

# Position Statement

## Continuity of midwife-led care



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This paper discusses continuity of carer. It focuses on continuity of care which is midwife-led and in so doing does not discuss continuity of carer when another professional may be the lead. It also focuses on the evidence base which refers to and describes midwife-led continuity of care. This terminology is therefore used throughout the paper. There may be other mechanisms for developing relationship-based care but to date these have not been researched.

### RCM Position on Continuity of Carer

The RCM is advocating for each pregnant women and new mother to see as few different midwives and other maternity staff – such as Maternity Support Workers – as possible across the whole maternity journey. Women should have the opportunity to form trusting relationships with midwives and others. We believe that this should be the aspiration for all maternity services.

### Background and context

Across the UK a policy intention for maternity services is for them to become safer and more personalised. The most recently published policy document is the National Maternity Review in England titled *Better Births*<sup>1</sup>. It states that,

'Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care: and where she and her baby can access support that is centred around their individual needs and circumstances.'

It continues,

'And for all staff to be supported to deliver care which is woman centred working in high performing teams in organisations which are well led and in cultures which promote innovation continuous learning and breakdown organisational and professional boundaries.'

NHS England and the Department of Health have committed to taking the recommendations of the Maternity Review forward<sup>2</sup>. Similarly, the other countries of the UK mention continuity of carer as a direct policy intention:

- Scotland: *A Refreshed Framework for Maternity Care in Scotland* (2012)<sup>3</sup>
- Wales: *A Strategic Vision for Maternity Services in Wales* (2011)
- Northern Ireland: *A Strategy for Maternity Care in Northern Ireland 2012-2018* (2012).

The RCM believes care which is based on a model which increases the likelihood of women being seen throughout pregnancy, labour and the postnatal period by a midwife or a small team of midwives they know and trust should help to deliver this policy intention as it enables a relationship to develop.

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# Background and context

Continuity of midwife-led care is endorsed across the UK because it is an evidence-based maternity service model which has been shown to result in high levels of satisfaction for women and improved outcomes.

Continuity of midwife-led care has been shown to result in improved outcomes including<sup>4</sup>:

- women are 7x more likely to be attended at birth by a known midwife
- 16% less likely to lose their baby
- 19% less likely to lose their baby before 24 weeks
- 15% less likely to have regional analgesia
- 24% less likely to experience pre-term birth
- 16% less likely to have an episiotomy.

Further, both the Scottish and English Maternity Experience surveys from 2015 find that women who had continuity of midwife-led care were more likely to have more positive maternity experiences than women who didn't. For example, in the CQC England survey<sup>5</sup>, experiencing continuity of carer was positively correlated with getting consistent advice, getting help when contacting a midwife, feeling listened to, and having confidence and trust in the midwives. In Scotland, seeing different midwives was frustrating for women, and they associated this with poorer communication and inconsistent information and advice<sup>6</sup>.

Every maternity service should therefore be developing models of care based on continuity of midwife-led care. Such models should be based on the same principles as outlined in the evidence base.

These are the following.

- A single midwife known to the woman provides care and sees her consistently throughout pregnancy and postnatally and is her main or first point of contact.
- That midwife co-ordinates and navigates care for the woman, is an advocate for her and maintains oversight.
- The model may be based on caseloading where one midwife provides the majority of the care handing over care to a partner the woman knows if she should be unavailable, or may be based on team care where a woman has a named midwife but meets the small team of midwives<sup>7</sup> during her pregnancy and that team share out-of-hours cover.
- Midwives in the model can be community or hospital-based.
- Midwives can look after a population encompassing all clinical risk or those of lower clinical risk.
- Midwives form positive relationships with the wider multidisciplinary maternity team to ensure ease of referral.

A strategic and dedicated approach needs to be taken to the introduction of continuity of midwife-led care models. Such an approach would involve the following.

- Commissioners/planners in partnership with local providers defining the continuity model they wish to implement, building the requirement for such models into their service specifications and workforce planning processes.

- Commissioners/planners working with providers ensuring the appropriate financial resources are in place to deliver continuity of care and that they are targeted in the right place.
- Commissioners/planners and providers benchmarking current provision of continuity of midwife-led care against which progress can be measured.
- Key performance indicators for maternity services being developed including measures on continuity of midwife-led care with particular attention to populations such as socially vulnerable women and/or those with complex medical and obstetric needs. Maternity information systems would support the gathering of such evidence.
- Ensuring that every midwife and student midwife has an understanding of the evidence base that supports continuity of midwife-led care models.

## Necessary conditions for implementation

The introduction of continuity of midwife-led care models across maternity service requires a significant change in maternity service provision and particularly requires most midwives to work very differently from at present.

Certain conditions are necessary if midwifery-led models of continuity of care are to be successfully introduced and maintained for the long term.

These include the following.

- Maternity services must be funded and staffed appropriately<sup>8</sup>. This should be judged against the recommendations in NICE Safe Staffing Guidance<sup>9</sup> with due regard to specific local need.
- As the RCM and the NICE Safe Staffing Guidance advocates for sufficient staffing for every part of the service<sup>10</sup>, midwives working within a continuity of carer model will not routinely be expected to cover for shortages in other areas of service, unless in exceptional circumstances.
- Midwives must have the autonomy to develop their own working patterns which recognises their work-life balance and supports their own health and wellbeing like that of the women they care for.
- Midwives working within a continuity of carer model must be supported through an initial and continuing education programme helping them to work constructively together as a high performing team.
- Midwives working in a continuity of carer model must agree to the outcomes they are expected to achieve, measuring those outcomes and being prepared as a group to work towards achieving these outcomes.
- Pay, terms and pensions of those providing continuity of carer must be fair and reflect working patterns adequately. To this end, it is imperative that the Agenda for Change contract is used to its fullest and those flexibilities around on call, overtime and annualised hours, for example, are subject to negotiation with the RCM.

## Further considerations

Given that the introduction of midwife-led models of continuity of care requires a major change in the provision of maternity care the RCM recommends the following.

- The introduction of these models is evolutionary.
- These models develop alongside traditional maternity services provision with the balance between new models and traditional models gradually changing and the need for the number of midwives working in the new models and the traditional models carefully and continually assessed.
- Further research is undertaken to better understand the costs and potential savings associated with continuity of carer and the experiences of staff working within continuity models.
- High quality maternity leadership that supports innovation is fostered and rewarded. Workplace cultures develop that raise morale and promote shared trust and personal responsibility.
- Different approaches to staffing are considered, such as how part-time workers can be integrated into new models of care or how to make the best use of Maternity Support Workers.
- Maternity services consider working collaboratively with midwives who have already developed models of service delivery based on continuity of carer, but who may be working outside of typical NHS employment models.

## References

<sup>1</sup> The National Maternity Review (2016). *Better Births. Improving outcomes of maternity services in England. A Five Year Forward View for maternity care.* <http://ow.ly/tcAW300BKBt>

<sup>2</sup> Parliamentary Question in the House of Commons. *Maternity Services: Written question – 3595.* 27 April 2016. <http://ow.ly/5hVE300BKFD>

<sup>3</sup> It is unlikely that the 2016 review into maternity and neonatal care in Scotland will move away from endorsing continuity of midwife-led care.

<sup>4</sup> Sandall J, Soltani H, Gates S, Shennan A, Devane D. (2016). Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews* 2016, Issue 4. Art. No.: CD004667. DOI: <http://ow.ly/UDIS300BKPJ>

<sup>5</sup> Care Quality Commission (2015). 2015 survey of women's experiences of maternity care: Statistical Release. <http://ow.ly/h0Jo300BKRG>

<sup>6</sup> NMAHM-RU and Scottish Government (2015). Having a baby in Scotland 2015: listening to mothers. An Official Statistics publication for Scotland. <http://www.gov.scot/Resource/0049/00490953.pdf>

<sup>7</sup> Current successful modules in the UK are typically based on teams of 6–8 midwives (see 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. [http://www.gtc.ox.ac.uk/images/stories/academic/skp\\_report.pdf](http://www.gtc.ox.ac.uk/images/stories/academic/skp_report.pdf)). The latest Cochrane review is inconclusive on the exact size of the team for the best benefits from midwife-led continuity, but within the studies reviewed a form of midwife-led continuity is 'team midwifery' whereby a woman will receive her care from a number of midwives in a small team, the size of which can vary (see Cochrane Database of Systematic Reviews 2016).

<sup>8</sup> The National Maternity Review 2016.

<sup>9</sup> NICE (2015). Safe midwifery staffing for maternity settings [NG4]. <https://www.nice.org.uk/guidance/ng4>

