Better Start Bradford Innovation Hub

Continuity of Carer
End of Contract Report - July 2020

This is a report provided by the Better Start Bradford Innovation Hub (BSBIH) for the Better Start Bradford (BSB) and the Continuity of Carer (Clover) team. The document provides an overview of the Continuity of Carer project's performance and findings from the implementation evaluation. The design of this evaluation is described in more detail in the Evaluation Plan Summary, which was approved by key stakeholders from the BSBIH and BSB in Nov 19.

Authors: Sara Ahern, Laura Bates, Kathryn Willan, Charlotte Endacott, Tracey Bywater, Maria Bryant, Josie Dickerson, and the Better Start Bradford Innovation Hub

Version 3.0

Approved by:

Tracey Bywater Innovation Hub Academic Lead

Maria Bryant Innovation Hub Academic Lead

Josie Dickerson Better Start Bradford Innovation Hub Director

Produced for Better Start Bradford

Executive Summary

Project overview

The Continuity of Carer project is a relationships-based model of midwifery care where a named midwife co-ordinates and personally delivers the majority of care to each woman and her baby during pregnancy (the antenatal period), during labour and at the birth (the intrapartum period), and the early weeks as a new parent (the postnatal period).

In this model, the named midwife is backed up by a 'buddy' midwife or a small team of midwives. This allows the woman and her midwife to get to know each other well and to build a trusting relationship. The project is universal but allocated on a blinded case selection basis and based on capacity.

This project is a partnership between Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) and Better Start Bradford and is delivered by the Clover team. It builds on previous work delivering personalised midwifery (provided by the Opal team) between 2015 and 2018. For details of this project evaluation please see the BSBIH Personalised Midwifery End of Contract Report which can be requested from the Innovation Hub team.

The current report provides findings from an evaluation of project delivery between 1st March 2019 and 29th February 2020 and includes a range of data sources including project monitoring data, a questionnaire survey and qualitative interviews with midwives and women.

Project performance

Implementation

The target for implementation was for Clover midwives to have a maximum caseload of 25.
The proportion of Clover midwives working within this caseload maximum was 100%. With an average caseload of 20.
This means the project is in GREEN.*

Fidelity

The continuity target was that all women would see their named midwife or 'buddy' for at least 70% of their appointments and during labour/birth. 48% of women received this level of continuity, placing the project in RED.*
99% of women had continuity during the antenatal period, 66% during the postnatal period, and 53% at birth.

Satisfaction

The target was for all women to report their overall care as 'definitely good' via project questionnaires.
Of the 47 women that completed a questionnaire, 89% reported this level of satisfaction with their care at every time point .
This means the project is in AMBER.*

*See Appendix (page 10) for progression criteria cut-offs

Recommendation 1

Continuity models of care aim to enhance birth outcomes for women but numbers included in this evaluation are too small to assess impact on birth outcomes. Findings do demonstrate, however, that continuity at birth was only achieved for half of women, and suggest it is not a as highly valued as other components of the model. Midwives report that it causes challenges due to a lack of skills and difficulties in the usual labour teams. Midwifery should consider the value of the intrapartum continuity and, if it is deemed essential, this model should to be reviewed to establish how better levels of continuity can be achieved.

Recommendation 2

As was found in the previous evaluation of the Personalised Midwifery model, continuity can be achieved in the antenatal and postnatal periods and is highly valued by women and midwives as a way to develop relationships, build trust and enable discussion of mental health concerns. Key components of the model were found to be the same as those identified by the Opal team: flexible appointments, reduced caseload, MSW support. Pre and post-birth continuity of care for women living in disadvantaged area is achievable, highly valued and may enhance support of mental health issues. There would be benefits to rolling this model out to other disadvantaged areas in the City.

Recruitment and reach

How many women received the service?

176
women supported

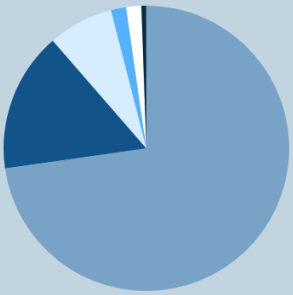
176 women were supported by the Clover team, including those who transferred over from the previous Personalised Midwifery project, Opal team. Accounting for multiple pregnancies, a total of 188 pregnancies were supported.

The target for the project was to support (or book) a minimum of 150 women per year. This means the project reached 117% of its target,

188
pregnancies supported

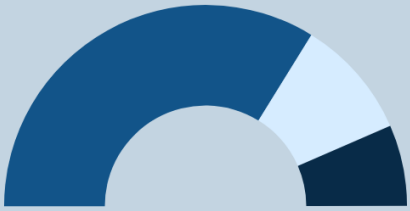
Who were the women who received the service?

Ethnicity*



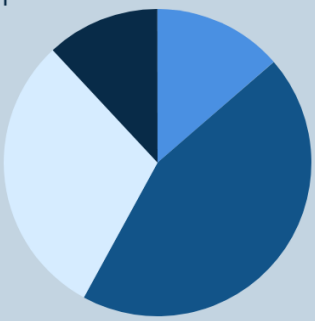
- Asian/British (72.73%)
- Not Stated (15.91%)
- White (7.39%)
- Black/African/Carribean/Black British (1.7%)
- Mixed/Multiple Ethnicity (1.7%)
- Other ethnic group (0.57%)

English language ability*



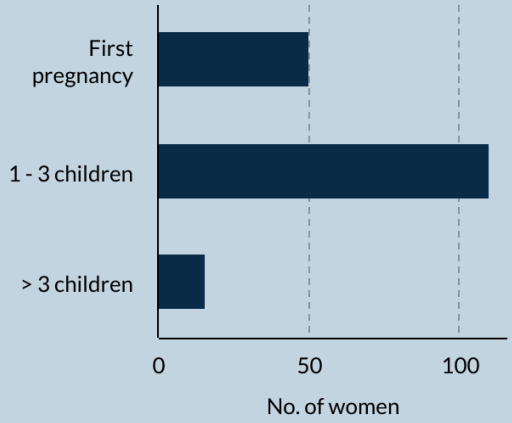
- Fluent in English (67.61%)
- Difficulty understanding English (19.32...
- No understanding of English (13.07%)

Age group*



- < 24 years (13.64%)
- 24 - 29 years (44.32%)
- 30 - 35 years (30.11%)
- > 35 years (11.93%)

No. of children*^



*values taken from women's first booking record ^no. of live births women had at time of booking for this pregnancy

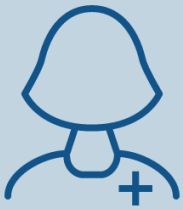
Implementation

Was the project implemented as planned?

The Clover team

As per the project logic model the Clover team comprised of a Band 7 Project Lead, 6 midwives , a Maternity Support Worker (MSW), and a ward clerk (admin). 1 midwife left the team and was replaced and a further ward clerk joined the team towards the end of 2019.

The project logic model states that a full spectrum of skills are required to provide caseload-care although there are no details provided of exactly what competencies should be acquired. Midwives attended a range of training over the course of delivery, an average of 11 types of training per midwife (min 1 max 17).



9/11 members of the Clover Team received Quality Improvement training

Pre-booking visits

Pre-booking visits by MSWs were previously found to improve access to care by reducing language barriers (by promoting better provision of interpretation and longer appointments), and increasing practical support (via home visits and clinics in well known community venues)

Nearly all the women supported by Clover team received a pre-booking visit. 173 women were offered visits (98% of women being supported by the Clover team). Of these 155 (90%) accepted and received a visit.

85% of pre-booking visits were undertaken by an MSWs with others completed by the wider Clover team.

of women were offered a pre-booking visit

of those offered a visit received one

Midwives' caseloads

Another key element of this project was managing reduced caseloads, i.e. the number of women that could be allocated to a midwife. Caseloads were to be capped at 25 women per year per midwife (pro rata) for 6 months rising to 30 per year if safety and workforce well being were maintained.

The target was therefore for midwives to have a caseload of 25 per year. 100% of midwives operated within this maximum caseload, with an average caseload of 20.

of midwives operated within maximum caseload

Implementation

Was the project implemented as planned?

Continuity of carer

The project aimed to ensure that all women received at least 70% of their care from their named midwife or buddy during the antenatal, intrapartum, and postnatal periods. 134 women had had their babies at the time of reporting and therefore had opportunity to receive care at each stage.

Continuity

Antenatal

Antenatal data recorded for n=134

99%

of women received >70% of antenatal care from their named midwife or buddy

100%

received >70% of antenatal care from the Clover team

Intrapartum

Intrapartum data recorded for n=134
but data about specific staff present n=129*

50%

of women received intrapartum care from their named midwife or buddy*

53%

of women received care from a known midwife at birth

Postnatal

Postnatal data recorded for n=118

54%

of women received an inpatient postnatal contact from Clover team

66%

of women received >70% of outpatient postnatal care from their named midwife or buddy

92% of women received >70% of outpatient postnatal care from the Clover team

Of women with data at all time points

48%

received >70% of **all care** from their named midwife or buddy and knew their midwife at birth

n=118 with complete data

* This is a result of how data is recorded and extracted from the system, not a failure to record by Clover Team

Qualitative findings

What midwives and women said about the model of support:

We interviewed XX midwives from the Continuity of Care (Clover) team and XX from the wider maternity service as well as 3 women who received their community midwifery care through Clover team to further explore implementation of the continuity model, the impact on women and midwives as well as considerations for further development of the model. Key themes from the interviews are presented below.

Managing expectations:

Clover team set expectations of the service early in women's pregnancies. Women reported understanding what to expect from the service, felt they could call anytime for support and knew in advance whether their named midwife would be present at the birth of their baby

Clover midwives reported broadening opportunities for mothers to meet the wider Clover team, through the GTT antenatal clinic and parenting advice sessions, increasing the number of 'known' staff and optimising women's experiences of some form of continuity. (See quote 1)

Discussions continue around the key point for a named midwife to support women during the intrapartum period. Clover midwives reported that attending labour and birth is the most difficult part of the model to implement but felt that this was not necessarily detrimental to women See quote 2)

"so as a team if we know the woman is due then we'll try to facilitate a meeting beforehand to go over her birth plan so she's seeing that familiar face again"
Clover midwife
1.

"the women in my caseload, they have not been remotely bothered, It's almost like it's the least important bit, they just want somebody to be kind"
Clover midwife
2.

Promoting well-being

Midwives reported that they felt the model enables staff wellbeing to be prioritised and promotes women and midwife welfare

Clover midwives felt the trusting relationship they developed with women allowed them to disclose mental health issues earlier. Similarly women reported feeling able to discuss their low moods and mental health

Clover midwives reported that continuity in the postnatal period promoted the disclosure, identification, and monitoring of women's mental health needs. They felt it allowed needs to be captured that would have been missed under traditional community care model

Women reported feeling well supported and felt able to talk about issues with their midwives (See quote 3)

"I know she wasn't my best friend, but I could talk to her like one"
Mum
3.

Facilitated implementation | Challenge implementation | Perceived positive impact | Perceived negative impact

Qualitative findings

What midwives and women said about the model of support:

Skills, capacity and resources:

Clover midwives reported that the model was vulnerable to staff shortages (e.g. long-term sickness) until changes were made to the on-call and off-duty pattern to reduce risk of burnout and prioritise staff well being.

Clover midwives reported that scheduling appointments to correspond with translator availability (compared to fixed scheduling practiced by community clinics) facilitates improved provision for women with language needs. Midwives felt this better supported informed decision making and risk management for these women (See quote 4)

Midwives felt that upskilling MSWs to undertake pre-booking appointments, venepuncture, baby care, baby heel prick testing and breastfeeding support has freed up midwives' time for appointments and preparation for on-call

Clover team facilitate informed choice around home birth for low risk women but reported not having their own equipment. Clover have requested approval for another home-birth kit bag.

> *"the women who initially start their pregnancy journey needing an interpreter for all of their translation, by the end, they're actually trying to speak English and they're becoming more confident"*
> **Clover midwife** 4.

The wider maternity context:

Clover midwives are considered an additional resource in maternity particularly supporting low risk births in the birth centre. Clover midwives report receiving good support from senior staff in the units

Both core and Clover team midwives acknowledge a competency deficit within Clover team at birth. Missing competencies amongst some midwives (e.g. suturing) and low confidence puts a strain on existing resources particularly for high risk populations (See quote 5)

Midwives felt that the separate funding and management of the Clover team creates inequity for midwives and women.There is concern within the wider maternity service around the current inequity of care offered to women in Bradford (see quote 6)

To improve integration into wider maternity, an SOP was created explaining how to identify Clover women and when and how to call in Clover midwives. However, midwives at the birth centre report feeling a dilemma as to whether to follow the SOP when women say they are happy to birth with core staff

> *"we do strive to support them but it has been at a cost to us emotionally and physically because its just relentless"*
> **Labour ward midwife** 5.

> *"I think the women in Clover team are lucky because they get continuity of a small team of faces whereas community midwives might have a caseload of 92"*
> **Core midwife** 6.

Facilitated implementation | Challenge implementation | Perceived positive impact | Perceived negative impact

Qualitative findings

What midwives and women said about the model of support:

Key findings from the interviews have been summarised in relation to the specific periods of service delivery for women.

Continuity

Antenatal

Continuity during antenatal home visits and flexible appointment times supports relationship development, and promotes confidence in women to communicate (including attempting English where English is not a first language), and enables midwives to follow up on their care needs

Postnatal

Women and midwives reported continuity of carer and extended postnatal care (up to 6 weeks) to be essential to the mother's emotional and mental wellbeing.

Established relationships and continuity at home promoted disclosure, identification and ability to monitor and support women's mental health needs that may have been missed under traditional community care, with earlier discharge and potentially less familiar midwife

Intrapartum

Continuity during the intrapartum period has been hardest to implement. The easiest component being labour assessments at home, which have offered women reassurance and advice on when to present at hospital.

Continuity during labour care and birth has been challenging because of the unpredictability of birth.

Changes made in February to the on-call and off-duty mean midwives now take a team approach to continuity and helping to avoid burnout.

Women appreciate receiving labour care and birth support from their named midwife but where this is not provided, disappointment appears to be short lived.

"*providing the core midwife is kind*"
Clover Midwife

Women's satisfaction

What women said about the support they received:

47 women supported by Clover team completed and returned questionnaires so results should be interpreted cautiously as this is a small sample with risk of bias.

16 (42%) were first time mothers
29 (63%) spoke English as first language

Choice is an important element of this model

98% of women said they were **always** given choice about their care during pregnancy

87% of women said they were **always** given choice about their care during labour & birth

96% of women said they were **always** given choice care for themselves and their baby postnatally

Women's experience of antenatal care

100% of women said they were **always** listened to during antenatal check-ups

98% of women said midwives **always** supported their health during pregnancy

96% of women said they were **definitely** given information about breastfeeding

93% Overall care in pregnancy was 'definitely' good

Women's care during labour and birth

91% of women said they were **always** listened to by the midwives

96% of women said they were given the support they wanted

96% Overall care in labour & birth was 'definitely' good

Women's experience of postnatal care

89% of women said they were **definitely** given enough information about possible emotional changes after birth

98% of women said they were **definitely** given the help they needed to care for their baby

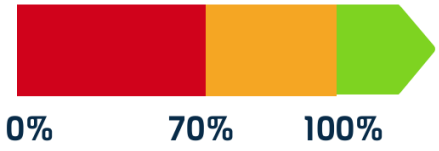
98% of women said they were supported with their health after birth

96% Overall care postnatally was 'definitely' good

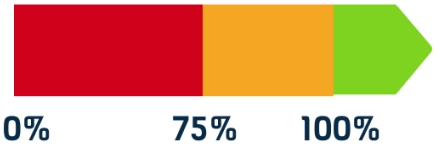
answered the question with the stated answer

Appendix - Progression Criteria Cutoffs

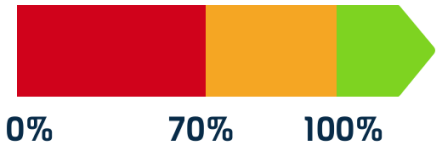
Recruitment



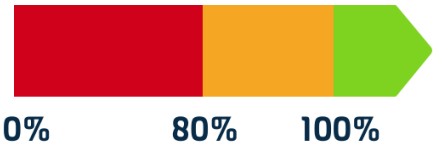
Completion



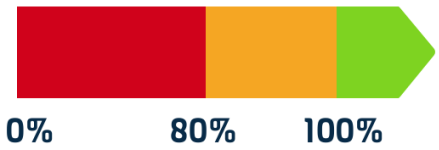
Reach



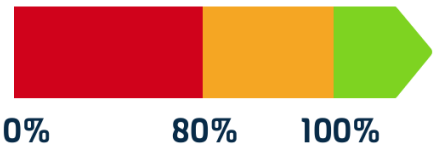
Fidelity



Implementation



Satisfaction



For more information on how progression criteria and associated cut-offs have been developed please see Bryant, et al., 2019 Use of progression criteria to support monitoring and commissioning decision making of public health services: lessons from Better Start Bradford. BMC Public Health