1. Introduction and Who Guideline Applies To:

As part of University Hospitals of Leicester’s (UHL) response to the National Maternity Review: Better Births (2016), a caseload midwifery pilot team is being introduced. The intention of this team is to improve continuity of care to women from Minority ethnicity backgrounds. The women within the pilot will have additional complexities, which increase their risk in childbearing. The team will provide all midwifery care to women, throughout the antenatal, intrapartum and postnatal period.

This guideline will set out the operational structure for the team, and for the wider multidisciplinary team.

2. Aims and Objectives of the Team

2.1. To reduce the incidence of poor health outcomes, that women from Minority ethnic backgrounds experience in the city of Leicester.
2.2. Ensure a named midwife provides consistent care to women, including all aspects of maternity care: antenatal, intrapartum and postnatal.
2.3. To build trusting professional relationships with women and their families.
2.4. To work in partnership with the wider multidisciplinary team to maximise safety.
2.5. To promote health and wellbeing for the women and their families during pregnancy and into parenthood.
2.6. For midwives to be autonomous managing their own diaries and workload; to maximise continuity, and ensure care is individualised.
2.7. To improve experiences for women and their families and improve midwives satisfaction in providing care.
2.8. To evidence the benefit of continuity of care for groups who are at-risk during childbearing.
3. Background

Women from minority ethnicity communities are up to five times more likely to die in childbearing and 121% more likely to experience stillbirth.

In the city of Leicester:

- 53.2% of births are to women from Minority Ethnic communities
- 5.2% of babies are born at term with a low birth weight
- 22.7% of Children are living in poverty
- Stillbirth occurs in 5.9 per 1000 births

(Public Health England, 2017)

This data is significant as it represents figures which are higher than national averages and higher than findings from the surrounding locality within Leicestershire and Rutland.

4. National Guidance

4.1. The National Maternity Review Report, Better Births (February, 2016) highlighted the requirement for change in maternity care across the whole system including; commissioning, funding, delivery and evaluation. Each local maternity system (LMS) was tasked with making improvements in:

- Personalised care
- Continuity of carer
- Safety
- Mental health care and services
- Multi-disciplinary working
- Working across boundaries
- A payments system

Continuity of care has been shown to improve outcomes in maternity. The evidence concludes that continuity can reduce stillbirth by 16%, decrease preterm birth by 24%, reduce late miscarriage by 19% and reduce intervention: episiotomy (16%) & epidural analgesia (15%) (Cochrane Database, 2016). Continuity of care also improves maternal and staff satisfaction.

NHSE has tasked trusts with achieving targets in relation to provision of continuity of care in maternity. The primary target was to achieve 20% continuity of care by March 2019. UHL achieved 19.3%. The next target is 35% total continuity by March 2020, which increases to 51% by March 2021.
4.2. The NHS Long Term Plan (January, 2019)

Looking ahead to the 80th birthday of the NHS, the Government has allocated additional funding for its ongoing operation and development. The Long Term Plan illustrates the implementation of the future developments, with a focus on addressing health inequalities:

“In maternity services, we will implement an enhanced and targeted continuity of carer model to help improve outcomes for the most vulnerable mothers and babies. By 2024, 75% of women from BAME communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife throughout pregnancy, labour and the postnatal period. This will help reduce pre-term births, hospital admissions, the need for intervention during labour, and women's experience of care” (NHS Long Term Plan, 2019)

5. Service Design

5.1 Structure

The pilot team will initially consist of 4.0 whole time equivalent (WTE) midwives, and 1.0 WTE maternity support worker (MSW). The midwives will be recruited on a fixed-term basis, from the existing establishment. The MSW will be recruited externally. The team structure will be arranged as follows:

5.2 Timescales

The pilot will launch once recruitment is complete and staff are able to be released from existing job commitments. The pilot will run for one year, with the potential for extension and expansion, if the pilot is deemed successful.
5.3 Base and working environment

The team has a base at Belgrave Children’s Centre. This includes an office area, a clinic room for use all day Monday and other rooms which can be booked via the centres admin staff. There is on street parking only. Equipment and stock required for practice will be stored here, and all team members will replenish this.

The centre is open during office hours Monday to Friday only, and is therefore inaccessible during evenings and weekends.

The team will need to work across all sites, dependent upon women’s needs and therefore will be issued with cross site 3Ps permits.

The team will be required to visit women and their families in various locations, and some lone working will be necessary. The trust has a lone worker policy (B27/2008) which aims to protect lone workers through the process of hazard identification, risk assessment and elimination. Team members must adhere to this policy.

5.4 Caseloads

The midwives will hold a rolling caseload of 35 women per year, per WTE.

Initially the teams will offer the service to women at staggered gestations. This will maximise continuity for women in the pilot, and ensure the team is operating at capacity from the launch. The gestation of women at launch will range from booking, to a maximum of 27 completed weeks. The maximum gestation of 27 weeks will ensure the majority of antenatal care, which takes place in the 3rd trimester of pregnancy, will be delivered by the caseload midwife. This will maximise the benefit of continuity and also work in correlation with NHSEs definition of continuity of care.

The pilot will be offered to women in the LE4 postcode, of the city of Leicester. This area is has a prevalence of women from Minority Ethnicity communities. Postcode specificity will enable research to effectively evaluate the pilot and its outcomes. The caseload midwives will liaise with community midwives practising in this location, to identify women who meet the inclusion criteria for the pilot. Ideally this will be prior to booking, utilising the trusts existing pre-attendance questionnaires.
5.4. Inclusion Criteria

To be eligible for the pilot team, women must meet at least one of the cultural criteria, plus one of ANY other criteria as follows:

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<thead>
<tr>
<th>Type</th>
<th>Example</th>
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<tbody>
<tr>
<td>Cultural</td>
<td>Minority Ethnicity Background&lt;br&gt;ESOL – Limited English&lt;br&gt;FGM, Asylum Seeker, Recent Migration</td>
</tr>
<tr>
<td>Medical</td>
<td>Smoking&lt;br&gt;Age &lt;18 &gt;40 BMI &lt;18 &gt;40&lt;br&gt;Medical Disorder&lt;br&gt;Autism/ADHD&lt;br&gt;Disability&lt;br&gt;Consanguinity</td>
</tr>
<tr>
<td>Social</td>
<td>Poverty and Criminality&lt;br&gt;Domestic Abuse ‘Honour Violence’&lt;br&gt;CSE Trafficking Modern Slavery and Gangs&lt;br&gt;Sex Workers, Single Parent Families</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Recurrent Miscarriage, Previous Preterm Birth, Previous IUGR, LSCS in 2nd Stage, Previous Bereavement, Previous BBA&lt;br&gt;Grand Multiparity, 2 or more LSCS&lt;br&gt;Previous Traumatic Birth Including: Shoulder Dystocia, 3rd or 4th degree perineal trauma, Abruptio, Admission to NNU, HIE and Massive Obstetric Haemorrhage</td>
</tr>
<tr>
<td>Other</td>
<td>LGBT Families</td>
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This criterion will focus on the women who have complexities, which tend to increase the risk in childbearing. The team’s resources are therefore focussed on those who will benefit the most. Targeting input and redressing the health inequalities experienced.

5.5. Format

Midwives will manage their own workload and diaries, offering antenatal and postnatal care at times and locations to women, which is mutually appropriate. Women will follow the routine schedule of care as set out by NICE antenatal guidelines, and in line with trust policies. Midwives should also attend significant hospital appointments, and participate in care planning where possible and of benefit.
5.5.1 Routine antenatal and postnatal care

Routine antenatal and postnatal care should be facilitated within daytime working hours, Monday to Sunday 0900 to 1700. Midwives should also facilitate antenatal and postnatal care if women are inpatients within the units.

Midwives will work with the wider MDT including, GPs, safeguarding midwives, social care services and antenatal services

The team will provide an antenatal education programme which is tailored to the needs of the women within the service.

Midwives will have access to interpreters and a telephone interpreting service, which should always be utilised if needed.

The team will hold regular meetings, to discuss referrals, caseloads, co-ordinate activities, to reflect, learn and share experience. Meetings will also enable timely resolution of any issues.

5.5.2 Standby Working

Midwives will operate on a stand-by rota, to cover intrapartum care. The intrapartum care will be facilitated in any of the Trusts birthing facilities and at home birth, if women have chosen this. In case of homebirth the pilot team midwife will be supported by a member of the homebirth team, who will be the second midwife.

Midwives will work contracted hours, as per 5.4 of the trusts rostering policy. The hours actually worked are likely to fluctuate from week to week and month to month due to the nature of the stand-by service. The rolling caseload of 35 women per WTE will provide approximately the correct amount of activity to fulfil WTE hours. Midwives within the team will record their activities and duty hours, and this will be supervised by the team Deputy and Matron. The trusts e-rostering system will be utilised, and updated to reflect hours worked.

The team will work in correlation with the Working Time Directive, which states that staff must not work more than an average of 48 hours a week, over a 17 week period. The Trusts Working Time Regulations policy states rest breaks must be taken as follows:

- Between 6 and 9 hours on duty; 30 minute unpaid break
- Shifts longer than 9 hours; 60 minute unpaid break, which can be divided

Midwives should not work more than 12 hours in a 24 hour period.

The team will be supported by core midwives within the units or at homebirths for rest breaks. The team will work in partnership with the MDT team including midwives, obstetricians and other labour ward professionals to ensure women receive optimally safe care.
5.5.3 Sickness/Absence

Any sickness or absence will be reported in line with the Trusts Sickness Absence policy.

5.5.4 Annual Leave, Rotas and Requests

The e-roster system will be used to make requests for days off and annual leave in line with Trust policy. Midwives are expected to work in a flexible manner. Due to the nature of this team, only one team member may take annual leave at any one time. This is the responsibility of the Deputy Team Leader to ensure leave is planned across the year effectively. At commencement of the team any existing authorised annual leave will be honoured.

When a team member has protected days off, the Team Leader should ensure that overnight on stand-by duties are not allocated on the last working day. This concept also applies to the last working day prior to the team member commencing annual leave. Team members are entitled to eight protected days off per roster period.

Rosters should be planned as far in advance as practical for the team, and available for the team to view a minimum of 8 weeks in advance. This is the responsibility of the Deputy Team Leader.

5.5.5. Expenses and Reimbursements

Any expenses incurred during the course of working in the caseload team will be reimbursed in line with the Trust expenses policy (B23/2011). Midwives will not be reimbursed for any penalty charges incurred during working duties.

When called from standby and working unsociable hours, team members will claim for enhanced hours as per form PCF2, accessible via the trust intranet. Guidance on completion of PCF2 can be found at: http://insite.xuhl-tr.nhs.uk/homepage/working-life/employment-info/payroll-service/payroll-forms/forms-and-guidance.
6. Referral Process

Consent from women should be sought prior to initiation of caseload care; women’s choice will be respected. Women may be referred by:

1. Midwives across the maternity service
2. Obstetricians
3. Self-referral
4. GPs

At the commencement of the team women will be accepted at 3 stages of their pregnancy; Booking, 20 weeks and 28 weeks. This will ensure majority continuity of care is achieved and the team has adequate workload from the start.

As the team establishes women should be booked by the caseload team, and it is the responsibility of the caseload team to work in collaboration with the trust, to action appropriate referrals. Referrals may include consultant clinics, specialist midwives, social services and ultrasound scans.

When women are booked by the core midwifery team and found to be suitable for caseload, a referral should be made to the caseload team. To ensure seamless and timely care is provided, this can be done in person or via the phone or email, whichever is most convenient. The team will work collaboratively with the local community midwives to identify suitable women.

The team will review all new referrals at their weekly meeting, and any inappropriate referrals will be directed back to the relevant service. The team will notify referring clinicians that a woman has been accepted into the team electronically. The team will keep an electronic database of women booked for caseload care – which will be updated with new information and clinical actions.

7. Service Delivery

7.1 Antenatal Care

- Eligible women will be seen by the caseload team as early as possible following referral. The caseload care model will be explained to women, and consent gained to continue with her care under this premise. Women should be given the contact details of her named midwife and for the standby phone, in addition to contact numbers for the maternity unit. The team will explain which numbers are appropriate in various circumstances.

- Caseload midwives are responsible for making any necessary referrals for women, and navigating women through their care pathway as pregnancy progresses. Women will follow the schedule of appointments as defined in NICE guidance, as a minimum. Extra appointments will be facilitated when required at the named midwife’s discretion and recommended if deemed salient to the woman’s care. All antenatal appointments...
should be conducted by the caseload team midwives – with the named midwife facilitating as many as is possible.

- The team will devise and deliver an antenatal education programme and facilitate a clinic to complete screening for diabetes.
- On admission to one of the units with suspected labour, or for a spontaneous rupture of membranes assessment, or any Maternity admission, the caseload midwife should endeavour to attend provide care. The core maternity staff in the maternity unit should not delay any necessary treatment, and should provide care until the caseload midwife attends.
- Should the woman require admission to the ward during pregnancy, the caseload team should aim to review the woman once a day, and continue to co-ordinate her care in collaboration with the core staff in the maternity unit.
- Should the woman require induction of labour, the caseload midwife should commence the induction process with the woman, as per normal protocol. Dependant on the clinical situation, the caseload midwife may wish to hand care over to core staff until the woman is requiring labour care/one-to-one care. The caseload midwife is not required to stay with the woman in the absence of uterine activity, unless she has other needs that require 1-2-1 care.

7.2 Care in labour

- Women should be counselled regarding place of birth in line with current guidance and in collaboration with the multi-disciplinary team. Women can be referred to the Birth Choice’s clinic should they require additional input into their choice of birth setting.
- A link consultant obstetrician will support the team with intrapartum care plans.
- Elective caesarean sections should be attended by the woman’s named midwife and continued until the woman is recovered onto a postnatal ward.
- Women should be advised on the signs of labour and encouraged to contact their named midwife or standby phone when they experience any of these symptoms.
- When the woman requires assessment, the team midwife should meet the woman at her chosen birth place, complete an assessment and continue care if she is in labour.
- Intrapartum care will be prioritised, and on occasion it may be necessary to rearrange some community clinical activities. Women must be made aware of this likelihood when counselled at the first appointment.
- If the woman chooses to give birth at home, it is the responsibility of the midwife on duty to ensure all of the appropriate equipment required is available at the woman’s house, and that a second midwife is called from the homebirth team. In the event of no homebirth team availability, a member of the caseload team should respond as second midwife, this may not be necessary in the latent or 1st stage of labour. Should hospital transfer be necessary, an ambulance will be called and the caseload midwife will accompany the women during transfer and remain to facilitate the hospital birth.
- If the woman goes home from the maternity unit in early labour, the caseload midwife can resume normal activities/return home.
- If the woman requires continued intrapartum care, the on duty midwife will provide this care for up to 12 hours. The midwife should not work for longer than 12 hours.
continuously or if they feel unsafe to continue. Handover of care to team members should be arranged as soon as it is required.

- Whilst a caseload midwife is providing intrapartum care on the labour ward or birth centre, the labour ward coordinator on duty is responsible for ensuring the caseload midwife is provided with a rest break.
- Intrapartum care should be provided to women in line with Trust and NICE guidance.
- Following birth, the caseload midwife is responsible for completing all of the routine documentation and transferring the woman to the postnatal ward or home. After transfer to the postnatal ward, the caseload midwife should hand over the care to core midwifery staff.

7.3 Postnatal care

- If the woman has birthed at home, the attending midwives should stay at the woman’s home for at least two hours following time of birth, and ensure she will be visited within 24 hours by one of the team.
- The caseload team should review women and babies on the postnatal ward at least once a day, until they are discharged home. Discharge from hospital should take place as soon as is deemed safe to do so. The caseload midwife should provide support with infant feeding in line with ‘Baby Friendly’ initiative. Discharge home should be undertaken by the caseload midwives. In times of high activity in the team, the ward may need to discharge the woman to ensure no unnecessary delays.
- The first home visit in the postnatal period will take place within 24-48 hours of discharge from hospital, and should be conducted in the woman’s home by the woman’s named midwife where possible. All postnatal visits thereafter should also be conducted by the caseload team, and may be facilitated in the woman’s home or at the clinic.
- Based on the assessment at the first home visit the woman will have an individualised plan of postnatal care devised in partnership with her, based on her needs and the clinical picture. Telephone advice will also be available from the caseload team, and this should be explained.
- Emergency contacts should be provided to the woman and her family.
- The caseload team are responsible for conducting routine tests such as the newborn bloodspot test, and for ensuring maternal and neonatal wellbeing is maintained as per NICE guidance.
- Women should have a minimum of three postnatal visits from the caseload team, and additional visits will be arranged if necessary.
- If the woman requires obstetric postnatal assessment and/or readmission to the maternity unit, the caseload midwife should attend with the woman and conduct the initial assessment in collaboration with the multi-disciplinary team.
8. Transfers

If the woman moves out of the Trusts catchment area, care will be transferred to the women’s local service. If the woman moves beyond the team LE4 catchment area but within LLR – the decision to continue caseload care will be made on a case by case basis.

9. Students

The team will support a small number of student midwives in conjunction with the link universities and the trusts clinical placement facilitators. Ideally this will be for the duration of their case holding placement.

10. Clinical Audit and Guidelines

- A copy of all maternity unit guidelines and policies are available to all staff via the intranet.
- The caseload midwives will complete all relevant data collection and work in partnership with the research team to evidence the outcomes for women.

11. Education and Training

The team will complete all necessary mandatory training, and keep up to date with relevant guidelines and evidence. Additional support will be offered to update team members working in new locations, the education team and core staff will provide support with any additional training required. Some additional training may be offered in areas such as holistic therapies, and other training to improve experiences of women in their care.
11. Supporting References


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<th>CONTACT AND REVIEW DETAILS</th>
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<tbody>
<tr>
<td>Guideline Lead (Name and Title)</td>
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<tr>
<td>Executive Lead:</td>
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<tr>
<td>Details of Changes made during review:</td>
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