnatal care. There is much debate in the midwifery literature about the importance of having a known midwife to look after you when you give birth. Continuity of carer for labour and birth is a challenge to provide in Powys and would require a significant shift in how midwives work.

Respondents were asked whether they had been cared for by a midwife whom they knew. The majority of respondents said that it was important for them to have a midwife whom they either knew or had met prior to birth. We went on to ask the respondents how many midwives they thought it was reasonable to see overall when receiving care. The majority felt that a small number 1–3 midwives would be reasonable.

Respondents were asked to rank in order of preference the different models of care that could be considered when exploring different ways of working. The highest ranking option was care from a small team of midwives.
(three), second highest ranking was care from one midwife working with a partner midwife, and third highest was one-to-one care with just one midwife. From this brief survey it would seem that knowing your midwife is important to women and models for improving continuity would be received well.

To see me doesn’t mean you know me

Discussions have focussed on what it means to have a ‘known midwife’, antenatal continuity versus known midwife in labour, and sustainability of a new model in practice.

The client group were engaged in an online chat through the Bump talk forum asking them what they felt it meant to have a known midwife and whether this was important to them. Twelve women participated in the online chat group. Opinions varied amongst the women in relation to ‘knowing the midwife’ and were predominantly based on their own personal experiences. Some of the women were very positive about their experiences with midwives whom they had got to know and felt that antenatal continuity was of absolute importance. The women also indicated that having a known midwife in labour would also be valued, however, the women expressed a high level of care for the midwives and suggested that while they might like to know the midwife who looked after them, they were concerned that this expectation was unrealistic for the midwives to provide it. When asked what it would mean to ‘know the midwife’ generally women suggested that they would have to have met them more than once to feel that they knew them. The quotes below represent some of the comments received during the chat:

‘I would really like to have met them properly, as in had a chat at the birth centre or had at least one appointment with them. I do appreciate that this is an ideal scenario though, as depends on when you actually go into labour etc.’

‘I was really lucky because the midwife that I saw for most of my appointments throughout my pregnancy also helped to deliver my baby at home! I know that realistically it can’t always happen that way but it did make the experience even better. I can’t fault the care I received during my pregnancy, labour and postnatally, I thought the midwives were fantastic!’

‘I really wouldn’t mind at all as long as there were detailed notes. There’s nothing more frustrating than going over the same thing several times.’

‘I’m 36 weeks now and I desperately want my midwife to be there when I give birth as I feel that a new one around will only stress me out and slow down/stop my labour. I’m quite a sensitive person and I feel that having my midwife there, someone who’s been through the whole pregnancy with me will be very helpful and calming.’

‘I have been luckily enough to have all four of our children at home, three of our children were delivered by my community midwife, had I not built a relationship of trust with my midwife I’m not sure would of my pregnancies and labours gone as well as they did.’

‘I found that for me the part where it’s vital that you have a relationship with your midwife is for the appointments following the birth, helping you get to know your baby and support with feeding, someone who you have shared your anxieties with before so they can support you with your concerns. I found that my 36 week appointment put to bed my worries about the birth particularly the second time around and provided I had a confident midwife at the birth I felt ok. Fortunately, having met most of the midwives during both babies I knew my delivery midwife already and she was fantastic as were all the other midwives I met along the way. There’s is something really lovely about having the same midwives heavily involved in the arrival of all of your babies, I felt really sentimental at my last appointment and really grateful.’

Are midwives ready for continuity?

The task and finish group also surveyed midwives to gain a better understanding for what midwives see as important in relation to continuity. Many midwives have raised concerns about the potential new model and what effect it may have on their personal life and on-call commitments. Sample rotas were also circulated. These were not intended to cover every eventuality, to represent a whole off-duty, or the cover provided by the whole north/south team, but rather to show different patterns of on-calls that could potentially work if midwives adopted teams of 3–4. The following responses were received from the midwifery teams:

‘This model of care would work for me personally but with a much smaller caseload of women to make it practical and ensure periods of time when not on call. Also it would be helpful to have a ‘buddy’ midwife who could cover sickness or act as second midwife.’

‘Yes I would be in favour of this, as long as it didn’t mean more on call (more than two per week or three over weekends); but would be concerned for a midwife’s work/life balance and am not sure those with small children or elderly relatives would be able or willing to offer this.’

‘I am absolutely against more on calls to be able to cover our own women in labour. If I am working then of course will care for own lady but do not want to be committed for all of my ladies.’

‘So within Powys, the difficulty will be annual leave and maybe burn out. If your caseload is moderate it should work but would mean being on call 24/7. I think there are quite a few midwives that would not be happy to do this.’

‘There would be no work/life balance for me and my family. My marriage and family are more important
to me than providing care to all my own low risk women in labour!’

‘Women do not expect this and are completely understanding when advised that their named midwife may not be at the birth. The model of care needed to provide this service is not sustainable. I feel it would be a big change in the system for very little benefit.’

‘Also my understanding from user questionnaires is that antenatal and postnatal continuity is more important to women, and that having your named MW present at your birth is just a bonus!’

What are the challenges faced when trying to implement continuity of carer models?

The majority of answers from midwives focused on the importance of work–life balance, family commitments and a reluctance to give more on-call commitment to the service. There appeared genuine concern for sustainability of the model and risk of burnout. During a recent travel scholarship visiting New Zealand, one of the authors (Marie) was fortunate to spend time with midwives and observe the partnership continuity model there. Marie was struck by the number of midwives who reported feeling burnt out, and the current issues around recruiting lead maternity carers.

Marie went to New Zealand with very firm beliefs about the advantages of one-to-one care and building relationships with women. She had not really considered, however, the longevity of such models — the impact of burnout and the potential disadvantages when a woman doesn’t connect well with the midwife. The women she met in New Zealand were very clear that having one midwife doing all of your care didn’t always result in them feeling safe, particularly when that midwife had a large caseload, or was tired or stressed. However, some midwives and women in New Zealand had adapted the model to work in pairs or small groups of four, which appeared to result in similar levels of satisfaction and was more sustainable and the women reported feeling safer. One woman described it as:

‘One midwife but with two bodies - two eyes, two ears and two brains to look after me.’ (Lewis 2018)

For some midwives in Powys, the responses indicated a belief that women do not care whether they know the midwife looking after them in labour, and that women are content with not knowing the midwife so why should they put themselves out to provide this?

Wickham (2008), in her opinion piece, suggested that the incidence of doula support in UK births was rising as a result of negative experiences of NHS maternity care. Anecdotal evidence from contact with doulas in another health board would appear to support this view. Stockton (2010), in her description of the role of doulas, suggests that women can benefit from their support. That doulas will spend time ‘being’ with women, building a rapport and gaining the woman’s trust and respond to the woman’s individual needs. We would suggest that in part this is possible when the individuals get to know each other over the antenatal period and form a relationship. Wickham (2008) suggests that where midwives are unable to provide the service that women want, women will no longer want midwives; this is important to consider when exploring the concept of continuity of carer and its facilitation of trust between midwife and mother. If midwives are unable to understand what women are placing trust in them to do, they are unlikely to be able to uphold that trust, resulting in a withdrawal of trust in midwives. It is therefore essential for research to be carried out to develop understanding of the concept of trust, what it means to women and how continuity of carer for intrapartum care can facilitate this. In Marie’s PhD study exploring trust in the midwife–mother relationship, women clearly articulated a desire to get to know their midwife, with the identified goal being preparation for the day of the birth (Lewis 2017). Feeling safe has been explored from various contexts within the midwifery literature: in Anderson’s (2000) Chapter (5), Feeling safe enough to let go, the author discusses her grounded theory research involving 16 women and their experiences of the second stage of labour. She described women’s accounts of their fears during this intense stage of labour and highlighted that a woman’s predominant fear was of losing control. Anderson (2000) also described the need for a woman to feel safe in naturally ‘letting go’ and allowing her body to be in control.

The women in Anderson’s (2000) study suggested that the midwife was crucial in allowing them to feel safe in entering this altered consciousness — letting go psychologically in order to give birth. This would leave women vulnerable to the power of those surrounding them and would indicate the importance of knowing the midwife and trust between midwife and woman.

For many women today their main relationships within maternity services are with midwives. Timmis (2010), in her opinion piece about caseload midwifery, described the improved safety, effectiveness and satisfaction experienced by women who were cared for by midwives providing continuity of care. Continuity is associated by Timmis with higher levels of trust, enabling women to feel confident and able to discuss sensitive issues and their values. MacLellan’s (2011) discourse analysis of the art of midwifery described four fundamental midwifery skills identified in the literature: presence, guardianship, intuition and confidence. She suggested that women value more than the mere presence of a midwife but that what was important was the trust resulting from knowing and understanding a woman intuitively.

Are midwives confident to provide continuity to all women?

Some of the midwives’ responses indicated a lack of confidence in providing intrapartum care to all
women and fear about midwives’ ability to move through the care pathway with women:

‘A small team would and could work well, however I am not keen to follow women into DGH as I class myself as a specialist in giving low risk intra-partum care and feel that I would not benefit the high risk women by trying to care for them in labour in an environment where I do not feel comfortable. In my experience, most women if informed from the start they would be looked after by a hospital based midwife in labour, will be happy with this.’

‘I would prefer to remain with the essence of community care and I’m not interested in going into high risk area I left my last job to move to community.’

‘This is not a model of care I would like to adopt. High risk women should be cared for by midwives who work in this field every day, I do not feel I am specialist enough to give the best care.’

‘I would not want to regularly work in a DGH/high risk setting and have the uncertainty of where I will be working on a day to day basis. I would not feel able to care for women well (or safely) in DGHs where I am uncertain of policies/Drs/team members/ where equipment is etc.’

Way forward for Powys

Following much discussion and debate the group felt that it was very difficult to propose a model of change for the entire service. Some of the staff comments and those of the women demonstrated a lack of understanding for how a caseloading model could or should work. It was noted that the topic had generated a high level of emotion within the teams and that the group had been unable to conclude a best practice model as midwives were unable to visualise how such a scheme could work within our current culture and practice. It was acknowledged that some midwives’ comments indicated a lack of accurate information about the work of the group, such as being asked to work 24/7, being on-call for the entire period that the woman is due, and having less antenatal continuity as women would see all four midwives. However, this was not how the planned caseloading model would be implemented, as the group had never suggested pure 1:1 caseloading.

Therefore, it was felt that rather than recommend a change or not to the current service model it would be advantageous to recommend a clinical pilot caseloading scheme in one area of Powys. This would allow midwives and women to experience how the new model could be developed and delivered that was sustainable and acceptable while still achieving evidenced-based care. The pilot caseloading model would use midwife volunteers and explore over a 12-month period how this scheme could work in Powys. The scheme would be evaluated with input from an independent practitioner. The outcome of the pilot evaluation would then be used to influence the decision for service change or not and at that point the process for implementing such a change would be followed. The pilot commenced in April 2018.

Conclusion

Continuity of carer appears to create emotive responses from women and midwives, sometimes appearing to be in direct opposition to each other. Whether this truly reflects all midwives’ and women’s views is difficult to ascertain through a survey review, as the method inherently appears to attract those to comment who feel the most passionate about the subject. Developing models to meet both sides appears to be an enormous endeavour and can be deeply frustrating for all, as each side appears to be given more credence than the other. Dipping the Powys toes through a pilot into improving continuity feels to be a prudent and sensible approach. The future feels both exciting and daunting — watch this space…

Declaration of interest

Both authors have worked previously in full continuity/caseloading models and enjoyed it.

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References


