# Supporting and Sustaining Continuity of Carer in Practice (SCCIP) across Lancashire & South Cumbria: A service evaluation

**Authors:**

Dr Anna Byrom, Dr Claire Feeley, Naseerah Akooji, Professor Gill Thomson

**THRIVE research centre**

University of Central Lancashire


**June 2021**

# A. Background

The conclusion of the maternity review '*Better Births'* was that the maternity services should be safe and personal [1]. Continuity of Carer (COC) was one of the main proposed changes in policy and has been at the heart of the National Maternity Transformation agenda[2]. However, existing models of maternity care, throughout England are fragmented[1]. A variety of COC teams have emerged around the country, with some pre-dating the policy guidance. In some places there is minimal COC provision. In others, it is offered with teams of different sizes, at different points in the maternity journey (often antenatally and postnatally, but less often including the intrapartum period) and/or to specific groups of women only. The NHS Long Term plan continues to offer policy direction for COC and there are explicit directives for maternity units, throughout England, to increase their COC establishment, throughout the childbearing continuum[3]. There is a need to support the ongoing implementation and sustainability of the recommended NHS England Better Births COC model throughout the local maternity system[3].

The NHS England Better Births COC Model shifts the emphasis from institution-based care to a woman-centred service where a known midwife, supported by colleagues within a small group practice, follows women and their families throughout their childbearing, birth and early postnatal journey[2]. COC has known benefits for childbearing women, babies and families and the midwifery workforce [4, 5] and is promoted as the optimal model of maternity care across global and national maternity policy. As a focus of the Better Births Maternity Transformation Programme and now within the Nursing and Midwifery Council [NMC] future midwife standards of proficiency[6], there is a continued need to identify learning from early adopter COC sites across the Local Maternity System [LMS].

Despite the empirical evidence-base, implementation of COC presents a challenge for the maternity transformation agenda and programme, with local maternity units facing barriers to implementation and sustainability[7, 8]. National reviews and local evaluations of COC are being undertaken to assess these barriers, and solutions to them. In this study we are undertaking local evaluation across three maternity Trusts within our Lancashire and South Cumbria Local Maternity System (LSC-LMS). In LSC-LMS there are a range of COC teams. Many of them function as small midwifery practices, based in the community setting or from midwifery-led settings (such as birth centres). The teams work alongside other health care professionals, including an assigned obstetrician. We aim to address a critical gap in knowledge in relation to the local sustainability of scaling up midwifery COC, and the consequent impacts on the maternity system as a whole, costs, outcomes, and workforce implications.

# B. Methodology

## B.1 Design

A service evaluation design, drawing from realist methods was undertaken to help appreciate **"What works, for whom, in what contexts and why?"**[9]**.** This was an appropriate approach to evaluate COC as a complex social intervention that is being implemented in a local context. The evaluation focused on five different levels: the childbearing women and their partners, the individual practitioners, the maternal and newborn health care team, the organization providing maternal and newborn care and the larger health system or environment in which the organizations are embedded.

## B.2. Aims and Objectives

This project aimed to evaluate the implementation of the COC Better Births care model in three different maternity trusts and three COC teams across the LSC-LMS; examining what works to support successful practice and ways to overcome identified barriers. The objectives were:

1. To evaluate facilitators and barriers to the implementation of the COC Better Births model identified by service users, health care professionals and policy makers;

2. To explore which aspects of the various local models are important for women and their families;

3. To assess the percentage of women that have COC (as defined by NHS England Better Births COC Model[2]) throughout the maternity episode over the duration of the study;

4. To understand, collect and evaluate maternal and newborn outcomes to demonstrate successful implementation of COC;

5. To provide stakeholders with evaluation data and recommendations on 'what works' from existing COC group midwifery practices to adjust new models and approaches as it is applied across the LMS.

## B.3. Data Collection

It was intended that five forms of data collection would be used in the evaluation outlined as follows:

### *B,3.1. Stakeholder group meetings*

A system-steering group meeting was held with the Continuity of Carer Workstream group. This group guided the development of the project aims and objectives and identified three CoC teams to offer local insights. At the time of commencing the evaluation project, only three of the four maternity services had established CoC teams (LTHTR, UMBHT and ELHT), so these became the focus of the evaluation project. Local stakeholder groups were then coordinated at each of the three sites selected for inclusion. These local meetings were held on three occasions (prior to, during and at the end of the evaluation) in each of the three local COC teams recruited to the study. The purpose was to determine the underlying beliefs, philosophies and principles of key players in the implementation process, in terms of what they think makes the current system work (or not) and who it works best for; and (at the baselines session) what they anticipate will work/not work in the new model. Invitations and information about the stakeholder group were disseminated by the continuity leads at each site. Staff included in these meetings comprised of continuity midwives, non-continuity midwives and midwifery leaders (continuity leads, team leaders, matrons and a consultant midwife).
The stakeholder meetings were not recorded, rather they were used to provide wider contextual information and to inform data collection.

### *B.3.2. Documentary review*

One of the key tasks when undertaking a realist evaluation is to find out what stakeholders believe to be the 'mechanism of effect' of the existing programme, and of the new one (i.e. COC)[9]. To help prime the focus of stakeholder meetings and interview/focus group with participants, documentary evidence (i.e. meeting notes, protocols) was sought to help inform prior beliefs, philosophies and practices operating within the organisation. It was intended that relevant resources would include publically available documents from

professional, management and facilities meetings at the Trust, with the local Maternity Voices Partnership (the service user group), and with the relevant commissioners of maternity services/national Better Births staff/teams; Trust guidelines; previous reports relating to the implementation of the new programme; and any other documents that might indicate how local stakeholders understand the underlying programme theory of the new model of care. Monthly reports, generated for and by the LMS CoC workstream, were available and highlighted an overview of the number of CoC teams establishing over the study duration and the numbers of women, people and families receiving CoC care. However, despite repeated requests, more detailed, local documents were not available. Only one Standard Operating Procedure (SOP) was provided by one team and some summary data offered by another, therefore, a documentary comparative analysis could not be carried out.

*B.3.3. Survey of staff perspectives of local CoC models across the LMS and national policy directives*

A mixed-methods online, confidential and anonymous survey was created via Qualtrics to explore staff perspectives, experiences and insights in to their local COC models and the national NHS England Better Births COC Model in all four maternity trusts in the Lancashire and South Cumbria LMS. The survey included initial demographic questions relating to Trust, COC status and profession. Based on COC status and profession (included student midwives and maternity support workers), further questions were asked relating to models of work, years in maternity service, midwife band, MSW band and year of study. Twenty questions were posed to all participants with answers given on a Likert scale ranging from Strongly disagree (1) to Strongly agree (5). An option for Not Applicable was also provided. Open-text question were also included to capture participants views on: how they feel about continuity of carer models (e.g. any benefits or challenges); any concerns related to working in a COC team; and what is needed/recommendations to work in a COC team. The survey was distributed through key contacts in the maternity trusts and via social media.

*B.3.4 Qualitative interviews*

Health professionals, stakeholders and women who received COC were invited to participate in telephone/online qualitative interviews and/or focus groups at each of the three sites. Trust personnel were recruited by email invitations and dissemination of participant information sheets coordinated via heads of service and supported by stakeholder involvement. Women participants were initially approached to participate in the study by professionals working within the COC teams. Following agreement, the women's contact details were shared with the evaluation team, and further details (information sheet and consent form) were shared. In all occasions, participants were asked to contact the evaluation team within two weeks if they wished to take part. All service-user participants were offered a £20 voucher to thank them for their participation. No participant opted for a focus group, preferring to be interviewed.

*B.3.5 Routine clinical data analysis*

It was also intended that routine clinical/service related data recorded by the COC teams would be collected and used to a) demonstrate congruence with continuity practices and b) identify (where possible) any outcomes shown to be impacted by COC care models. A minimal dataset was developed by the UCLan research team (see Appendix 1), disseminated to the COC teams. However, mirroring the ongoing and known issues of data capture across the LMS, only one dataset was provided. Therefore, no analysis could be carried out.

### B.4. Data analysis

The survey answers were submitted via Qualtrics and on the closing date, all data was downloaded. The quantitative data was analysed in Stata 16. Descriptive analysis (frequencies) was performed on all demographic data by Trust. For the Likert Scale questions, the average (median) score was calculated for each question, by COC (e.g. those who did and did not work in a COC team) status. The qualitative data was extracted and subjected to thematic analysis with the support of excel.

All qualitative data (e.g. interviews/focus groups, notes from stakeholder meetings, open text survey responses) were subject to descriptive qualitative analysis, with data reported in separately sections (survey, interviews). Braun & Clark's [10] thematic approach was used which involved an iterative process of reading, identifying key codes, grouping codes into sub-themes and finally creating themes that were reflective of all views expressed. In accord with the aim of this study, consideration was made of contextual level factors, and data was analysed and framed into clear recommendations and a toolkit of transferable lessons for future COC implementation.

### B.5 Ethics

This proposal was shared with all the Research & Development departments at the three maternity trusts and classified as a survey evaluation (and thus not eligible for full NHS ethics review). Ethics approval was granted from the Health ethics sub-committee at the University of Central Lancashire (project no: HEALTH 0128).

## C. Results: Survey

### C.1 Findings

Data was extracted on 23rd March 2021. A total of 137 participants consented to take part in the survey and 123 completed/provided data. The participant's role, demographic details and currently working practices (COC or otherwise), broken down by the four maternity Trusts are presented in Table 1. It should be noted that initially not all questions were mandatory to answer on Qualtrics (this was edited halfway through the survey being open) so some questions were not answered by all participants.

**Table 1: Participant information**

| | **Blackpool Teaching Hospitals (BTHT)** | **East Lancashire Hospitals (ELHT)** | **Lancashire Teaching Hospitals (LTHT)** | **Morecombe Bay NHS Trust (MBHT)** | **Total** |
|---|---|---|---|---|---|
| | | | | | |
| **Overall responses** | 12 | 28 | 53 | 30 | 123 |
| | | | | | |
| **Midwife** | 11 (1 COC) | 20 (1 COC) | 43 (17 COC) | 23 (2 COC) | 97 (21 COC) |
| **Student** | 1 (1 COC) | 6 3 (COC) | 7 (0 COC) | 2 (0 COC) | 16 (4 COC) |
| **MSW** | 0 | 2 | 3 (1 COC) | 5 | 10 (1 COC) |
| | | | | | |
| **COC** | 2 | 4 | 18 | 2 | 26 |
| **Non-COC** | 10 | 23 | 35 | 26 | 94 |

| | | | | | |
|---|---|---|---|---|---|
| **Midwife Band (n=95)** | | | | | |
| 5 | 0 | 1 | 4 | 2 | 7 |
| 6 | 9 | 14 | 33 | 16 | 72 |
| 7 | 2 | 5 | 5 | 4 | 16 |
| **Year of study (students - n=16)** | | | | | |
| **1st** | 0 | 1 | 0 | 1 | 2 |
| **2nd** | 0 | 1 | 5 | 0 | 6 |
| **3rd** | 1 | 4 | 2 | 0 | 7 |
| **MSW Band (n=10)** | | | | | |
| **2** | 0 | 1 | 0 | 0 | 1 |
| **3** | 0 | 0 | 3 | 5 | 8 |
| **Years in maternity services** | | | | | |
| 0-2 years | 2 | 1 | 6 | 5 | 14 |
| 3-5 years | 1 | 2 | 10 | 5 | 18 |
| 5-10 years | 2 | 7 | 6 | 6 | 21 |
| 10+ years | 6 | 11 | 24 | 12 | 53 |
| **Team in operation** | | | | | |
| < 3 months | 1 | 1 | 1 | 2 | 5 |
| 3-12 months | 0 | 2 | 5 | 0 | 7 |
| > 12 months | 0 | 1 | 11 | 0 | 12 |
| **COC model team** | | | | | |
| Shift pattern | 1 | 2 | 7 | 1 | 11 |
| 50/50 | | | 3 | | 3 |
| Homebirth | | 1 | 5 | | 6 |
| Mixed caseload | | 2 | 4 | 1 | 7 |
| Caseload 1-1 | | | 7 | | 7 |
| **Current model of work** | | | | | |
| Birth centre | 0 | 4 | 4 | 1 | 9 |
| Hospital | 5 | 7 | 13 | 11 | 36 |
| Other | 1 | 4 | 5 | 7 | 17 |
| Rotational | 0 | 4 | 8 | 2 | 14 |
| Traditional community | 3 | 3 | 5 | 4 | 15 |
| **Plan to work in COC (n=94)** | | | | | |
| **Yes** | 8 | 16 | 27 | 16 | 67 |
| **No** | 1 | 6 | 8 | 9 | 24 |

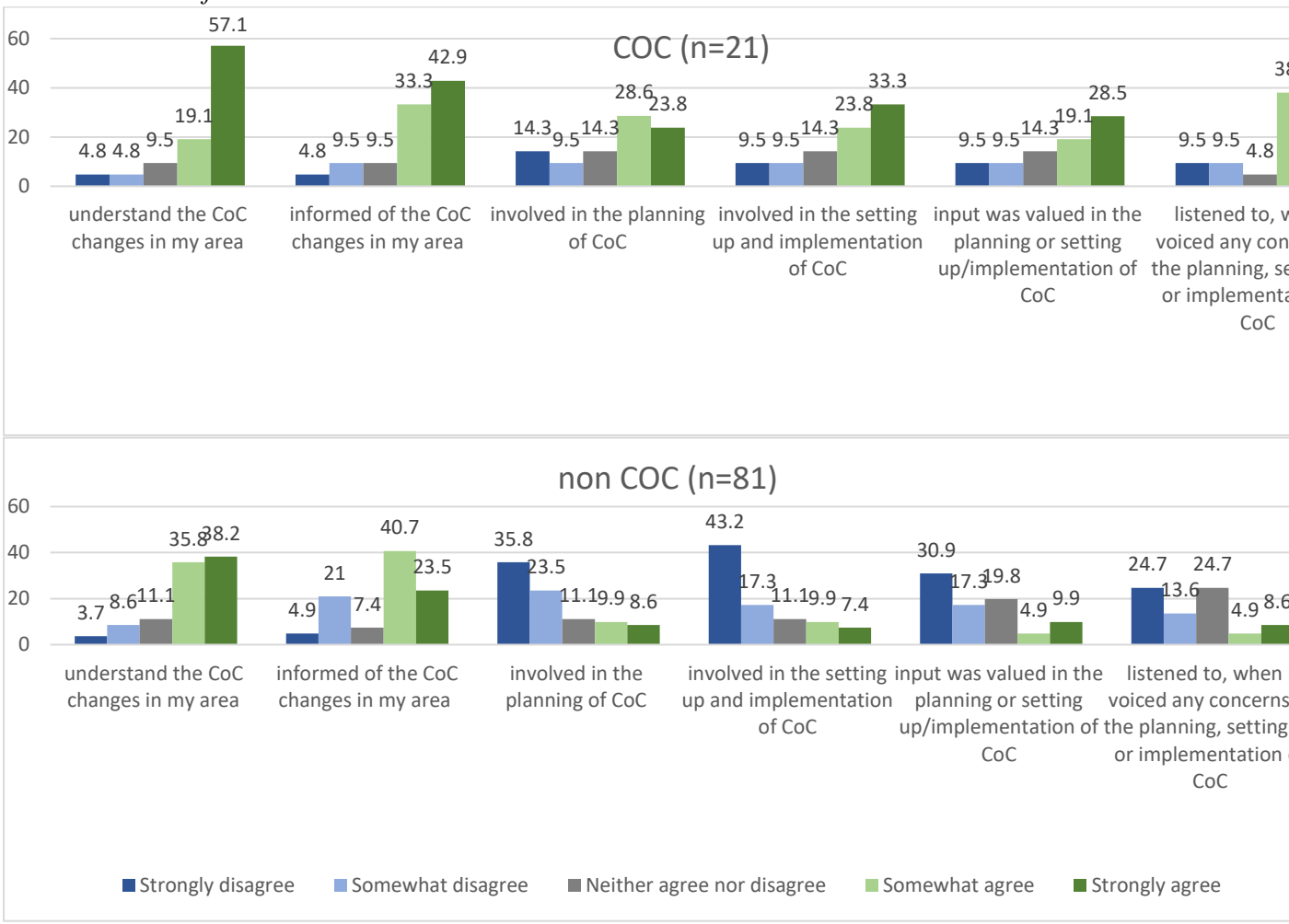
In the following sections, the descriptive/quantitative data is reported first, followed by thematic analysis of the qualitative data.

### *C.1.1 Quantitative survey results*

The quantitative data is reported within three key areas to align with the topics addressed within the survey namely: information and involvement in COC; perceptions of and feeling prepared for COC working; and resources and support needed for COC working. In the three areas,

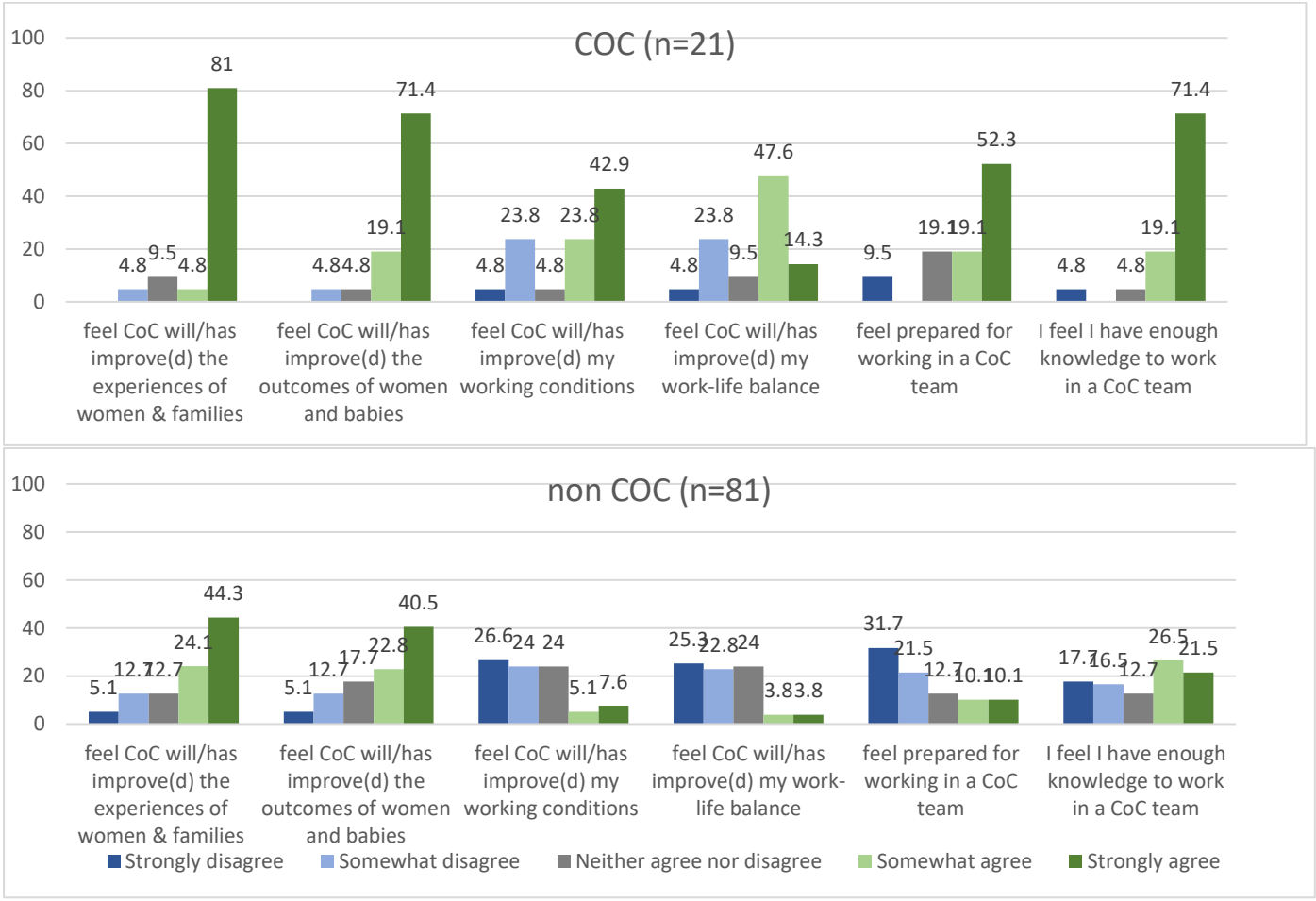
participants responses to each of the associated questions are presented in bar charts and reported separately based on whether they were or were not working in a COC team for comparison purposes.

*C.1.1.1 Information and involvement in COC*



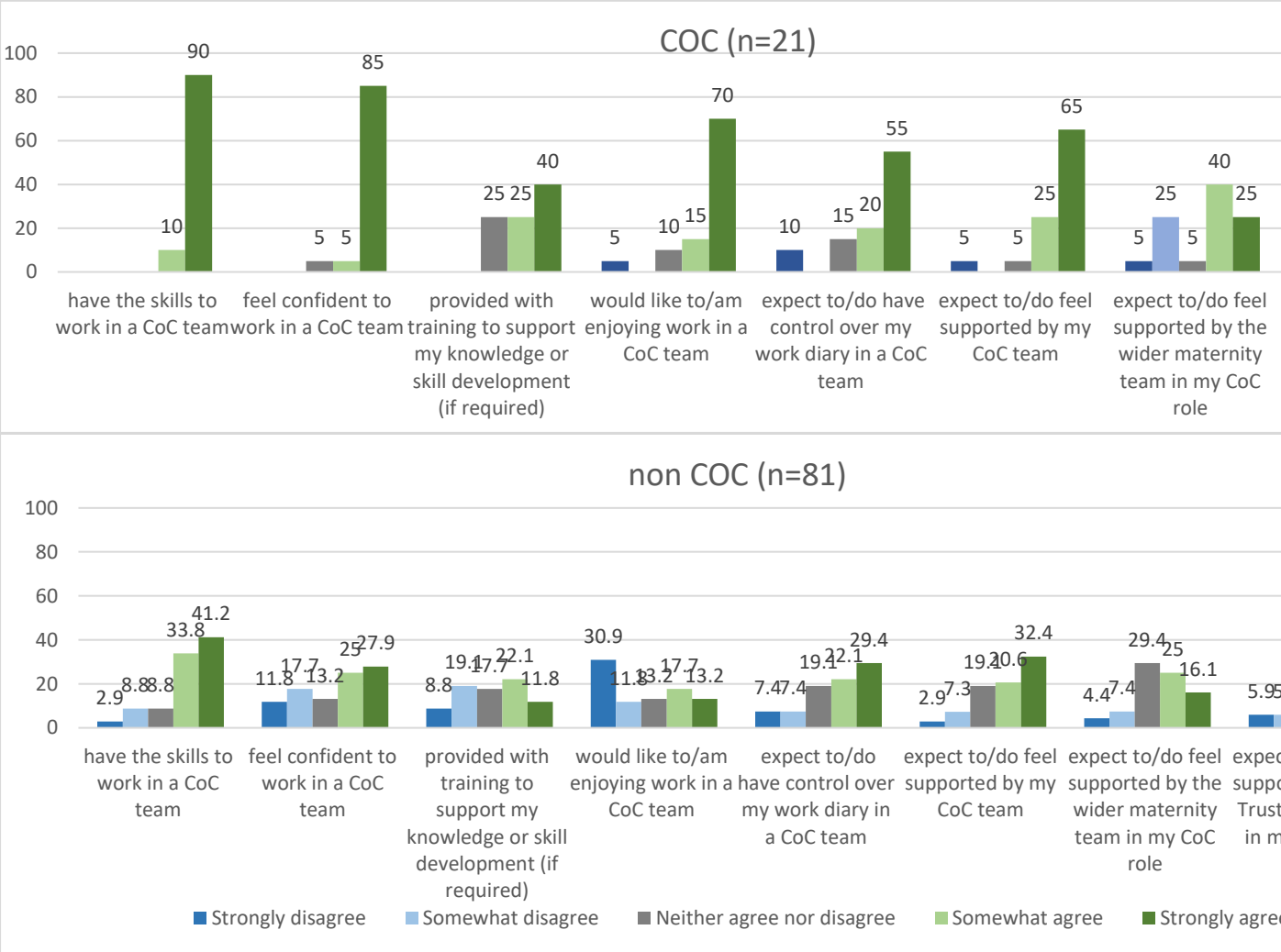

The majority of both COC and non-COC participants agreed (strongly or somewhat) that they understood and felt informed of changes in their area, but differences emerged when asked about involvement in planning and implementation of COC. Around 50-60% of COC participants strongly agreed with being involved whereas more than 60% disagreed with the same statements in the non-COC group. A similar trend occurred when asked about their input being valued and being listened to with non-COC participants tending to disagree.

### *C.1.1.2 Perceptions of and feeling prepared for COC working*




Both COC and non COC groups agreed that COC will improve experiences and outcomes of women, families and babies with 70-81% of COC participants strongly agreeing with these statements. There was less strong agreement in the COC group when asked whether they feel COC has improved working conditions and work life balance (60%) and 50% of non-COC participants disagreed with this question. High numbers of participants in the COC group felt more prepared and that they had enough knowledge to work in a COC team whereas the non-COC participants had a more varied view on these questions, and a majority (31.7%) strongly disagreed with feeling prepared for working in a COC team.

*C.1.1.3 Resources and support needed*




A high majority (80-90%) of COC participants felt they had the skills and confidence to work in a COC team; 75% in the non-COC group agreed that they had the skills, but only 52.8% considered they had confidence. A similar, but not as stark, trend was also apparent when asked about training with a mixed view in the non-COC group. Further, 70% in the COC group reported strong agreement about enjoying work in a COC team compared to 40% in the non-CCO group. For statements relating to expectations about being supported by COC team, the wider maternity team and by the Trust leadership, the COC group unsurprisingly had higher rates of agreement (65-90%) when compared to the non-COC group (41-53%).

*C.1.2 Qualitative findings*

These findings represent the views of 18/26 participants who were working in a COC team and 40/ 94 not working in COC across three of the sites (MBHT, ELHT, MBHT) at the time of the survey.

*C.1.2.1 Positive perceptions of the continuity model*

Three key positive perceptions of continuity working were highlighted in regard to 'relational working', 'improved outcomes women and families' and 'job satisfaction.'

*Relational working*

A key area of benefit of COC working related to providing women with a better service due to opportunities to build strong and trusting relationships with the women throughout the childbearing continuum; with this comment reported by midwives who did and did not currently work in a COC team. For example:

> '[Coc] Facilitates the building of strong relationships between midwife and woman and family, resulting in a more streamlined service.' [LTHT_COC]
>
> Benefits will be building a lasting professional relationship with women and families [BTHT_Non-COC]

Two of the non-COC participants reflected on their previous COC practices and the benefits of *'allowing me to get to know most of the women in my team and their families […] and 'improving low risk midwifery care'* [ELHT_Non-COC] and how *'the relationship with the women and her family was really positive and rewarding'* [MBHT_Non-COC]

Through the relationships and knowing the women, midwives described delivering greater individualised care based on the woman's needs and wishes; further benefitting women through avoiding repetitive conversations with other maternity professionals:

> Working within a continuity of carer model allows me to build trusting relationships with women and families. I know their needs, wishes and preferences. The women aren't having to explain their background/situation to numerous professionals. [LTHT_COC]

*Improved outcomes women and families*

In line with the respondents' high agreement to survey statements of how continuity will improve experiences, both COC and non-COC participants recorded benefits '*for the mum, her family and the midwives'* [ELHT_Non-COC]. Some considered it could help to improve outcomes for participants women with more complex needs:

> A COC model for women with altered health and those from poor socioeconomic background could reduce mortality and morbidity rates in these groups. [ELHT_Non-COC]

Others benefits concerned offers of '*seamless'* '*safer care'* due to '*being 'more attuned to the woman's physical and mental well-being'* [ELHT_COC]. Others reflected on how continuity helped to reduce fears and improve maternal satisfaction via its *'woman-centered approach* […]. One participant using their previous role within a traditional community setting as a reference, highlighted the safety benefits in comparison:

> 'I am more 'with woman' now than I have ever been in my career. I know my women; I know when something is not quite right and know their needs and wishes. I thought I had that on community but I actually didn't now I know how case-loading facilitates time to care for women.' [LTHT_COC]

*Job satisfaction*

Many COC midwives reported job satisfaction due to improved team practices. The continuity model was described as *'rewarding'* and *'enjoyable'* and particularly if they provided intrapartum care – *'it is the best job, a brilliant way of working* [LTHT_COC]:

> Benefits include working diary around home life commitments. Less stressful as flexible working, not rushing to a clinic and not working in areas you're not used to i.e., covering antenatal clinics. [LTHT_COC]

Similar views were also expressed by a few of the non-COC participants in relation to how positive relationships with women would enhance their motivation for the role – '*gaining job satisfaction from building solid relationships with colleagues and women*' [MBHT_Non-COC]. One, for example, reflected on how her previous experience of team working helped to develop vital skills, was an important anecdote for burn-out, and how her positive reflections on this role were sustained by opportunities to continue to *'see'* women she had cared for:

> Absolutely pivotal in my own professional development in terms of decision making, workload planning and building confidence. It was really satisfying to provide care for them in subsequent pregnancies too. I still see some of the women I cared for and their now grown up children; However, this [when talking about negatives of potential burnout] can be balanced with the advantages of caseload midwifery in terms of job satisfaction. [ELHT_Non-COC]

*C.1.2.2 Challenges of continuity working*

Multiple challenges to COC working were reported by COC and non-COC participants in regard to *'insufficient resources'*, *'limited gains for midwives'*, '*us and them'*, '*transitional issues', 'loss of/lack of key skills', 'work-life balance', 'reinventing the wheel', 'exacerbating/disrupting workloads', 'not necessarily what women want or need'* and *'lack of management/organizational support'.*

<u>*Insufficient resources:*</u> Non-COC participants raised concerns of not being enough '*day/feet on the street to do this properly'* [BTHT_Non-COC] and '*shortfalls in staffing due to sickness'* [ELHT_Non-COC] creating pressure for the remaining team members. One participant provided a rather sceptical perspective of her Trust failing to provide *'adequate resources'* and that if the COC team was successful, how praise would be inappropriately attributed:

> Given prior and long experience of working in this trust, I doubt that the service will be given adequate resources. The success will, as usual, depend upon the hard work dedication and sacrifice of the team staff. Any lapse will be attributed to the team while any success will be attributed to the management [BTHT_Non-COC]

These concerns were also reflected in the reality of those who were working in a COC team - '*staffing related, mainly due to COVID/sickness'* [LTHT_COC]. The impact was felt to be greater due to the small size of the team so covering staff sickness that entailed additional on calls more women to care for, was challenging. However, this participant also reported *'we have always found a way to get through'* [LTHT_COC], suggesting a strong commitment from their team.

Organisational issues such as staffing the second midwives required at homebirths were also identified, with one participant reporting reluctance from the hospital staff to attend:

> When the rest of the unit does not support homebirth and staff won't move from where they are. [LTHT_COC]

<u>*Limited gains for midwives:*</u> A challenge reported by non-COC participants only, concerned the limited financial gains for midwives – where there was an expectation of *'getting more from us as the midwives* […] *- but with no financial gain*' [BTHT_Non-COC]. Participants' reflected that the '*on-call payment is flawed'* with staff being on-call more frequently but *'paid at a lower rate per hour than their contracted hourly rate'* [ELHT_Non-COC]. This was perceived to have created a system that was 'not fair' to those who relied on '*enhancement pay'* [LTHT_Non-COC]. Participants also complained about the potential of having to use their own car and pay additional insurance costs but with no reimbursement. One reflected on how the potential for this *'significant extra expense to my household'* was a key reason as to why she was '*currently seeking employment away from midwifery'* [LTHT_Non-COC].

<u>*Us and them:*</u> A few of the COC and non-COC participants raised issues of an 'us and them' divide between those who did and did not working with a COC team. One participant from East Lancashire Trust reported:

> Not me personally but I feel it sadly has made some midwives feel it's us and them which is hard when you are in the middle of it and hear it from both sides. [ELHT_Non-COC]

Others reflected concerns of *'feeling isolated'* due to hospital-based staff being '*not always welcoming'* [LTHT_Non-COC]. Lack of support and understanding of the continuity model and way of working from the wider maternity team was raised across the sites by COC participants. In some cases, the participants reported negativity from wider team members; either those who did not want to work in continuity or who did not *'fully appreciate'* [LTHT_COC] the scope and demands of the role.

<u>*Transitional issues:*</u> In some instances, the challenges were transitional as midwives adapted the model and way of working. For example, getting used to night on-calls or getting called out frequently in a short space of time and the subsequence tiredness were difficult. However, the midwives reported either *'getting used to it'* [LTHT_COC] or accepting the ebb and flow '*usually balances out'* [LTHT_COC]. Moreover, one participant acknowledged that improvements to the running of the team *'couldn't happen until you have actually worked in the model'* [LTHT_COC].

<u>*Loss of/lack of key skills:*</u> Some participants who did not work in a continuity model raised concerns of losing skills such as having *'no opportunity to still work in a birth centre*' [LTHT_Non-COC]. Others spoke of how they did not feel skilled or experienced *'provide optimal care'* [LTHT_Non-COC], and how they would need *'lots of help to upskill'* [MBHT_Non-COC]. One the student participants reported:

> As a student I do not feel prepared to work in a COC team once qualified. I would like to see students be given the opportunity to be part of the COC teams during our training to build up our knowledge and confidence in this different model of care. [LTHT_Non-COC]

Other concerns related to how continuity models created pressure to be a *'jack of all trades in every areas'* [ELHT_Non-COC] with one reflecting:

> There has to be core staff in all areas for the knowledge and experience of other staff to rely upon for safety and efficacy [ELHT_Non-COC]

*Work-life balance:* One of the main challenges raised non-COC participants (and reflected in 50% of respondents disagreeing to the statement of COC improving working conditions and work life balance) concerned an inability to maintain a work life balance and the potential for midwives to feel overwhelmed and for burn-out; with subsequent resourcing implications due to increased sickness and staff leaving. The issues related to staff being 'on call frequently', *'long hours'*, a lack of control such as *'not being able to decide what hospital area you want to work in*', disrupting days off due to *'feeling responsible for your caseload of women on days off*' [LTHT_Non-COC], coupled with a lack of management support; *'no support from higher up*' [MBHT_Non-COC]. While participants would reflect that while it was a '*brilliant concept'* that was *'beneficial to women and their families'* the risks of high caseloads and being *'on call all the time'* meant that the mental and physical toll was perceived as too great.

> Personally, I don't particularly agree with COC model as I don't think the work/life balance is adequate, particularly working full time and being on call. Hence, why I wouldn't choose to work on COC team [ELHT_Non-COC]

One participant also reflected that team leaders tried to present a different perspective on what was the known reality:

> I feel concerned about the amount of on calls I would be expected to do. I hear from team leaders that the COC model would mean less on calls but in fact I see this is not true when talking with colleagues currently working within this model. [MBHT_Non-COC]

Another participant highlighted how during her previous experience of continuity working she was *'misled into the idea of managing own workload'* while the reality *'remains dictated by those above to suit other needs in the service*' [ELHT_Non-COC]. Concerns were raised about the safety of this model of care for midwives as well as women. One participant reported:

> My concerns for the new teams currently being launched is that they have currently employed the on call model where the night calls for women in labour are covered by a midwife who has worked a day shift. I have already had caseload midwives saying they are tired, and it is a cause for concern as the team has only been up and running for a couple of months. I have to question just how safe this model of care is if the midwife is over-tired, not just from a patient safety perspective but from the safety of the midwife, e.g. driving home from work. My concern is that the on call system may lead to a higher level of burnout and that an integrated system would be more beneficial for the wellbeing of the midwives [LTHT_Non-COC]

Participants expressed concerns about *'not fitting in with home life'* and struggles with childcare arrangements, particularly for single parents; *'single parent so childcare at night may and already is an issue'* [LTHT_Non-COC]:

> On call does not work for my home life and I feel that the women's needs are being put before mine as a midwife, a daughter, a partner and a woman with her own life outside of work [LTHT_Non-COC]

Similar negative feelings from those working in COC teams were also raised. One participant who had previously worked in a continuity team spoke of her difficulties in managing the commitments and how she would not recommend it to others:

> Having worked in a continuity team in the last couple of years I would not in good faith recommend it to my colleagues. It is far too difficult to maintain a good work life balance, and far too difficult to switch off from, particularly when caseloads were increased against all the evidence. [LTHT_Non-COC]

Two participants reported *'minimal* [personal] *gains'* of COC working despite the amount of effort put in [LTHT_COC] and another having worked previously in continuity models felt it led to *'burn out'* [MBHT_COC]. Another participant felt it difficult to switch off away from work, raising concerns of sustainability:

> 'It is also very easy not to switch off on days off, as you have access to emails, databases, and we have a WhatsApp group we use for work purposes, but even when its muted it's hard not to keep checking. My concerns are that CoC team MWs are passionate about their work and go above and beyond but I hope this will not lead to burn-out.' [LTHT_COC]

<u>*Reinventing the wheel:*</u> Some considered that continuity did not mean that women received a '*better service'* [MBHT_Non-COC], with a few non-COC midwives arguing that they already provided *'excellent continuity'* (during antenatal and postnatal) and how a COC model would *'lose some of that continuity just for the labour part'* [BTHT_Non-COC].

> I would not like to be on call more and especially as the chances of seeing your caseload mums in labour is not that much more increased being in COC (from audits I have helped with some mums have better continuity outside of COC) [ELHT_Non-COC]

COC working was perceived as unnecessary due to '*reinventing the wheel'* [LTHT_Non-COC] and disrupting a service that already worked. Particularly when the reality of a midwife being able to support a woman during labour was perceived to be '*very minimal'*

> Most COC midwives I have spoken to don't seem to be at the births for their own caseload mums so I personally don't see how it differs to the care I give as a normal Community Midwifery seeing them antenatal and postnatal. [ELHT_Non-COC]

<u>*Exacerbating/disrupting workloads:*</u> Disparities between individual workloads within a team were problematic. The issue related to team members not carrying their own caseload effectively, thus delegating visits, increasing the workload of the other midwives:

> Ensuring all team members understand the importance of continuity and see their own women without asking another team member to see because they're too busy due to struggles with their own time management. This will ultimately affect the teams continuity of carer rates. [LTHT_COC]

Additionally, being called into the unit to make up staffing numbers, thus pulling the midwives away from their caseloading work, and a lack of understanding/support for their flexible working patterns were difficult:

> As we have control over our own diaries, management do not always understand that we work in a flexible way, keeping a record of our hours and taking time back if have accrued time. Often management feel that working flexibly is for the benefit of the service, stating that if we are attending an El LSCS we should start sooner than the e-rostered shift start. [LTHT_COC]

<u>*Not necessarily what women want or need:*</u> A view raised by non-COC participants only related to how continuity was not necessarily what women want. Participants argued how women want *'a friendly face'* [BTHT_Non-COC], a midwife who is *'safe and kind'* [MBHT_Non-COC] and for women '*to be made to feel included within their care plans and to be supported with their choices'* [ELHT_Non-COC]. There were concerns that case-loading could mean that women receive care *'by a midwife that does not share their values'* [LTHT_Non-COC]. There were issues raised about midwives being *'less objective'* if providing care in a *'high pressure environment like a delivery suite'* [MBHT_Non-COC] as well as issues being missed due to care being provided by *'just one midwife'*:

> I also worry that if it is just one midwife seeing a woman throughout pregnancy, something might be missed that another midwife may have picked up on [LTHT_Non-COC]

Whereas others felt that continuity models would mean that women who do not meet eligibility criteria would receive *'second rate care'* due to short staffing:

<u>*Lack of management/organisational support:*</u>
Most challenges from COC respondents stemmed from wider organisational issues such as limited support, communication, staff morale, lack of understanding of the continuity role/model of working. One participant, demoralised, left the continuity team a year after they began citing lack of support as the key issue:

> 'Yes - I joined a team positive and motivated, a year later I have opted to leave as no support (management, equipment, physiological, psychological) to look after myself.' [LTHT_COC]

Issues around planning and implementation were highlighted. The team disbanding at MBHT was cited as example of poor planning with a call to improve the level of support and guidance to ensure successful implementation:

> 'I do not think it has been planned well enough in the trust I work in. The initial team has failed and are just an extension of the HCMU. If it is going to work we need more support and guidance.' [MBHT_COC]

This was echoed at ELHT, where the participant stated implementation had *been 'not been in-depth, very surface level'* [ELHT_COC] whereby concern around a lack of SOP [standard operating procedure] guidance was raised.

Similar complaints and concerns were also expressed by non-COC participants, and reflective of the high numbers of these participants disagreeing with the statements on the survey concerning their involvement and input being valued and being listened to, as well as their mixed responses in terms of feeling prepared and having sufficient information on COC working. Participants referred to poor communication by management about roll-out of the continuity teams, a lack of involvement in any of the discussions or decision-making, and concerns over a lack of support. One reported:

> I do not have trust in senior management in ensuring staff health and wellbeing - with regard to rest periods and or covering short- or long-term sickness within a team [ELHT_non-COC]

*C.1.2.3 What was needed*

The final section reflects on key areas that participants considered needed to be in place for effective COC working. These areas related to *'effective team working', 'skill development', 'flexible working', 'sufficient resources'* and '*communication needs.*

*Effective team working:* Some non-COC participants referred to how successful team working required *'a robust support structure'* within *'an inclusive and supportive team'* [BTHT_Non-COC]:

> I feel I would need a supportive team and to have people I can go to seek support and guidance. [LHTH_Non-COC]

Effective team working was believed important in promoting morale as well as more practical related issues of *'covering on calls, childcare issues and any other commitment a midwife may have*' [LTHT_Non-COC]. Team members who had the same ethos of *'woman centred care'* and *'willing to help each other and share knowledge*' [MBHT_Non-COC] was considered important. These features were also highlighted as essential by those who were working within a continuity team:

> Teamwork we all support each other and cover each other when needed. Able to manage our team and staffing amongst ourselves. All aware of caseloaded women in the team and their needs when needed to step in for each other. The COC our women get is brilliant for them and us, we build excellent relationships with the women due to the level of COC we facilitate. [LTHT_COC]

The need for management support was reflected in only (41-53%) of non-COC respondents considering they would receive support from the COC team, the wider maternity team and by the Trust leadership. These respondents highlighted how collaborative working required strong and consistent support from management – and to ensure '*management involvement when implementing change'* [MBHT_Non-COC] such as a seamless system for *'referring in'* women and '*without complaint or criticism from hospital staff'* [BHTH_Non-COC]:

> Clear boundaries of what type of women you can care for- when will core staff take over. What if your lady became PET how can you assure that a core delivery staff member would take over when that woman became so unwell. [BTHT_Non-COC]

One also suggested a team base, which would help to facilitate effective team working:

> Dedication is good...having more of a base for COC team would help maybe within the hospital or somewhere with access to printer but not necessarily sharing an office that's used for other things as it's hard with COVID as only so many people allowed in a room. [ELHT_Non-COC]

This could also facilitate what one respondent who worked within a continuity team required in terms of *'regular catch ups with colleagues'* [LTHT_COC] to overcome the isolation of lone working.

<u>*Skill development*</u>*:* Non-COC participants spoke of the need to have suitable training to prepare them to work in a continuity model; with some of the students highlighting the need for this within their pre-registration training:

> I believe I would need skills to be able to work in any area of midwifery which I feel midwifery training does provide students with. However, I feel I need the experience of working in a CoC team prior to qualification. [LTHT_Non-COC]

Responses to the survey statements indicated that non-COC participants had fairly high rates of agreement in terms of feeling they had the skills for the role, with only just over 50% (52.8%) considering they had the confidence. This was reflected in the qualitative comments as while a few referred to training to provide clinical care to enable *'proficiency in every area of midwifery'* [LTHT_Non-COC] and '*care provided outside of the birth suite'* [ELHT_Non-COC], other comments concerned skill development in more practical and interpersonal areas. For example, some referred the need for more process related skills, such as *'time keeping and task management, delegation skills'* [ELHT_Non-COC], or to develop interpersonal abilities such as *'understanding family members*' [LTHT_Non-COC] and working with women with more complex needs: '*I would like more training, maybe in vulnerable families and mental health issues*' [MBHT_Non-COC]. Some midwives who worked in COC teams also described their specific support needs to continue working within the continuity model such as requiring support with *'skills - suturing cannulation'* [MBHT_COC].

<u>*Flexible working:*</u> Participants who did not currently work in continuity teams highlighted the need for increased control in planning their diary and without *'management calling on you to fill gaps in rotational rota, (for example, cancelling your planned ante natal class to cover p/n Ward)*' [BHTH_Non-COC]. With flexibility, self-management and retaining control over work diaries and day to day workload was cited as working well for some participants who worked within continuity team. Some of the non-COC participants highlighted a need for flexibility in who they supported, such as *'working geographically'* [MBHT_Non-COC] as well as *'childcare'* and *'working hours'* with some arguing that they only wanted to work 'night shifts' rather than being on call.

Those who worked within continuity teams also emphasized the need for flexible working to be maintained. First, flexibility was viewed as important '*so the team can support each other in times of high activity'* [LTHT_COC]. Second, flexible working needed to be supported by the wider Trust to ensure their caseloads and work commitments remained manageable and sustainable. Being called into cover the unit was cited due to lack of understanding of how the model works and the knock-on impact of being called away from their work commitments. They called for wider understanding and for their role to be protected:

> If left to go about your work as planned in diary then it is great and works brilliantly for both us staff and the women but then the unit expects you to be able to drop everything to cover need in unit (not fully understanding it's not that simple as we have appointments organised with women. [LTHT_COC]

A further facet of flexibility concerned giving individuals choice as to whether they worked in a continuity team; *'let staff choose whether they want to or not'* [LTHT_Non-COC]. A few raised concerns of their age, adapting to an on-call system and how they did not want to work in a high-risk unit or in the community *'as in going into people's houses'* or *'driving my car round all over either'* [ELHT_Non-COC]. One participant stated '[COC working is] *literally my worst nightmare*' [MBHT_Non-COC]. The negativity towards continuity reflected in only 40% of non-COC respondents expectations of enjoying work in a COC team. Some respondents, as highlighted earlier, raised concerns of how being forced to work in a continuity team would lead to staff leaving the profession:

> I know of very few midwives in support of this model. The impact upon those with limited support and limited childcare is likely to lead to many seeking alternative employment. [LTHT_Non-COC]

<u>*Sufficient resources:*</u> Respondents highlighted a need to ensure safe staffing numbers to '*cover for sickness so other team members are safeguarded from burn out'* [ELHT_Non-COC] and for appropriate remuneration (such as through providing car allowances and on call rates). Several participants suggested that *'hospital staff to cover their own on call and for community to cover homebirths'* [MBHT_COC]. Given the challenges cited earlier, this may overcome issues of hospital staff being reluctant to attend a homebirth and of continuity midwives being called into cover the unit's activity. One participant suggested the model should include more midwives to reduce on-call requirements and its impact on antenatal and postnatal visits (however the exact type of continuity model was not clear):

> More staff means less on calls each in a week! (which is what puts staff of the coc model) as the on calls would be shared out more so not as often and that then in turn allows you more working days to fit in and see the women in your caseload improving the coc even more and also help cover essential visits when staff in team are on days off or sleeping following call out. The biggest improvement that is needed would be to allow more staff in the teams so that then there are less on calls to be covered by one midwife in one week. [LTHT_COC]

A further participant also reflected that staffing issues could help to be resolved by including Maternity Support Assistants.

<u>*Communication needs:*</u> The need for improved communication was highlighted from a COC and non-COC perspective. Those working within continuity teams identified a need for *'greater communication and staff morale needed improvement'* [ELHT_COC]. Two comments from MBHT (now disbanded) related to clearer communication of the role, responsibilities and expectations were required:

> Skill mix, understanding of roles and responsibilities as there has been very little info on what to expect or to do! [MBHT_COC]

Communication was raised between the continuity and wider teams to increase knowledge of how the role works and for more engagement *'events to spread the news and experiences of our good work once we can'* [LTHT_COC]. With this suggestion also echoed by non-COC respondents – '*more information is needed regarding the CoC role*' [BTHT_Non-COC]:

> Maybe they could speak to other staff regularly to let us know how they feel working in these teams. What's working well for them etc. [ELHT_Non-COC]

As some participants highlighted the need for *'people being more open to change'* [MBHT_Non-COC] and for continuity midwives to be *'committed to the model of care'* and *'motivated'* [LTHT_COC] – communication events to raise awareness of how it works in practice and to overcome concerns may be a positive solution.

## D. Results: Qualitative interview findings

### D.1 Findings

Interviews were conducted during January-April 2021. A total of 28 participants were interviewed, including: 14 MCoC midwives, 12 midwifery leaders with experience of working within or working alongside MCoC models. Additionally, one stakeholder, and one service user who had received continuity care were interviewed. Across the sites, we interviewed 9 midwives from ELHT, 10 from LTHT and 7 from MBHT. Demographic information was obtained that included band, role, year's of experience, experience of COC, see Table 2. As there was only one service user and one stakeholder recruited, their demographic data is not presented to ensure anonymity.

*Table 1 Demographics of midwives*

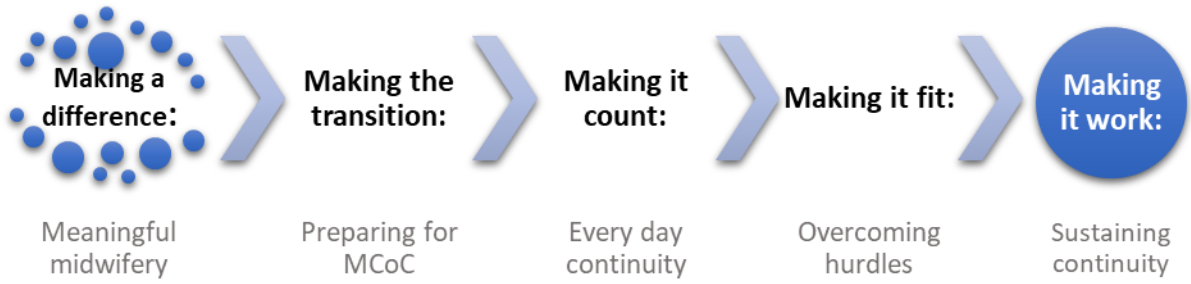
| **Midwife participants total** | 26 |
|---|---|
| | |
| **Ethnicity** | |
| White British/Scottish/Irish | 24 |
| British Asian | 1 |
| Pakistani | 1 |
| | |
| **Band** | |
| Band 5 | 1 |
| Band 6 | 13 |
| Band 7 or 8 | 10 |
| Band 6/7 shared position | 2 |
| | |
| **Position** | |
| Continuity midwife | 15 |
| Manager/leadership position | 8 |
| Shared position | 2 |
| Hospital | 1 |
| | |
| **Year's qualified** | |
| 0-2 | 2 |
| 2-5 | 4 |

| | |
|---|---|
| 5-10 | 6 |
| >10 | 14 |
| | |
| **Prior to this post experience of COC** | |
| Yes | 13 |
| No | 12 |
| Unknown | 1 |
| | |
| **Time in current COC post** | |
| 0-2 years | 15 |
| 2-5 years | 3 |
| 5+ years | 1 |
| Unknown | 5 |
| N/a | 2 |

*D.1.1 Qualitative thematic analysis- 'Making MCoC Transformations'*

The qualitative findings have been synthesised here from the local, individual descriptive analysis from each site. In this section, the collective thematic analysis 'Making MCoC Transformations' is reported. This global thematic network captures the insights, perceptions and experiences of continuity of carer midwives, leaders and service-users across the three sites included in the evaluation. It presents the ways in which local services are being transformed across the system from the perspectives of those involved in MCoC.

**Figure 1 – thematic network analysis – 'Making MCoC Transformations'**

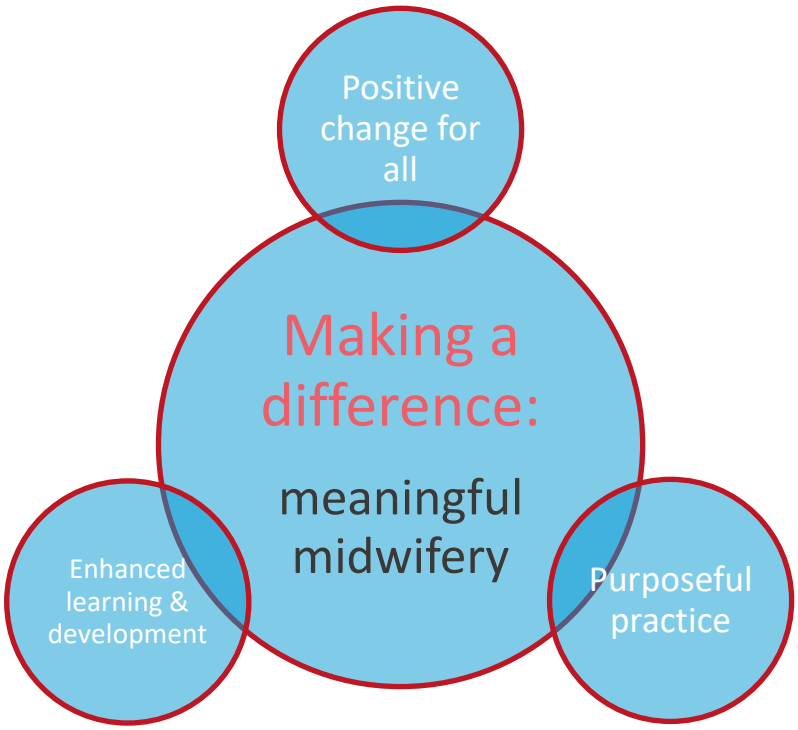



The global thematic network was generated from five organising themes (Figure 1) highlighting how the move to MCoC is 'Making a difference' offering 'meaningful midwifery' models of care for staff and families across the LMS. The thematic network, of these organising themes, outlines the movement towards 'Making it work' and 'sustaining continuity' in practice by capturing the participants' everyday experiences of MCoC including how staff and services are 'Making the transition' towards MCoC by focusing on 'Making it count' and 'Making it fit' alongside wider service- or personal- demands and needs. Collectively, these organising themes highlight what seems to work well for staff, families and the service, generally, alongside MCoC challenges and how to overcome them. The next section will present each of the five organising themes in turn.

*D.1.1.1 Making a difference: meaningful midwifery*

Across all teams and individuals interviewed, MCoC was seen as 'Making a difference' and offering 'meaningful midwifery' models of care for both staff and service-users. Perceptions and experiences of MCoC were positive in terms of the meaning they generated. 'Making a difference: meaningful midwifery' as an organising theme was informed by three basic themes; 'A different way of working', Purposeful practice' and 'Enhanced learning and development', as captured in Figure 2.

**Figure 2 – Organising theme 'Making a difference: meaningful midwifery'**




**Positive change for all**

> Satisfaction for mum, family, midwife: it's an all-rounder. [LTHR Staff_04]

For most of the midwives interviewed, MCoC offered '*a positive change for everybody'* and '*a whole different way of working'* [LTHTR Staff 09]. Participants were enthusiastic about the mutual benefits of continuity such as providing better care for women through more time for each appointment, building a relationship and being available to offer advice or reassurance. All had experience of fragmented care models and some compared the two, noting that continuity '*makes a difference when you know that about one person and see several times… in the care for them and me as well'* [ELHT_STAFF_07].

The participants shared the difference between integrated teams and MCoC teams in terms of caseload numbers and how, where and when care is offered:

> The integrated teams average around about six to eight midwives per team. Their caseload is in the hundreds, obviously compared to the continuity team, which there

> are currently seven midwives in the team who, as a full time equivalent, would have a 36 women caseload and work throughout the whole continuum though, so the various birth settings that there is. It's not just midwifery-led there [in the MCoC teams]*.'* [LTHR_STAFF_03]

Some midwives hadn't realized how maternity services are *'actually a lot more fragmented and different'* than expected helping them to understand just how '*important* and *special'* MCoC is, as a model of midwifery care [LTHTR Staff 08]. Those participants working in MCoC models described how having a chance '*to just caseload women doing all the care in the home*, *without having to do the clinics, was something that was perfect'* [LTHTR Staff 10] compared to other community or hospital-based midwifery roles.

However, some participants reflected how the '*extremely celebrated'* MCoC teams sometimes created '*conflict between colleagues who had been providing that service for years'* striving for continuity in an integrated model and not being recognised for the work, or being asked to move areas and teams to make space for a new MCoC team [LTHTR Staff 05]. For other midwives interviewed, the realities of working in the MCoC didn't feel too different from usual community midwifery models, as there was a lack of intrapartum care cover or continuity:

> It was working like a really well-oiled community team, I suppose, at the time when I joined, so it wasn't that dissimilar to what I was doing before [UMBHT STAFF 02].

Despite this, all participants interviewed, recognised the benefits of MCoC for families and felt it offered purposeful practice opportunities, as discussed in the next basic theme.

**Purposeful practice**

> Oh, for me, it has been amazing because this is like my dream job. This is the sort of midwifery that made me want to be a midwife, so I have absolutely loved it. [UMBHT STAFF 03]

Midwives reported that MCoC offered them a sense of purpose. They shared personal perspectives on how their teams seem to '*all enjoy it'* and '*fully embrace it'* as a model of midwifery care with some sharing that no one '*regrets the decision'* to become a MCoC midwife [LTHTR Staff 09]. Even though MCoC could be tiring the midwives love working this way. The relationships formed also helped staff to find work more worthwhile, amidst the usual stressors:

> It's busy and it's full-on, and the times when it is quite draining, but the positives that you get from being a continuity midwife kind of outweigh it all, you have the times when you have kind of looked after somebody all the way through, you've had a lovely relationship and it kind of makes it all worthwhile. I think it's a really positive way of working. [LTHTR Staff 07]

Positive feedback from women also seemed to create a reciprocal beneficial cycle for midwives:

> And obviously the job satisfaction is brilliant. And the feedback we get it's just phenomenal. And some women, they were just happy that they've seen the same midwife. And, you know, and some are very vocal about what support they've got and what a difference it's made. And it's lovely hearing a lot of positive feedback. It's just you really feel like you can nurture them and support them through that journey.' [ELHT_STAFF_06]

For most staff, the relationships and connections they forged with women and families in their care generated the most meaningful midwifery moments. Building a relationship through '*familiarity and trust'* enabled midwives to offer more support '*about mental wellbeing, or anything about labour and birth'* [LTHTR Staff 08]. Following women, people and families '*the whole journey through, from when you first meet them through to discharging them'* offered the '*biggest job satisfaction'* [LTHTR Staff 11].

Working with smaller caseloads was also reported to help improve relational team working for the MCoC compared to the traditional, integrated midwifery teams as highlighted by one of the participants:

> 'building relationships with their women, actually encourages their team to also build that relationship together and work really well together. A tradition model of midwives in their team, sometimes they don't even know they're in the same team as somebody, you know. There's not as much camaraderie' [LTHR Staff 03]

The midwives interviewed felt everyone in the team are '*happy to the point where they never want to go back'* With some staff sharing how they '*used to do bank shifts and now I look at the bank shifts online and I can't even bear the thought of going and doing a community shift or even a birth centre shift now*' [LTHTR STAFF 11]

Recognising the benefits alongside the differences between existing models of midwifery care and MCoC models highlighted learning and development needs of those working:

> I think we've known for years how positive this would be on women's experience but also on outcomes for families. I think that midwives will really embrace this; they just need to learn a different way of working. [LTHR Staff 06]

The next section will explore the learning opportunities MCoC offers and how this strengthens meaningful learning and development opportunities.

**Enhanced Learning and Development**

Participants shared how MCoC offered learning and development opportunities that strengthened existing knowledge and skills. Midwives valued the opportunity to work in diverse areas and across the entire midwifery service, maintaining and enhancing all their midwifery skills:

> I have seen it first-hand, better outcomes. I've had amazing home births, I've had amazing Birth Centre births with my women, and I want more. [ELHT_STAFF_08]

The MCoC midwife participants shared how MCoC has enhanced their learning and development which helps to make their experiences meaningful. This learning '*has been a highlight'* because of feeling '*much more confident'* in their '*abilities and skills'*.

> I think the learning is amazing, because you have to learn because you're on your own and you've got to find the answer, so you, you do, you find the answers. So it's made, made me more confident and more independent and being able to just do, do things myself and figure it out, rather than being in, on a ward where you just ask somebody. You just kind of, you've got to kind of figure it our yourself. [LTHTR Staff 07]

Part of the learning and development midwives experienced was associated with the increased accountability and responsibility for women and families' care, needs and outcomes. Those interviewed shared how they felt challenged by the accountability and responsibility, initially, captured here, by one MCoC midwife:

> I think it's just the relentlessness of it because you don't ever, it's all on you isn't it, that responsibility is, predominantly your responsibility. Like if, if you don't see them who else is going to see them? [LTHTR Staff 09]

However, most participants discussed how this was part of the learning cycle and transition to MCoC:

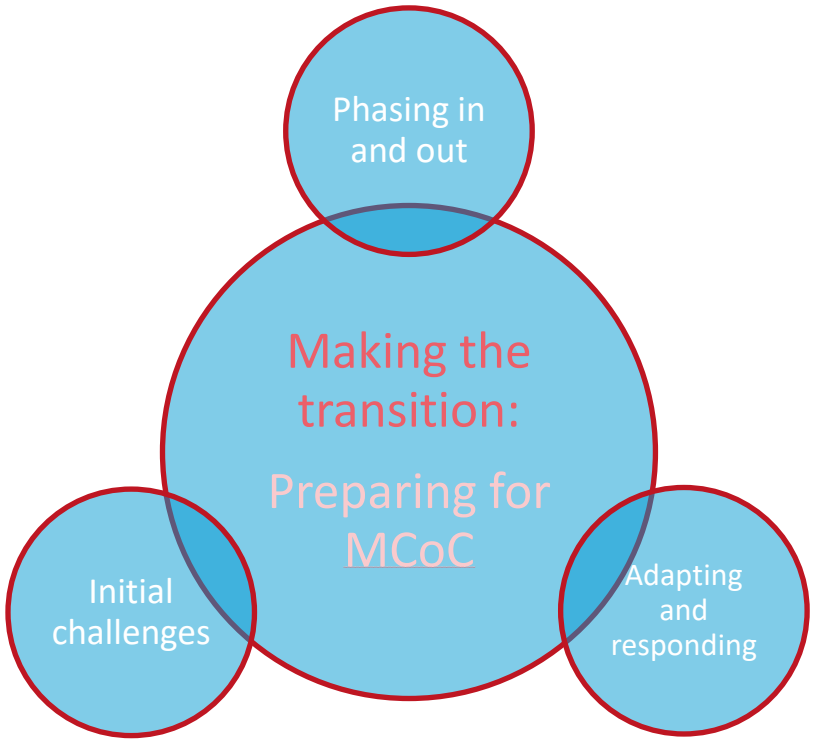
> I think after a while you get used to it and you get used to being able to go, no I've finished now, and that's the end of it. But at first it is quite difficult to get yourself used to that, because these women are constantly on your mind. [LTHTR Staff 07]

The importance of developing knowledge, skills and navigating the accountability and responsibility for care was considered important to support individual midwives' transition to MCoC, aspects captured in the next organising theme.

*D.1.1.2 Making the transition: preparing for MCoC*

This organising theme captures participants' perspectives on 'making the transition: preparing for MCoC' both as individuals and at a service-level. This is underpinned by three basic themes: 'a phased approach' outlines the steps of implementation; a review of 'adapting and responding' to the MCoC policy directives alongside the varying needs of local families, individual staff members, teams and the service as a whole. Finally, facing and addressing the 'initial challenges' of the local transformation to MCoC are also presented.

**Figure 3 – Organising theme 'Making the transition: preparing for MCoC**




**Phasing in and out**

Across the sites included, there was clear motivation from the midwifery leaders to implement MCoC, following the publication of the Better Births report.

> It started off really good. We were well supported. We used to have really good team meetings and discussions and we'd be brainstorming and we'd think, right, we're going to do this and we're going to do that [UMBHT Staff 01]

However, initially, some leaders shared how a lack of national direction led to feelings of uncertainty and staff '*didn't really know what it would look like'* [LTHTR Staff 06]. As such, prior to setting up the first teams, extensive preparation was undertaken, by the midwifery leaders. This leadership varied across the sites. At LTHTR this was shared across senior leadership and the CoC lead, at ELHT and UMBHT this was primarily led by the continuity of carer leaders (Band 7). Regardless of approach, all leaders interviewed, reported that early preparation took time, with some describing the initial landscape as '*cloudy*' and '*a struggle to start to look for one team'* [ELHT_STAFF_01]. This led to sites taking tentative, step-by-step approaches was, some leaders interviewed shared how they had *'lots of meetings, head*

*scratching, how might this look? What might this look like? What are the different models?'* They then '*looked and thought, okay, we need to start somewhere. So let's start off with one team.* [LTHTR STAFF 01].

Choosing the MCoC model/s to implement was based on experience and sharing knowledge from other maternity services *'were trying to look to see what's worked in other places? What hasn't worked in other places?'* [LTHTR Staff 06]. Care was taken to think about skill mix and the types of midwives to be recruited:

> I'd ask them to think very carefully about the part-time aspect of midwives working. I'd ask them to think very carefully about the number of Band 5s that they had. An experienced Band 5 is different to a new Band 5, so they just need to think very carefully about that and how setting up a new team and having a new Band 5 can be very onerous [UMBHT STAFF 01]

There was a lot of trial and error, over the first phases of implementation with some participants sharing how they had to '*completely unravel'* [LTHTR Staff 02] an early complex care MCoC model as it was unsustainable and was not meeting the Better Births recommendations. This was also shared by midwives interviewed at UMBHT:

> As it stands at the moment, it's not a continuity model, it is hybrid set of midwives who are working in exactly the same way that they always have, there's no clear… there's no clear vision for how that's going to become continuity from the women's point of view. [UMBHT STAFF 04]

Therefore, a phasing in and out process occurred, 'phasing in' related to identifying appropriate women to receive continuity; 'phasing out' related to ensuring women who were not eligible were appropriately cared for by existing models of care.

> So we fiddled around with staffing. We always knew I think from the offset that we weren't going to touch staffing on the ward, because it just didn't seem to make sense. You wouldn't really see the benefit and it would be a nightmare trying to staff the ward and provide continuity. So we always thought we'll leave the ward out of it, so let's look at the intrapartum areas, let's look at the community areas. [LTHR STAFF 01]

From the team midwives' perspective, this transitional time was valued for *'finding their feet, figuring out what to do'* [ELHT_STAFF_02]. For those in the diabetic team, the transitional period was likened to an *'induction'* [ELHT_STAFF_05] period.

**Adapting and responding**

Engaging with staff was viewed as essential to drive change as *'they [the midwives] are so instrumental in setting up'* [ELHT_STAFF_01]. Moreover, one participant reported that attending their annual update day which included videos and insights about the continuity teams provided her with the *'inspiration'* [ELHT_STAFF_07] to join a team.

> when we first started was I had a day with the team where we talked about caring conversations and what that would entail. We set up – I don't like using the words 'ground rules'; I prefer to say 'ways of working' – what were our preferred ways of

> working. I tried to delve a bit deeper with them. If they said what they wanted to happen, I asked them for examples of how that might happen [UMBHT STAFF 01]

Some of the midwifery leaders interviewed discussed the different transitional needs of midwives dependent on where they had worked previously:

> Different midwives from different areas obviously have slightly different training that they need to complete…. they were all supported to go on that…Community Obstetric Emergencies Day, which is really useful; and those of us that were going from community towards obstetric unit did some shifts to orientate…..everybody was working through their own training needs at their own pace, and orientating to the unit at their own pace. [UMBHT STAFF 04]

During the interviews, the continuity midwives also voiced various skill needs. For example, one participant not used to the team approach of shared working acknowledged some development was required:

> So, one of the things that I […] didn't expect to be a skill set that I had to learn, was working in a team (laughs). I'm used to just dealing with my workload and then asking for help if I need it, but really being able to manage it. Whereas now, it's a bit different because I need my team to help me with my caseload and I need to help them with their caseload because we had the unpredictability of intrapartum care to accommodate. [ELHT STAFF 03]

To help with skill development, safeguarding and mental health specialist midwives were enlisted to offer regular ongoing support. These midwives met with the continuity midwives (every two/three months) to go through cases, and to seek advice and specialist support. In other circumstances such as substance misuse, it was decided that joint care between the continuity midwives and specialist was the preferred approach to delivering effective care while meeting the continuity targets:

> So I think we've worked through that, that they're going to do joint care so where the where the drug liasion midwife will go to the home and do an appointment with her, the caseloading team, the caseload midwife will join and do a midwifery input because we can't say all these ladies can't be part of continuity of carer models, but also, we can't say, well, they're under a caseload model so they don't need that specialist input. [ELHT STAFF 01]

Ensuring staff had access to clinical supervision was also considered important, to support staff adaptation to new ways of working:

> I had intended to sort of make sure that we had clinical supervision built into the team so the midwives were able to talk. I think some of the team members would've adapted the way they worked, which would've been fine. [UMBHT STAFF 01]

Midwives interviewed shared their own personal adaptability with one participant valuing the opportunity of *'whatever works, go with it'* approach, excited to *'mould [the team] it into something'* [ELHT_STAFF_09]. Conversely, the other participant was keen '*to sort out some teething problems now, really, before I start'* [ELHT_STAFF_08]. The next theme will share more insights in to some of the early challenges reported.

**Initial challenges**
Midwives interviewed shared how setting up MCoC can be challenging initially:

> It's a bit hard and dirty and you get to the top of the mountain and you feel great but it's a bit of a climb to get there [LTHTR STAFF 01]

While staffing was cited as an ongoing challenge and issue, resonant across the NHS, some key system challenges were identified in the early preparation process, at some sites: the IT systems and the booking system (women's initial appointment). The lack of end-to-end IT system was a key challenge in setting up the first team, whereby to identify the correct women to start receiving continuity of care, the team had to physically go to the different clinics to: '*literally sift through folders and clinic folders to find women of the relevant gestation for the team, for when it commenced of the appropriate postcodes etc.'* [ELHT_STAFF_01]. The lack of end-to-end system also meant that a new data management system had to be set up by the manually. In addition, continuity midwives were expected to input data for each care episode for reporting and evaluation purposes. Collectively, the lack of end-to-end system, sifting through records to identify eligible women, setting up a separate data management system and the inability to check women's records on a moment-by-moment basis was described as excessively time consuming and problematic. At the time of the interviews, a new end-to-end system was being implemented across the System which should overcome the IT issues and challenges.

Sustaining motivation, across staff, beyond the initial interest was also challenging, in the early phases of implementation:

> Initially, in the first year, there was a lot of motivation. We had enthusiastic midwives, a lot of motivation and that is what they wanted to do, is be involved in the continuity of carer model, but as time went on, from my experience you found that that enthusiasm started to go a little because on-call was the main issue with that. [LTHR STAFF 04]

There was also feelings that management time and involvement was limited due to wider pressures of demands across the service:

> It started off really good. We were well supported. We used to have really good team meetings and discussions and we'd be brainstorming and we'd think, right, we're going to do this and we're going to do that. And then that all sort of stopped, firstly with the pandemic and then other various things that were going on in the Trust. So, it's been a bit of a struggle really trying to get more involvement with the managers. [UMBHT STAFF 01].

Beyond these early phases, adaptations and challenges there was the everyday continuity experiences that will now be considered in the next organising theme.

*D.1.1.3 Making it count: everyday continuity*

This organising theme arose from the three basic themes: 'covering care', 'going above and beyond' and 'everyday challenges' (see Figure 4). It captures the participant views, perspectives and experiences of 'everyday continuity' and how staff make their work count for women, people and families alongside their colleagues, the wider service and their own personal lives.

**Figure 4 – organising theme – Making it count: everyday continuity**


**Covering care**

Many participants discussed the day-to-day experiences of working within a MCoC team. Ensuring they were covering the care for the essential visits was important to the midwives interviewed:

> So you could as long as the essential, there's a midwife that's able to cover the essential visits. So if you're the only on-midwife that isn't a potential on-call for that day, then obviously you need to know that you're able to facilitate the visit, the essential visits, like the primaries and the day fives that are on the list for the midwives that are on a day off or on annual leave, or sick. [LTHTR Staff 09]

Participants enoyed the benefits of increased autonomy over their work diary and increased autonomous working:

> No, it's so much better you're in charge of your own workload, you've got that flexibility and, you are answerable to yourself and your women, but there's just so much more, you've not got people over your shoulder all the time. You can really be autonomous and look after these women. [ELHT_STAFF_06]

It was important to some participants that covering care also involved being flexible to each other's personal life too:

> I used to do five nine-to-five days, but that seemed really heavy for me. So, as a team, we agreed that I could do four slightly longer shifts but I could have a little bit more rest time, which has been really good. [UMBHT STAFF 03]

The rostered model was valued by some as having set shifts gave a structure to their diary to allow for antenatal/postnatal care planning:

> I'm quite happy with the way it works. I have a lot more free time because I'm only on call once or twice a week… This is good to me (laughs). [ ELHT_STAFF_02]

However, the rostered model made it more challenging for midwives to cover intrapartum care, due to the on call rota system, where the midwife on call usually covered care for the whole teams' caseload:

> I've been at the birth of about five or six of my ladies. I think my colleague [another team midwife's name] was about ten months in before she was at the birth of any of her ladies, so… I've been quite lucky really, I've managed to be at quite a few. Antenatally and postnatally… pretty much a hundred percent of antenatal care is covered [LTHTR STAFF 07]

Another aspect of the transitional phase related to the teams taking ownership for specific roles, so the day to day running of the team was a shared responsibility:

> Somebody to allocate the women, so the women that will book, rostering, someone to arrange our team meetings and like the parent craft teaching, other one to do like feedback online to do our statistics, and we do a newsletter monthly, the other continuity teams do a monthly team email (muffled) on what they've been doing. [ELHT_STAFF_07]

The more experienced midwives were mindful of less experienced midwives in the team and reported care and consideration for the workload by taking on team managerial tasks to provide support:

> As a more experienced midwife, I sort of feel a bit more responsible for making sure that the team is run well because they're dealing with enough and they don't want to be worrying about the off-duty or the holidays or the things that we're sort of taking ownership of because we've got— Not me, but some of the other midwives who've got more experience with that kind of management. [ELHT_STAFF_03]

The focus on covering care and the passion, motivation and commitment displayed by those interviewed led to many participants 'going above and beyond' in their work supporting families. This is covered in the following basic theme.

**Going above and beyond**

Many of the participants shared how they felt MCoC encouraged a commitment to caring '*that you fully give yourself a hundred percent all of the time'* [LTHTR Staff 09]. Finding the

work meaningful enabled the midwives to enjoy busier moments, even when they worked overtime:

> The fact that I enjoyed doing it made it easier. You know, it made life easier and I never got home in time, but that was my choice. So it's not that the Trust are telling me or my manager's telling me that you have to stay, it was my choice and I wanted to do that. So, it was hard. It's not easy, having to manage 18 women on your caseload, as well as managing the team, but I loved it. I truly enjoyed it. [LTHR Staff 04]

For some midwives '*being sort of overworked to a degree, like for your own women feels a little bit less frustrating than being responsible for everybody else's women as well'* [LTHTR Staff 09]. Yet, for some participants they experienced an expectation to go above and beyond to help cover care and support their colleagues.

> It's easier just to say, okay yeah I'll do it, rather than say, actually no, it's not my job to triage somebody with a reduced foetal movement, that's, you know, that's what day assessment is for. [UMBHT_STAFF_04]

This extra support and care were also recognised by service-users who valued midwives 'going above and beyond' for them. Midwife participants shared that those women with previous experience, of other models of care, '*are so grateful for it [MCoC] and feel it's a really good model and they're quite privileged' to be experiencing it* [LTHTR Staff 09]. However, this midwife also reported how women and families could be left disappointed to have '*been promised this continuity of carer and then their midwife leaves or becomes sick and the promise and expectation is took away'*. Positive feedback was also captured by a local stakeholder, included in the interviews, who shared that local women, people and families offer excellent feedback, all the time from having the same midwife or team of midwives:

> I very rarely hear anything negative about continuity of carer at all from anybody, and that comes from those that are delivering that service as well. In everything, I think that it works and I do champion it. [Stakeholder 01]

Despite the positive feedback and the desire to go 'above and beyond' in their work, participants also reported everyday pressures, presented in the next basic theme.

**Everyday pressures**

Many of the everyday pressures related to 'covering care' and some of the consequences of being expected to go 'above and beyond' your working hours due to staff shortages:

> there's times where we've got people off sick or… it just, or somebody's on like, like off for a good few weeks for whatever reason, then there is obviously gonna - the continuity is impacted on. [LTHTR STAFF 07]

Lack of management support and general understanding of MCoC models and roles also created pressures for some midwives interviewed:

> So things are going unnoticed, when we are working over our hours, nobody is pulling us up and saying, are you okay, do you need support. There's pressure from, pressure from outside of the team, it's like those midwives or staff that don't understand how we work expect more of us than what we perhaps should be doing. [UMBHT_STAFF_04]

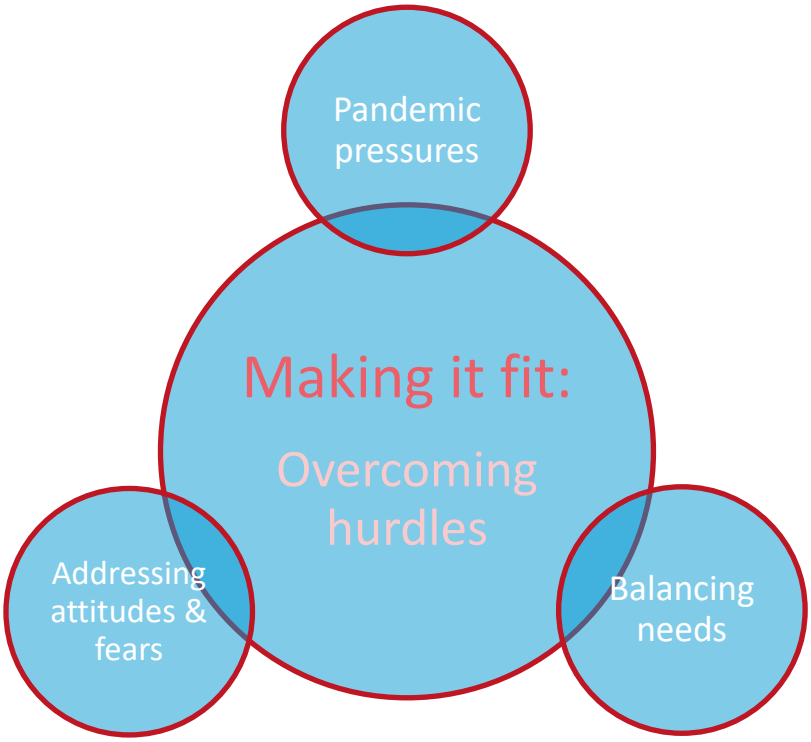
Another everyday pressure related to challenges with on-calls, especially those in geographical teams. One participant observed that in the team continuity model they are *'on call for a lot more women'* [ELHT_STAFF_04] because they are on-call not just for their caseload but the whole team. Some highlighted difficulties sleeping when on-call, but also recognition that over time this would get easier. Covering on-calls was difficult as only one person is on-call each night. If the midwife was called out earlier in the night, returned home to bed, the rest of the night is not covered. This was raised as a particular issue for the weekend roster as '*the Trust won't pay for two on-calls at the same time'* [ELHT_STAFF_03]. Pay for on-calls was also raised as problematic whereby the payment structure was reported to be at the mid-point of a band, unfairly disadvantaging those at the top of their band. Additionally, an issue of *'owing hours'* [ELHT_STAFF_06] was raised; where a midwife is called out at night and cannot work the next day shift, they are down on their contracted hours.

Some of these everyday pressures were a result of wider, system and service-level challenges, issues that will be explored in the next organising theme.

*D.1.1.4 Making it fit: overcoming hurdles*

This organising theme developed from the three basic themes: 'pandemic pressures', 'balancing needs' and 'addressing attitudes and fears'. Collectively, this theme outlines the system and service-level challenges and hurdles experienced by the participants and how they worked to overcome them, where possible. Systemic pressures were experienced differently across the sites due to the varying service contexts, structures and associated demands.

**Figure 5 – organising theme – Making it fit: overcoming hurdles**




**Pandemic pressures**

All of the interview participants shared insights in to how the COVID-19 pandemic influenced and impacted on their service and experiences of MCoC. At the time of the interviews, staff had been working in drastically different working environments, for over a year due to the pandemic. Four teams, three at LTHTR and another at UMBHT had established MCoC just prior to COVID-19 but all other teams had been implemented during the pandemic which impacted on staff experiences.

The pandemic brought staff sickness and self-isolation and increased pressure across the rest of the team, during a particularly busy times:

> As we've developed the teams, then they've had a much larger ratio than what they would have normally had of women and then they've had sickness as well with COVID, which hasn't helped, so that's been quite difficult with that. So they're just manageable and that's why really we aren't in the position to do another team at the moment. [LTHR STAFF 02]

Also, some staff changed what they felt able to manage, as a result of pandemic-induced burnout, which resulted in existing teams having to adapt and limit their approaches to MCoC:

> And then after Covid everybody feeling worn out; some members of the team saying, no I don't want to do that anymore; the rest of us had to change the way that we wanted to work in order to accommodate those team members who'd joined but then changed their mind [UMBHT_STAFF_04]

Meetings conducted online were also reported to negatively impact team building, cohesion and effective decision-making. For example:

> So, because we've not been able to get together, I don't think the more experienced midwives have been supporting the less experienced midwives as well as they could've done. And I think just the day-to-day running of the team is more difficult because we can't all just get together once a week in a room [ELHT STAFF_03]

The lack of a communal work base compounded the issues of social distancing, isolated home working and a separation between work and home:

> A lot of our admin work is done from home. And I think switching off in general…you might be on your day off and you're still reading it. [ELHT STAFF 02]

However, the pandemic did also bring some positive benefits for some MCoC teams. At LTHTR the home birth MCoC team received more bookings and the 'midwives were amazing and brought the rate of homebirths up to about 4.6%' [LTHR_STAFF_02]:

> We didn't let COVID stop us. We absolutely didn't let it stop us, it worked out well for us in the end. [LTHR STAFF 06]

Part of the approach taken was a balancing the needs of the policy directives, service-users, midwives and service. These issues will now be explored in the next basic theme.

**Balancing needs**

This theme presents the complexities of balancing needs across staff and service-users, policy and service delivery, alongside the wider contextual demands. Balancing the transition is an area already covered in 'Phasing in and out', leaders developed business plans to plan the ratios of core staff to continuity midwives and vice versa:

> Working out the establishment was very difficult. That was quite a challenge, but we got there in the end and we worked out how many midwives we would need. We worked out the core and… we did a business plan, basically. [LTHR STAFF 02]

There was also the need to balance the skills mix, across the teams to ensure effective support was offered:

> The two Band 5s were very hard work because they needed a lot of support. They were excellent midwives but they needed a lot of support.
> [UMBHT STAFF 01]

Building in support for staff, whilst considering how teams' skills were balanced was essential alongside balancing individual staff's working preferences that became challenging, as services developed with their transformation:

> When they work in the core teams, they kind of think they can do full-time hours over three long days, I don't work Fridays, I don't work Mondays, they can't see how actually that flexibility that those teams offer can be a really good way for you and your family (muffled). [LTHR STAFF 06]

Creating balance across continuity midwives' hours and diaries was also a concern, especially when juggling on calls and wider caseload demands. One participant reported being well supported on the obstetric unit to leave once she had worked her hours, however, concerns were raised whether that will be feasible once all teams were rolled out:

> Yeah, I think it works quite well for us at the moment because we're the only Continuity Team. So, say I was working all day Sunday and I did visits till four and then I was called out at nine, come two, three, four in the morning, depending on what's going on with the woman … totally fine to say to the shift coordinator, "I was working all day yesterday. I've done seven hours. The lady's fine. I need to go home and I need someone to take over.". [ELHT_STAFF_03]

Another area of balance related to weighing midwives' needs with women, people and families' needs:

> The ones that we did first, which weren't sustainable with the staff, were better for the women because the intrapartum care was better for them, because there was more chance of all of their women being cared for. [LTHR STAFF 02]

Balancing pay and enhancements was also reported as a concern for some staff

> So no major decisions, or like investigations have been made into percentage uplifts, and I think some of the midwives coming from the obstetric unit were concerned that if they weren't rolled out very regularly that they might lose the, you know, because you wouldn't get nightshift enhancements, and they were worried that their pay would drop. [MBHT STAFF 04]

Some of these issues contributed to staff attitudes and fears, as discussed in the next basic theme.

**Addressing attitudes and fears**

In this theme, participants' concerns over midwives' attitudes and the impact on ongoing transformation are presented alongside a review of the fears exposed across the midwifery workforce and how participants are trying to overcome them.

A key issue raised by many participants related to wider staff perception that MCoC has been tried before and failed:

> The initial response was it's not worked before, so why would it work again? And that was – and it still is a little bit like that, but that was the biggest problem and that's why it was quite difficult at that time to say – there wasn't the same kind of

> government back up and the same kind of funding that there is available now. We've always known that women-centred care is better for maternity, for women and for their families. So, that was quite a challenge at the beginning. So that was how the engagement started and how it was going, really. We luckily had a couple of teams, so staff could see how it was working and how it wasn't working within those teams because we did have quite a few challenges, even initially.
> [LTHR STAFF 02]

Sharing clear, honest insights helped to shape the development of new teams and support new ways of 'seeing' MCoC in everyday practice. Yet, there was some trepidation from the leaders about the reactions of staff, who view aspects of MCoC as impractical and 'fluffy'

> some of the attitudes of some of the midwives there, I'd just get laughed out if I started talking about the fluffy stuff because they don't like the fluffy stuff.
> [UMBHT STAFF 01]

Negative perceptions of MCoC were outlined from many participants, across the study, with some staff feeling that current phased approaches, discussed in 'Making the transition' organising theme, lead to inequitable, 'post-code' lottery care:

> I think there is still some thoughts of it being unfair on other women that aren't part of a continuity team, because they don't get those same opportunities [LTHTR STAFF 07]

Some participants shared insights into the myths and misinformation spread across the midwifery workforce leading to negative attitudes, fears and resistance:

> There's a lot of scepticism and there's a lot of inaccurate information. There's a lot of Chinese whispers. There's a lot of, "Oh well, you know, I don't want my work-life balance to change. I'm not being on-call every night." [UMBHT STAFF 01]

This negativity seemed to be contagious and also led to the CoC leads feeling drained. Yet positively, those with better understanding and experience of working in similar models and approaches had more optimistic attitudes to MCoC, which helped to counter the negative impact:

> Some are really resistant, and I'm working with quite a few resistant midwives at the moment, so that's quite draining. Another group of midwives that I'm working with are… they're not resistant because they're already doing good continuity as well because they also work in the Birth Centre. [UMBHT STAFF 01]

Assessing the attitudes and preferences of staff was considered essential and required open conversations and consultations:

> "What can we do now? Let's think of another way of working." They're talking about this rostered model. We looked at what interest there was within our team for a rostered model, and this was all just the two of us doing all of that. There was an appetite for it [LTHR STAFF 06]

Some staff interviewed reflected that negativity is usual when introducing change and captured the relief that MCoC works:

> There will always be a conflict. There'll always be somebody who finds… not fault with what's happening but just finds issue with something being celebrated that wasn't celebrated when they were delivering it. I think everything that you do is always going to have these issues and, yeah, I'm just glad that it works because now I think we've got six Continuity teams [LTHR STAFF 05]

Moving beyond the criticisms and challenges of change, 'making it work' to sustain continuity are now considered in the next organising theme.

*D.1.1.5 Making it work: sustaining continuity*

This organising theme brings together all the findings, from across all participants, on 'making it work: sustaining continuity'. It developed from 5 basic themes: 'preparation and support'; effective leadership and management; communication and collaboration; flexibility and adaptability and 'autonomy and protection' (see Figure 6). Crucially, these themes offer useful recommendations for ensuring MCoC implementation and sustainability in practice.

**Figure 6 – organising theme – 'Making it work: sustaining continuity'**


**Preparation, support and resourcing**

As highlighted in Making the transition organising theme, it was important to staff to ensure appropriate, meaningful and timely preparation and support:

> I felt like my team members would support me if I needed them to, which was really good. [UMBHT STAFF 02]

The more experienced midwives were mindful of less experienced midwives in the team and reported care and consideration for the workload by taking on team managerial tasks to provide support:

> As a more experienced midwife, I sort of feel a bit more responsible for making sure that the team is run well because they're dealing with enough and they don't want to be worrying about the off-duty or the holidays or the things that we're sort of taking ownership of because we've got— Not me, but some of the other midwives who've got more experience with that kind of management. [ELHT STAFF 03]

Participants yet to start in their team identified they would need '*support from fellow midwives who are out there'* [ELHT_STAFF_07] and identified that each team member would have

different skillsets, 'with strengths and weaknesses', that could be used in a collaborative way for shared support.

Ensuring sufficient resourcing was also considered crucial for the success of MCoC; from appropriate staffing levels, payment uplifts, equipment and reporting technology. All these factors are needed to sustain continuity:

The need for effective preparation, support and resourcing offered was closely linked to effective leadership and management both within and around the MCoC teams.

**Effective leadership and management**

Participants shared how essential effective leadership and management was both from a senior level within the Trust but also from the CoC and team leaders:

> Leadership plays a massive role, as you probably know, and to keep the team working effectively, safety is one of them. So, making sure that they're up to date with their training was a major one for us at this Trust because obviously we have to comply and be safe. Building their confidence is another thing, and also having that time for them to come to me to discuss any concerns that they would have. So as a PMA as well, I had that opportunity where I could have the one to one clinical restoration with them, and I found that quite beneficial because it helped me to build my team. [LTHTR STAFF 04]

It was important to the midwives to feel strong visionary leadership from their maternity unit leaders:

> We are lucky, and I say it all the time, in everything that I do. I am very lucky to have such a proactive Trust, in the fact that they do listen, watch and learn. And because it's working, let's keep growing it, let's keep seeing what we can do. [LTHR STAFF 05]

In places, lack of senior direction and leadership created barriers to effective implementation, leaving CoC and team leaders feeling powerless to enable change:

> There's no support there from managers, there's no vision or, there's no culture that is pushing forward for this meaningful change. It feels very much like they're trying to tick the box in terms of numbers, but it's not in the spirit of continuity. We didn't have a voice, it felt very much like we were told to be quiet and let them do what they wanted to do, rather than using our knowledge and experience to develop it in a true continuity model. That, that's been really challenging in our role, to not feel valued… not feel heard. [UMBHT STAFF 04]

Midwives interviewed also highlighted the need for effective personal leadership and management skills to ensure individual case-loads were overseen effectively and workload managed:

> I think regularly, at least once a week, you kind of need to go through all your ladies and just see if there's anything that needs doing in that particular week. And then, so tonight obviously I'm on-call, so tomorrow's there's nothing in my diary. [LTHTR STAFF 07]

Nurturing effective communication and collaboration was a crucial part of effective leadership and considered important to sustain MCoC in practice, as presented in the next theme.

**Communication and collaboration**

However, plans were in place to manage this moving forward with ongoing communication central to progression:

> So, again, it's keeping them communications up and keeping them in the loop, this is happening because things sometimes happen where practice changes one day. Not everybody just tells it, just talking all the time.' [ELHT STAFF 01]

Other issues arose around different styles of working, some kept in close communication throughout the working day '*to check in with each other'* [ELHT STAFF 04] and to offer each other support. However, other team members did not engage in the same way.

Honest and open communication was also considered essential by one of the midwifery leaders:

> I think, definitely communication. I'd try and improve that and just, like I say, keep everybody updated on a regular basis on how things are moving and why we're doing what we're doing. Being open and honest with them about things you need to do and about your plans, how you're going to make the teams. [UMBHT STAFF 2]

Close-knit relationships between team members were seen as vital to good communication and effective working - for some this was working well, and the team was reported to be cohesive.

> The whole of continuity is all about relationships, every single aspect of it, but the midwives in the team have to learn how to manage their own relationships if it's to work, and we've had to work very hard with that in our team. [UMBHT STAFF 01]

It was important to midwives interviewed that all team members collaborated and shared work evenly, they reported that some staff were '*a bit more singular in their approach and it's very much, this is my work and that's what I'm bothered about. Whereas everybody else seems to be very much a team, we're all going to work this together. Whilst we've all got our own priorities we also need to look out for each other as well'*. [LTHTR STAFF 07]

This team working offered greater flexibility and adaptability which was another essential feature of MCoC to support sustainability, now presented.

**Flexibility and adaptability**

Participants, included in the study, shared how important it was for MCoC midwives, leaders and the maternity service as a whole to have flexibility and adaptability. They outlined how valuable it was to work in a model that could be flexible around service-user needs:

> that's the beauty of the continuity model, is that we can be that – we can allow that flexibility. You can say okay, that's fine, you know, see if you can change the

> appointment for the lady if you had any. Change your day, change your plan, or we get one of the colleagues to go instead, if it was an essential visit. It was the flexibility, that was great in the model. [LTHR_STAFF_04]

Other midwives interviewed appreciated being able to fit their life alongside their caseload:

> you've got more flexibility. Which is the part, I found the idea brilliant with continuity, having that flexibility to work a morning and then just work an afternoon the next day on your day off, or whatever you wanted to do, just to fit in with your caseload. [UMBHT STAFF 2]

For some, this flexibility was essential and changed the need for special contracts, enabling family-friendly working:

> Whereas now in the caseloading team I would decide when I do my visits, so I don't really need family friendly contract anymore because in theory I could work any day of the week when my kids are in childcare. [LTHTR STAFF 11]

The drive to build relationships with women and people in their care resulted in a desire to adapt their lives to the needs of their caseload:

> "Yeah, this is the way that I want to work. I want to look after – these are the women, I want to be here for them, and I'm prepared to have that flexibility. And I'm prepared to say, I'll work half a day that day and I'll go and do a couple of hours that day and I'll manage my own book." [LTHR_STAFF_ 01 INTERVIEW]

Some midwives shared how this adaptability was reciprocal, with the women and people in their care being happy to shift their appointments around the needs of the wider caseload:

> It can be challenging if you've got somebody that you specifically need to see on a certain day and you're on-call the night before and you've been called out, therefore you've got to then rearrange that visit. But the women, they then work with us and they know that we have to be flexible because they know that when they're in labour, then they'll be the top of our list of priorities. So they're quite happy to (muffled) to do that. It doesn't have to be a specific appointment time, set in stone, if that makes sense. [LTHTR Staff 10]

However, it was also considered important to have some clear structures and boundaries with work patterns to help avoid burnout, as captured by one midwife interviewed:

> I think you kind of have to be a little bit, you have to keep yourself in a little bit of a work frame of mind; and I think that, if you were doing that all the time, I think it would have an impact on your family life, and your mental health, because you're not able to switch yourself off. [LTHTR STAFF 07]

Some of the flexibility and adaptability was enabled through having autonomous working environments that were protected by effective leadership and management. These issues are now considered in the next theme.

**Autonomy and protection**

MCoC enables midwives to work autonomously, having the freedom to direct their own working lives and patterns, as individuals and as MCoC teams. This was supported directly by some of the leaders interviewed:

> We set that up and we gave them free rein really and said do this how you want. [LTHTR STAFF 01]

For sustainability of MCoC, it was essential that this autonomy was protected as captured by some midwives:

> We're very lucky in that respect that we're not asked to cover any of the other service. We do go out to (muffled). The community team would go first, but if there was nobody available, then we will back that up. [LTHTR Staff 10]

This protected autonomy improved midwives leadership, accountability and independence, resulting in self-managed teams:

> Yes, so I'd say the biggest difference is that the [MCoC] team do not require as much hand holding and like to be independent and take responsibility. Also, I think they just take ownership, so I think that is their team. They take ownership, that's their caseload of women, they would – I wouldn't need to necessarily oversee certain things because I know that they're interested to do that and that will get done. [LTHR_STAFF_03]

It was also important for midwifery leaders to have autonomy to develop services and manage change with the freedom and independence, as captured by one lead midwife:

> Well, being given the autonomy to be able to go and work with those midwives and to help them set up the teams. To give them help and support and advice, share our experience from the [MCoC] team and to really work with them to set up things. [UMBHT STAFF 01]

**Thematic summary:**

The five organising themes have outlined the perceptions, views and experiences of those midwives and leaders interviewed as part of the evaluation. They capture the impact of MCoC on their working lives from the meaning it offers to the challenges posed and ways to overcome them. These insights have helped to inform some key recommendations, alongside the survey data, captured in the next section of this report.

# Key recommendations

**Effective team working:** Supportive team working is needed to ensure trust-based relationships, to rely on each other's support, to effectively communicate issues, and for debriefing purposes.

- While regular text-based contacts are important for ongoing communications (i.e. via WhatsApp), staff should be provided with Trust-based phones, rather than an expected reliance on personal devices;
- Initial and ongoing team away days should be coordinated to help team members bond, to develop effective communication strategies, to understand the team's skill-mix, and to discuss/develop effective team working;
- Regular face to face meetings should be organized, and key decision-making should be made in these forums so that all team members can contribute and feel involved;
- Band 7 Link Midwives should be established in all key birth settings to ensure continuity midwives had a key point of contact, to troubleshoot and to relay information across hospital staff and continuity midwives:
- A dedicated team base that includes computers and printers is needed for team members to meet in person, to develop a sense of team ownership, and to store core clinical-based equipment, e.g. baby scales, sonic aids, blood pressure equipment etc.

**Data management:** A lack of appropriate IT systems created difficulties for assessing KPI progress and extent to which 'continuity' could be provided.

- A core data set of variables needs to be agreed that is manageable and meaningful;
- A dedicated IT system should be established to record the core data set and ideally with inbuilt links to wider Trust-based recording systems for automatic population of demographic and key clinical data;
- An administrator should be employed to support data input, management and reporting, and to free up essential time for continuity staff;
- Regular assessments of the data set should be undertaken to elicit progress, gaps, and to identify suitable solutions.

**Management/resourcing support:**

- Robust management and operational support are needed to ensure the continuity team has flexibility, self-management and control over work diaries and day to day workload – individual practitioners' caseloads and work commitments need to be manageable and sustainable;
- Management need to agree and enforce clear boundaries in care provision, including care pathways for transfers, and management of IOL;
- Management should involve midwifery personnel in developing SOPs and guidelines so they feel involved and a sense of ownership;
- Continuity teams need to have sufficient staffing (i.e. two members on-call) to provide a safe and equitable service, to prevent disruptions to others working practices due to on-call requirements, to uphold an appropriate and healthy work-life balance, to protect against burn-out, and for staff members to be appropriately remunerated (i.e.on-call rates?);
- Opportunities to expand the skill-set of continuity teams by inclusion of maternity support workers should be considered.

**Identification of women and their needs:** Systems need to be established to help clearly identify target population and to ensure equitable working across the team.

- An online referral system should be used that collects core information, such as geographical area, and clinical issues to identify eligible women;
- A categorization system that utilizes holistic information (i.e. clinical issues, personal related issues such as mental ill health, family structure) can help to identify the amount of support/time for equitable caseload planning;
- Caseload decisions should be discussed and reviewed during regular face-to-face team meetings;
- Well planned and well communicated 'phasing in' of continuity working and 'phasing out' of existing systems is needed to ensure a seamless transition to new models of working, to prevent against overload, and to ensure women do not fall through the gaps.

**Training/Skill development:**

Staff need to have the skills and confidence to provide effective continuity of care.

- An introduction training programme that covers all core skills required for continuity working should be developed – the training should provide instruction into clinical, process-related (i.e. delegation, time management) as well as relational working;
- A training needs analysis (or use of a self-assessment booklet as developed at ELHT) should be undertaken with all core staff initially and on an ongoing basis (i.e. annually) to identify key gaps, and to offer suitable learning;
- Opportunities to discuss training/learning needs should be offered during team meetings and as part of supervision, so it is acknowledged as a team-based, rather than individual issue;
- A suite of training resources could be developed and shared via LMS wide resourcing portal for staff members to use (such as crib sheets to guide midwives through the various care episodes; films; presentations, etc);
- Mentoring/shadowing and ongoing support from specialist midwifery teams should be offered where possible, and to continue until the midwife feels confident for lone working;
- Non continuity staff should be offered opportunities to attend the core training programme to help build up confidence and motivation to join/work in a continuity team;
- Opportunities for Band 5 midwives to join continuity teams together with sufficient and appropriate support offers important prospects to develop capacities and skills;
- Continuity working/placement opportunities should be integrated into pre-registration midwifery training.

**Communication issues:**

Clear and regular communication on the expectations, roles and benefits of continuity team working is needed.

- Staff engagement events should be provided at regular intervals to raise awareness of COC working. These events could involve presentations on the evidence surrounding continuity models, clear insights into how continuity teams operate, and personal endorsements from those working within COC teams to help debunk myths, and raise interest and motivation;
- Maternity staff could book onto a staff engagement event convenient to them and to claim time back to encourage attendance;

- Regular opportunities (i.e. quarterly) to come together with wider colleagues, i.e. from other continuity teams could help to share good practice, collaborate on creating shared solutions and to raise morale;
- Clear boundaries on when/how to communicate via text-based messaging needs to be established to prevent against perceptions of pressure and overload;
- Team leaders could also facilitate drop-in or meet the team events for midwives to come and ask questions and find out further information about how the team operates.

# Next steps

The following list charts the next steps for the project:

- Disseminating the findings locally, at each maternity site.
- Sharing the work regionally and nationally
- Writing the findings for publication and wider dissemination
- Creating engagement and training resources with the MCoC midwives
- Ongoing evaluation, across the LMS and regionally, to be negotiated

As the following objectives of the study were unable to be considered due to no data being available for analysis, these would be important to review in the future:

- To assess the percentage of women that have COC (as defined by NHS England Better Births COC Model[2]) throughout the maternity episode over the duration of the study;

- To understand, collect and evaluate maternal and newborn outcomes to demonstrate successful implementation of COC

**References**


1. NHS England, *National Maternity Review: Better Births - Improving outcomes of maternity services in England: A Five Year Forward View for maternity care.* 2015.
2. NHS England, *Implementing Better Births: Continuity of Carer*. 2017.
3. NHS England, *NHS Long Term Plan*. 2019.
4. Sandall, J., *The contribution of continuity of midwifery care to high quality maternity care* Royal College of Midwives, 2017.
5. Turienzo, C.F., et al., *Implementation of midwifery continuity of care models for Indigenous women in Australia: perspectives and reflections for the United Kingdom.* Midwifery, 2019. **69**: p. 110-112.
6. Nursing & Midwifery Council, *Standards of proficiency for midwives.* Nursing & Midwifery Council, 2019.
7. Belling, R., et al., *Achieving continuity of care: facilitators and barriers in community mental health teams.* Implementation Science, 2011. **6**(1): p. 1-7.
8. Sandall, J., et al., *Discussions of findings from a Cochrane review of midwife-led versus other models of care for childbearing women: continuity, normality and safety.* Midwifery, 2009. **25**(1): p. 8-13.
9. Pawson, R. and N. Tilley, *An introduction to scientific realist evaluation.* Evaluation for the 21st century: A handbook, 1997. **1997**: p. 405-418.
10. Braun, V. and V. Clarke, *Using thematic analysis in psychology.* Qualitative research in psychology, 2006. **3**(2): p. 77-101.

**APPENDIX 1**

**CoC evaluation project: Dataset request**

- Data collection start date
- Number of midwives in organisation (WTE)
- Number of midwives in COC teams (WTE)
- Number of births in organisation over the data collection period

Team data (over the data collection period)

- Number of women in the CoC team
- Number of midwives in the CoC team
- Caseload per midwife
- Baseline info
  - Parity
  - Number of Midwifery led care
  - Number of Consultant led care
- Number of CoC caseloads who received 100% Continuity:
  - the perinatal period (all)
  - antenatal,
  - intranatal
  - postnatal
- Antenatal appointments:
  - number of appointments overall
  - number of appointments led by the named/CoC midwife.
  - Number of appointments led by a different midwife (doesn't need separating, just a total tally)
- Birth
  - number of births overall
  - place of birth (home/birth centre/obstetric unit)
  - IOL/spontaneous/ELCS
  - Named midwife attended through to the birth y/n
  - Transfer during labour (either from home/birth centre to hospital or requiring obstetric input during labour on the birth suite)
  - Birth outcomes:
    - mode of birth (SVD/instrumental/EMCS),
    - PPH y/n,
    - active/physiological third stage,
    - skin contact y/n
    - breastfeeding in 1st hour
  - Gestation at birth
- Postnatal
  - number of postnatal appointments overall
  - Number of appointments led by the named/CoC midwife.
  - Number of appointments led by different midwife.
  - Postnatal readmission y/n,
  - breastfeeding on discharge y/n