North West London was an ‘early adopter’ for NHS England’s Maternity Transformation Programme to fast track the implementation of recommendations in The National Maternity Review (2016). The North West London maternity team has developed this document to provide an overview of how change has been implemented within our maternity services, the challenges faced and to share lessons learnt. This toolkit contains practical advice and information, details of new ways of working, use of new technology and case studies.

The infographic below details the journey of the early adopter’s programme in North West London.

North West London received funding from NHS England to improve local maternity services and deliver the recommendations from the National Maternity Review, Better Births.
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### How to use this toolkit:

In the orange Next steps box, we make suggestions for you to think about for your service. Where there is an asterisk * there is a tool in the Appendices to assist you.
1. Who we are

The North West London Local Maternity System (LMS) comprises four hospital trusts, six maternity units and eight clinical commissioning groups, supporting approximately 29,000 births a year. The LMS covers the same areas as the North West London Sustainability and Transformation Partnership (STP) footprint, now known as the North West London Health and Care Partnership.

The LMS is made up of midwives, obstetricians, neonatologists, mental health specialists, GPs, health visitors, commissioners, representatives from NHS England, service users (Maternity Voices Partnership representatives) and the North West London maternity project management team. Representatives from other organisations are invited to attend periodically.

In late 2016, North West London was chosen as one of seven Early Adopter sites to receive funding from NHS England to improve local maternity services and to test the recommendations from the National Maternity Review, “Better Births”. With this funding the LMS was encouraged to “go further, faster” and to share the learning with other LMS’s across the country.

The NHS trusts providing maternity care in North West London are:

<table>
<thead>
<tr>
<th>Acute provider trust</th>
<th>Hospital site (maternity unit)</th>
</tr>
</thead>
</table>
| Chelsea and Westminster Hospital NHS Foundation Trust (CWHFT) | Chelsea and Westminster Hospital  
West Middlesex Hospital |
| Imperial College Healthcare NHS Trust (ICHT) | Queen Charlotte’s and Chelsea Hospital  
St Mary’s Hospital |
| London North West University Healthcare NHS Trust (LNWUHT) | Northwick Park Hospital |
| The Hillingdon Hospitals NHS Foundation Trust (THH) | Hillingdon Hospital |

Giving birth in North West London
The Early Adopters project started with a gap analysis, looking at the care currently being provided and the recommendations made in the National Maternity Review. As North West London has a history of engaging with the women and families in our area, we were pleased to find that many of the recommendations had already been achieved.

Key areas for improvement were identified:

- Improve the consistency of information women receive
- Increase continuity and personalisation of care within a small team of midwives
- Each team of midwives to have an identified obstetrician
- Improve women’s access to perinatal mental health services
- Improve quality of to postnatal care
- Improve handover to community services after discharge from maternity services
- Move towards electronic maternity records
- Enhance maternity commissioning.

Some of the above areas were identified as achievable within the Early Adopters two year project. Others were allocated to key areas of focus within the LMS Maternity Transformation Programme (see Chapter 13).

Next steps:

Undertake a gap analysis against Better Births to see where your LMS/maternity unit needs to improve (National Maternity Review 2016, Annex A, pages 100-111).
3. Vision and aim

The North West London LMS vision is to lead the way in providing first class, safe maternity care that offers choice and individualised continuity, with the family at the heart of everything we do.

Our vision will be achieved by:

- Increasing continuity of carer
- improving postnatal care
- ensuring consistency of information.

The aim is to improve the clinical outcomes and care experience for women and families using the maternity services in our area.

Our aim will be achieved by:

- Asking women for feedback on their experiences
- asking staff for feedback on working in new models of care
- assessing the health outcomes of women and babies through formal evaluation
- evaluating the operational and financial impact.

Definition of “continuity of carer”:

Women will have a lead midwife that is known to them, to coordinate their care, with antenatal, intrapartum and postnatal continuity being provided by a team of no more than six to eight midwives.

Next steps:

- Set out your vision
- state the aims for improvement
- be clear about the definition of ‘continuity of carer’.
The LMS held a launch event at the Royal College of Obstetricians and Gynecologists in London in April 2017. Approximately 100 members of staff attended from across the sector. Presentations from Baroness Julia Cumberlege, Professor Jane Sandall (Kings College, London), Sandra Smith (NHS England), Jacque Gerrard (RCM Director for England) and Pippa Nightingale (Senior Responsible Officer, NW London Maternity Transformation):

- Invited participants to give their views about maternity care in North West London
- invited staff to give their views on the proposed work streams
- shared initial thoughts on ways to improve maternity services (see below).

### Midwifery-led Care

**Who are we trying to help?**
- Healthy pregnant women without obstetric or medical complications
- Pregnant women local to our geographical location

**What are we trying to do?**
- Understand current models of how midwifery-led care is provided across North West London
- Develop personalised models of care adaptable to all maternity pathways and needs

**Top things we need to consider**
- Logistics for service redesign, opportunities and constraints
- Embedding new changes to workforce model and engagement
- Financial impact, cost of redesign and benefits realised
- How new care model integrates into holistic maternity system

**What are we trying to achieve?**
- Continuity of carer
- Reduction in adverse outcomes
- Improve maternal care experience throughout the care journey
- Better workforce design and experience

"Relationship or personal continuity over time has been found to have a positive effect on user experience and outcomes... Pre-term births have also been found to be reduced through continuity of the care."

Better Births report 2016

### Postnatal Care

**Who are we trying to help?**
- Pregnant women
- Women seeking postnatal information / advice
- Improve postnatal maternity experience and outcomes for women.
- Empower women to make informed decisions on their pathway
- Develop personalised models of care adaptable to all maternity pathways and needs
- Integrate services with antenatal pathways

**What we would like to ask you**
- How would you like to be involved?
- Testing continuity of care or carer
- What are likely barriers / blockers to the postnatal care model?

"Relationship or personal continuity over time has been found to have a positive effect on user experience and outcomes... Pre-term births have also been found to be reduced through continuity of the care."

Better Births report 2016

**Top things we need to consider**
- Financial impact: Lack of funding for postnatal care
- Team work: Staff work / life balance, working hours
- Consistency of information and advice
- Holistic approach to model of care design

**What are we trying to achieve?**
- Consistent information and advice
- Model of care suitable for mothers and workforce
- Realistic and effective model within current financial environment

### Next steps:
- Involve the multi-disciplinary team from the outset
- have some initial ideas to promote discussion
- use publicity to launch your vision – make it special!
5. Mapping the existing pathways

Following the launch event, we formed a working group with representation from all the trusts. This included obstetricians, midwives, GPs, Consultant Midwives etc. Working groups in each trust were also established to align with the aims of the Early Adopters Project.

The first task was to map the existing pathways of care for all the maternity units. This enabled the LMS to see where best practice in continuity of care existed and where improvement was required.

This is an example of a process-mapping exercise* in North West London.

Next steps:

- Map your own current maternity pathway*
- look for evidence of best practice/continuity of care
- Identify areas where improvement is needed.
As trust-based steering groups developed proposed models of care, staff focus groups were set up and SurveyMonkey questionnaires sent out to ‘test’ the appetite for change. Clinical leads (heads of midwifery, matrons and consultant midwives) were identified as ‘transformation champions’ so that staff could ask questions. There were regular staff bulletins, team meetings and emails to keep everyone up to date with the progress.

As expected, many wanted to know how the new models of care might impact on their work-life balance, salary, part-time working patterns, travel etc.

Feedback from staff indicated an interest in providing enhanced antenatal and postnatal continuity with some midwives being interested in working in a caseload model for specific cohorts of women (for example, socially vulnerable women and women with diabetes).
No review of maternity services would be complete without finding out what women thought about our existing services and our emerging ideas for new models of care. Information and advice was sought from the one existing Maternity Voices Partnership. Co-production became a model for harnessing the knowledge of service users. Throughout the project we held several events at local children’s centres to find out what mattered most to women. What they shared confirmed that we were heading in the right direction.

A dedicated website * for women to provide feedback was set up, which has received over 2,000 hits since it was launched. The feedback helped the LMS to define, refine and develop new models of care.

“I would like to be able to build a relationship with one midwife”

“Wish I could see the same experienced midwife throughout my pregnancy and postnatal care”

* https://maternitynwlondon.commonplace.is

Next steps:

• Identify key stakeholders - involve staff of all levels from the outset
• get opinions from staff about how they would like to work
• involve service users/maternity voice partnerships early on and continue to work with them throughout the process
• nurture existing and emerging Maternity Voices Partnerships. Refer to the National Maternity Voices Toolkit on the National Maternity Voices website.
Arising from extensive consultation with the maternity workforce and service users across North West London, three preferred new models of care emerged (see Appendices for further details):

<table>
<thead>
<tr>
<th>Model 1 – Caseloading</th>
<th>Model 2 – Birth Centre</th>
<th>Model 3 – Hybrid (community linked to labour ward)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuity throughout full pathway</td>
<td>Continuity for low risk women suitable for birth centre care – full continuity</td>
<td>Continuity in community team, linked with labour ward team – full continuity</td>
</tr>
<tr>
<td>Teams of four to six midwives</td>
<td>Teams of six to seven midwives</td>
<td>Community team of six midwives</td>
</tr>
<tr>
<td>Buddy system – named midwife and one buddy</td>
<td>Team approach to birth, with named midwife for antenatal and postnatal care</td>
<td>Linked team approach</td>
</tr>
<tr>
<td>Caseload of 30-40 women (depending on risk)</td>
<td>Ratio of 1:60</td>
<td>Ratio 1:50 (antenatal &amp; postnatal)</td>
</tr>
</tbody>
</table>

Working groups in the trusts began plans to introduce these new models of care. Staff were recruited to the new teams, through internal and external recruitment. Timelines for the new models of care were agreed.

Our engagement with service users revealed that women also wanted better and more consistent information from their midwives.

Following this engagement we found there was a need to:

- Develop a suite of information booklets for pregnancy, birth and beyond
- Launch our maternity Mum & Baby app.

The Early Adopters Project Management team, in collaboration with maternity staff and service users, set about revising and writing materials for these exciting elements of the Early Adopters work (see case studies in Chapter 12).

In addition, the LMS also had the aspiration to:

- Define the role of the Band 3 Maternity Support Worker in collaboration with Health Education England North West London. Work towards developing a bespoke job description and skills passport that will meet the needs of all the trusts in the sector is in progress. A further objective is to develop a Level 3 Apprenticeship Programme for these valuable members of the maternity team (see case studies)
- Set up and develop service user engagement through Maternity Voices Partnerships in all four trusts (see case studies in Chapter 12).

**Next steps:**

- Determine the priorities for your LMS/trust
- Draw up a timeline for implementation.
9. Planning and delivering new models of care

Model 1

This model is a pure caseloading model, with each midwife in the small team working in a “buddy” pair, carrying a caseload ratio of 1:30-40, depending on the complexity of each woman. This model offers the highest level of continuity across the pathway, with midwives being on call for their own women (and their buddy’s during rest periods). Care is provided in a variety of locations.

This model was implemented, adapted and tested in several ways across several North West London hospitals and included women with gestational diabetes, social complex factors, multiple pregnancies and women requesting a homebirth.

See these examples:

Model 1a: Caseloading

An example of a low risk caseload team

<table>
<thead>
<tr>
<th>Team size &amp; structure</th>
<th>Ratio of midwives: women</th>
<th>On call commitment</th>
<th>In/out criteria</th>
<th>Other information</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 WTE</td>
<td>1:36-40 per annum</td>
<td>2-4 on calls per week</td>
<td>Low risk at booking</td>
<td>&gt; 15% uplift on salary to ensure midwives are remunerated for on-call commitment</td>
</tr>
<tr>
<td>X1 Band 7 (Team Leader)</td>
<td>Team total 240 women per year</td>
<td>Buddy system (two/three midwives buddying up and providing 24 hour on call cover between them)</td>
<td>Living in a traditionally 'out-of-area' locality</td>
<td>Majority of antenatal care provided at home</td>
</tr>
<tr>
<td>X5 Band 6</td>
<td></td>
<td></td>
<td>Aim to increase MW led births (home and BC)</td>
<td>Complete autonomy and self-management</td>
</tr>
</tbody>
</table>

Lead Trust Contact: Natalie Carter, Consultant Midwife
natalie.carter@chelwest.nhs.uk

Model 1c: Caseloading

An example of caseload team for women with diabetes

<table>
<thead>
<tr>
<th>Team size &amp; structure</th>
<th>Ratio of midwives: women</th>
<th>On call commitment</th>
<th>In/out criteria</th>
<th>Other information</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 6 WTE</td>
<td>1:36 per annum</td>
<td>2-4 on calls per week</td>
<td>Women who have been affected by gestational diabetes in a previous pregnancy</td>
<td>&gt; 15% uplift on salary to ensure midwives are remunerated for on-call commitment</td>
</tr>
<tr>
<td>&gt; X1 Band 7 (Team Leader)</td>
<td>Team total 210 women per year</td>
<td>Buddy system (two/three midwives buddying up and providing 24 hour on call cover between them)</td>
<td>Women who are affected in current pregnancy with additional risk factors (i.e. social complexities)</td>
<td>Care provided in a variety of settings</td>
</tr>
<tr>
<td>&gt; X5 Band 6</td>
<td></td>
<td></td>
<td></td>
<td>Complete autonomy and self-management</td>
</tr>
</tbody>
</table>

Lead Trust Contact: Victoria Cochrane, Consultant Midwife
victoria.cochrane@chelwest.nhs.uk

Next steps:

- Consider which women would benefit from caseload care in your LMS/maternity unit
- Work out a business model for remunerating midwives to work in caseload continuity models.
Women enjoying a cup of tea with midwives

Midwives collect their actual hours worked every week, and are encouraged to balance over a 4 week roster period

Next steps:

- Encourage the midwives to work out their own shift roster
- allow for gradual step down from existing teams as new caseload teams develop
- consider how the changes will impact staff members not working in the new models of care.
Model 2

This was developed as an alternative to Model 1. Midwives are based in an alongside Birth Centre, working within a team of six to seven midwives, with a caseload ratio of 1:60-85 (depending on GP share care arrangement). Each midwife has a set clinical day in which s/he runs an antenatal/postnatal clinic. There is a buddy or team approach to care. Women are invited to join the Birth Centre team from Booking, enabling the midwives to do their own Bookings for the service. Women receive all their antenatal care in the Birth Centre and return for some postnatal appointments. There is a team approach to provision of intrapartum care, with photo booklets and/or ‘meet the midwife’ sessions, used to introduce other team members. This model meets Better Births objectives by providing care right across the maternity pathway.

This model has proved popular across in North West London, with further teams set to launch soon. It has proved popular with midwives, who have been able to hone their skills by providing care across the maternity pathway, without needing to be on-call.

Model 2: Birth centre model

<table>
<thead>
<tr>
<th>Team size &amp; structure</th>
<th>Ratio of midwives: women</th>
<th>On call commitment</th>
<th>In/out criteria</th>
<th>Other information</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 7.2 WTE</td>
<td>&gt; 1:59 per annum (7 bookings per week)</td>
<td>&gt; No on calls</td>
<td>&gt; Low risk on referral for maternity care</td>
<td>&gt; Women who do not remain low risk go back into routine care</td>
</tr>
<tr>
<td>&gt; X6.2 Band 6</td>
<td>&gt; Team total 364 women per year</td>
<td>&gt; Set AN/PN clinic shifts</td>
<td>&gt; Mixture of nights/weekend s for other shifts</td>
<td>&gt; All antenatal care offered in antenatal clinic by named Birth Centre Midwife</td>
</tr>
<tr>
<td>&gt; x1 Consultant Midwife (who has a small caseload and supports team)</td>
<td></td>
<td>&gt; Women contaced and offered care under model – opt in or out</td>
<td></td>
<td>&gt; Birth Centre always staffed with one ‘caseload’ midwife (to provide intrapartum care to caseloaded women) and one core midwife (to provide care to all non-caseload low risk women)</td>
</tr>
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</tbody>
</table>

Example of weekly caseload roster

Next steps:

• Encourage the midwives in the team to work out how they want the model to work. Flexibility in the implementation is key.
Model 3

This hybrid model was developed in response to the desire to provide continuity of care for women planning to give birth on the labour ward, because they have obstetric, medical risk factors or complex social factors. Each woman has a named midwife to co-ordinate care in the community during the pregnancy and after the birth. There is a linked team present on labour ward to provide intrapartum care. Midwives are introduced through ‘meet the midwife’ sessions and/or photo booklets (see case studies).

This model has also proved popular in some of our maternity units and enables women who are not low risk to receive continuity of care from known midwives. It emerged from an earlier iteration of a community model and has enabled hospital-based midwives to participate in the new models of care. Like Model 2, it particularly suits midwives who prefer not to be on-call.

Model 3: Hybrid model linking community to labour ward for women with complex social factors

CoC: antenatal > intrapartum > postnatal

<table>
<thead>
<tr>
<th>Team size &amp; structure</th>
<th>Ratio of midwives: women</th>
<th>On call commitment</th>
<th>In/Out criteria</th>
<th>Other information</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;6.5 WTE (community)</td>
<td>&gt;1:50 (antenatal &amp; postnatal)</td>
<td>&gt;No on-call commitment for staff working in the labour ward team.</td>
<td>&gt;Women will be seen in the community but will meet labour ward team prior to delivery.</td>
<td>&gt;Named midwife for each woman &gt;Aim for all antenatal and postnatal care to be provided by named midwife.</td>
</tr>
<tr>
<td>&gt;1 WTE Band 7 “champion” (to co-ordinate labour ward management)</td>
<td>&gt;Community link as in Model 3b.</td>
<td>&gt;Linked team approach enabling women to have continuity in the community and a known midwife on the labour ward.</td>
<td>&gt;Linked team approach enabling women to have continuity in the community and a known midwife on the labour ward.</td>
<td></td>
</tr>
<tr>
<td>&gt;6.7 WTE Band 6 (labour ward)</td>
<td>&gt;No on-call commitment for staff working in the labour ward team.</td>
<td>&gt;Sensitive information relayed between team members only. Band 7 champion will attend monthly team meeting.</td>
<td>&gt;Team leaders will work closely with Triage team to ensure smooth transition to labour ward</td>
<td></td>
</tr>
</tbody>
</table>

Next steps:

- Be creative as you develop models of care
- allow models to emerge according to your unique demographic.
Existing evidence for cost-saving caseloading models of care

From a review of four studies on caseloading care models, there is considerable research on the positive impact of providing continuity of care for health outcomes, women’s experience and workforce satisfaction. It is recognised as the gold standard by the Royal College of Midwives, and is encouraged by relevant regulatory bodies (NICE, Royal College of Obstetricians and Gynecologists, Nursing and Midwifery Council).

However, to date there is minimal research specifically comparing the cost of caseloading models with traditional models of care (likely due to the difficulty in comparing models). UK assessment of midwife-led care in comparison to obstetric-led care found savings of £12.38 per woman, equating to an aggregate cost saving of £1.6 million based upon the expansion of midwifery-led services.

A large randomised controlled trial in Australia found that caseload midwifery care was a highly cost-effective and safe model for women of ANY risk, incurring an average cost saving of AUS $566.74 (approximately £350.00) per woman.

What the evidence said:

“Lead author Professor Sally Tracy, from the University of Sydney, said caseload midwifery costs roughly £333 less per woman than current maternity care, and could play a “major part” in reducing health expenditure in countries like the UK.” (Ford 2013)

“A woman who receives care from a known midwife is more likely to:
Have a vaginal birth, have fewer interventions during birth, have a more positive birth experience of labour and birth, successfully breastfeed her baby, cost the health system less.” (London Strategic Clinical Network 2015)

“The balance of evidence is that relationship continuity leads to increased satisfaction among patients and staff, reduced costs and better health outcomes…” (Freeman & Hughes 2010)

The North West London Early Adopters team was tasked with testing new models of care to ensure that they are cost-saving and at a minimum cost-neutral for the trusts.
Using the existing workforce to deliver pilot continuity teams

Birthrate Plus® (the only national tool available for calculating midwifery staffing levels according to case complexity) recommends a ratio of 1:29.5 (midwives to births) with an increase of up to 1:35 when women give birth at home. These figures directly correspond to planned caseload numbers, in order to make the service in line with this guidance, and to make it cost-neutral/cost-saving.

Model structure inputs and outputs (source: NHS England)

Inputs-maternities
- Caseload (1:35)
- Booking appointment
- Number of antenatal appts
- Gestational length
- Labour duration
- Delivery method
- Postnatal appts

Inputs-Midwives
- Protected time rota
- Number of teams
- Annual leave
- Sick leave/CPD
- Time for team meetings

Assign maternities to midwives
- Midwives assigned in the following order: lead, buddy, team, other

Outputs
- Proportion of births covered by a continuity midwife (lead, buddy, team, other)
- Variation in number of hours worked per week by continuity midwives
- Total care time over 52 weeks

Utilising the current workforce to re-design how and where care is provided has the potential to bring together recommendations regarding ratios in Better Births.

Using current vacant posts as a recruitment opportunity will reduce workload significantly for core staff and make their use of time more efficient. Complex and time-consuming cases will have a team directly responsible, resulting in expert management.

In order for the new models of care to be cost-neutral or cost-saving there are other things to consider:

Next steps:
- Consider on-call payments/salary uplift
- set up equipment costs
- banding of staff
- travel reimbursements
- support staff needed
- coaching/mentoring for new team members (see case studies).
Despite the shortage of direct evaluations comparing the costs of caseloading models versus the standard model of care, there is sufficient evidence of the benefits of continuity of care models and the associated cost-saving potential, as indicated in the table above.

The indirect savings potential is vast for continuity models. Improved outcomes could be expected for each specific caseload group i.e. improved access to mental health services for vulnerable women, thus improved long term mental health, wellbeing and a reduction in the morbidity associated with this.
# Steps in launching a new maternity caseloading team

## Financial process

### Process steps

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<th>Phase 2 Modelling</th>
<th>Phase 3 Implementation</th>
<th>Phase 4 Post-launch</th>
<th>Phase 5 Next steps</th>
</tr>
</thead>
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<tr>
<td><strong>Who is involved?</strong></td>
<td><strong>Who is involved?</strong></td>
<td><strong>Who is involved?</strong></td>
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<td><strong>Who is involved?</strong></td>
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<td>EA Project team</td>
<td>EA Project team</td>
<td>EA Project team</td>
<td>EA Project team</td>
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<tr>
<td>Consultant Midwives</td>
<td>Consultant Midwives</td>
<td>Consultant Midwives</td>
<td>Consultant Midwives</td>
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<td>Inpatient/outpatient Matrons</td>
<td>Inpatient/outpatient Matrons</td>
<td>Inpatient/outpatient Matrons</td>
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<td>Deputy DoM's/HoM's</td>
<td>Deputy DoM's/HoM's</td>
<td>Deputy DoM's/HoM's</td>
<td>Deputy DoM's/HoM's</td>
</tr>
</tbody>
</table>

### Main activities

#### Phase 1 Planning
- Agree project plan & timeline
- Agree structure of team (criteria for eligibility, banding, governance etc)
- Assess ability to form team from existing/vacant or maternity leave posts

#### Phase 2 Modelling
- Review options for pay conditions (uplift vs. on call allowances)
- Consider short and long term costs of team (travel expenses, equipment, training, mobile phones)
- Internal and external staff recruitment
- Forward thinking of potential risk to existing team stability on new team launch
- Review and agree model between senior managers prior to implementation
- Consider potential for double running costs during set-up

#### Phase 3 Implementation
- Ensure senior/exec level approval is received before implementation of new way of working
- Prior to launch, agree where posts are taken from equitably to minimise impact on existing teams
- Remove posts from existing teams to avoid backfill with bank/agency
- Consider strategies to minimise impact on clinical workload during phased implementation of new team
- Engage with healthroster to form appropriate template for team

#### Phase 4 Post-launch
- Capture impact on workload in existing teams/areas
- Ensure change forms are completed to reflect new pay conditions, cost code etc.
- Monitor workload, hours worked and activity removed from core teams to ensure modelling predictions sufficient to represent real-time working practice
- Monitor and manage impact and implications for new and existing teams
- Continue monitoring of workload, hours worked and long term cost implications of new service
- Consider lessons learned and existing modelling when up-scaling or expanding

### Key learning/step

- Multi-disciplinary planning on where posts to create new team can feasibly come from
- Careful consideration to impact of new model on existing services, and strategies to mitigate risk
- Remove posts from roster templates in advance, ensuring overlap spending and backfill with bank/agency cannot occur
- Capture and manage impact on existing services, and support period of transition in collaboration with senior midwifery team
- Consideration of longer term financial impact of new service
## Steps in launching a new maternity caseloading team

### Workforce process

<table>
<thead>
<tr>
<th>Process steps</th>
<th>Phase 1 Planning</th>
<th>Phase 2 Modelling</th>
<th>Phase 3 Implementation</th>
<th>Phase 4 Post-launch</th>
<th>Phase 5 Next steps</th>
</tr>
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<tbody>
<tr>
<td><strong>Who is involved?</strong></td>
<td>EA Project team</td>
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<td>Consultant Midwives</td>
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<tr>
<td><strong>Main activities</strong></td>
<td>• Agree project plan &amp; timeline</td>
<td>• Review options for potential new models of care with all levels of midwifery workforce</td>
<td>• Complete skills assessment to inform orientation period for new starters</td>
<td>• Support clinical areas affected by redistribution of staff</td>
<td>• Audit against set metrics expected to be affected by intervention</td>
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<td></td>
<td>• Consult staff on preferred alternative ways of working</td>
<td>• Following agreement of model, create job description in Trust format</td>
<td>• Ensure Healthroster template created and rosters competed for first 8 weeks</td>
<td>• Monitor workload, hours worked and activity removed from core teams to ensure modelling predictions sufficient to represent real-time working practice</td>
<td>• Research and development opportunities</td>
</tr>
<tr>
<td></td>
<td>• Assess ability to form team from existing/vacant or maternity leave posts</td>
<td>• Cascade internal expressions of interest to current workforce</td>
<td>• Consider strategies to minimise impact on clinical workload across service</td>
<td>• Sharing, teaching and learning to/from other sites regarding new way of working</td>
<td>• Sharing, teaching and learning to/from other sites regarding new way of working</td>
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<tr>
<td></td>
<td>• Map current models to form overview of current position of workforce within model</td>
<td>• Submit external job advert to NHS Jobs</td>
<td>• Circulate finalised standard operational policy to staff</td>
<td>• Make adjustments to model as required if challenges arise</td>
<td>• Sharing, teaching and learning to/from other sites regarding new way of working</td>
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<tr>
<td></td>
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<td>• Agree pay/conditions</td>
<td>• Team launch event and engagement with comms</td>
<td>• Regular supervision and support for staff working</td>
<td>• Sharing, teaching and learning to/from other sites regarding new way of working</td>
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<td></td>
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<td>• Draft standard operational policy</td>
<td>• Review any guidelines that may be affected by intervention</td>
<td>• Team building away-days and training opportunities</td>
<td>• Consider lessons learned and challenges to workforce when up-scaling or expanding</td>
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<tr>
<td></td>
<td></td>
<td>• Engage with workforce on planned launch of new model and impact on existing services</td>
<td>• Run bespoke, MDT training for teams</td>
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<tr>
<td><strong>Key learning/step</strong></td>
<td>Early engagement with workforce to ensure buy-in and positive regard for upcoming changes to workforce and service</td>
<td>Allow substantial time to fully recruit to teams, may take several rounds of advertisement</td>
<td>Engagement with workforce regarding impact of new way of working and transition period</td>
<td>Support new team during period of establishment, and capture and learn from challenges</td>
<td>Consideration of longer term impact on the workforce of new service</td>
</tr>
</tbody>
</table>
We took three approaches to evaluate the work done to transform maternity services in North West London:

1) **National evaluation**

SQW, an independent research and consultancy organisation, has evaluated the transformation of maternity services in seven sites across England, including North West London, on behalf of NHS England. This evaluation collected feedback from:

(i) The local maternity workforce regarding their experience of providing maternity care, and
(ii) women accessing maternity services, to understand their experiences of receiving maternity care.

The outcome of this evaluation was reported nationally via NHS England in 2019.

2) **North West London local evaluation**

A) **Quantitative**

Imperial College Health Partners (ICHP), the North West London academic health sciences network were appointed to evaluate the models of care being piloted across the six maternity units.

The evaluation includes:

- Impact on clinical outcomes (including seven primary + two supplementary outcomes for each of the two new models one and two)
- Continuity of carer achieved
- Model cost/benefit with financial narrative: set up costs, running costs and benefit analysis, including workforce requirements
- Impact on workforce experience
- Impact on women’s experience.

Matched cohort data was collected to compare the outcomes from the new models.

B) **Qualitative**

One Plus One was contracted to evaluate the impact of the new models of care on women’s experience, using interviews and data from friends and family tests, user engagement events, the Commonplace website, and feedback from Maternity Voice Partnerships.

One Plus One also evaluated the impact of the new models of care on workforce experience, using interviews, feedback from staff focus groups and surveys.

The evaluation of the maternity Early Adopters transformation programme, co-authored with ICHP, is due for publication in conjunction with this toolkit.
Internal audit of transformational changes

Each team of midwives working in the new models was asked to complete specially-designed Excel spreadsheets to capture data, some of which was used for the formal evaluation detailed earlier; the rest will be used for continued internal audit and learning.

As an example, here is a section of the Excel spread sheet for Model 2 (Birth Centre):

North West London Early Adopters Programme
Model 2 - Birth Centre Caseload

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<table>
<thead>
<tr>
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<th>t1</th>
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<td>No of antenatal appointments after caseload</td>
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<td>Total number of USS Seen by Obstetrician?</td>
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<td>Transferred out of MW and care antenatally?</td>
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<td>Seen by other HCP? Who/ why</td>
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</table>
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Below is an example of the spreadsheet used to capture data on continuity Key Performance Indicators (KPI’s) for community group practice:

**Mandatory**

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<th>Number</th>
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<td>KPI 4</td>
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</table>

<table>
<thead>
<tr>
<th>Delivery Month</th>
<th>Maternal NHS no</th>
<th>Baby NHS No</th>
<th>Has the woman been allocated a team?</th>
<th>Has the woman been allocated a ‘named’ midwife?</th>
<th>Is there a mobile contact number for the named midwife?</th>
<th>Total combined antenatal and postnatal number of team midwives met</th>
</tr>
</thead>
</table>

**Next steps:**

- Decide which clinical outcomes are important for your service
- employ robust evaluation methods and techniques to explore and explain your local outcomes.
12. Case studies

In this chapter we present case studies providing insight into aspects of the North West London Early Adopters work.

A. Developing the “Mum & Baby” app
B. Developing Maternity Voices Partnerships
C. Improving postnatal care
D. Maternity information booklets
E. Development and use of photo booklets
F. Maternity service transformation
G. “Making Every Contact Count” training
H. Team coaching
I. Developing the maternity support worker
J. Reflection of a caseload midwife: Daisy team
K. Reflection of a service user: Daisy team
Case study A: Developing the “Mum & Baby” app

Background

In November 2018, the North West London Local Maternity System (LMS) launched the ‘Mum & Baby’ app, available for free on Apple and android platforms. The LMS worked with service users and clinicians to design an app which would work as a woman’s personal guide for pregnancy, birth and early parenthood.

The app offers a digital solution to several Better Births recommendations, namely, all women having a personal care plan; the choice of all three birth settings and choice of which hospital in North West London they would like to give birth; and increasing midwifery-led births. The app also contains extensive clinical care information that supports safety and perinatal mental health services.

The app acts as a single point of access and “digital front door” to maternity services. We anticipate that this will increase self-referrals to maternity services and early booking to meet the 10 weeks target.

Getting started

Arising from the gap analysis of Better Births in mid-2016, the North West London LMS identified that the National Maternity Review recommendation to provide Personalised Care was only partially achieved.

A clinically-led app, funded by Chelsea and Westminster’s hospital charity “CW+”, known as “Mum and Baby”, already existed within the sector. The original purpose of this app was to provide personalised postnatal information to women giving birth at Chelsea and Westminster Hospital. In late December 2017 the North West London LMS agreed to fund and support the app expansion and the launch across the six maternity units in our local area.
The new app is a sector-wide digital source of public health, antenatal, birth and postnatal information for all women and families having their babies in North West London. The new app enables women to:

- Understand their choices for antenatal care, birth and beyond
- Access essential and evidence-based information on pregnancy, birth and early parenthood, with links to trusted organisations and expert advice
- Create personalised care plans to support with choices for antenatal wellbeing, birth preferences, after their baby’s birth and birth reflections
- Track appointments and have accurate information for their service of choice.

Information is also available in booklet form for women and families without access to a smartphone.

The booklets may be viewed/downloaded at: https://www.healthiernorthwestlondon.nhs.uk/documents(maternity

Project development

- The North West London Early Adopters (EA) project team, managed the development and expansion of the app from the very start to the launch, in collaboration with the app developer, Imagineear Limited.
- A clinical working group, including lead midwives/senior midwives and obstetricians from each of the maternity trusts, was appointed to work with the EA team.
- A wide ranging group of stakeholders were invited to participate in writing, reviewing and commenting on the content: women, consultant midwives, obstetricians, physiotherapists, anaesthetists, midwives, health visitors, community maternity champions, IT specialists, communications teams etc.
- Using the Plan-Do-Study-Act cycle, colleagues and service users were invited to comment on material as it was produced. Regular teleconferences and face to face meetings were held as the app progressed and service users tested the content on their electronic devices.
- Once the content was approved, the app was subject to a careful clinical risk assessment, GDPR and safety and equality impact assessments.
- We developed a plan to ensure that the app is continuously updated, current and accurate.

Expected benefits

- Improved experiences of maternity care for women and their families
- More meaningful choices being made by women
- Increased self-referrals and early bookings to meet the 10+6 weeks target.

Through this app, the LMS has achieved the Better Births recommendation: choice and personalisation.
Case studies

The impact on practice

• This app acts as a consistent, evidence-based source of information for women who are pregnant or are thinking about becoming pregnant and acts as an initial point of access into maternity services.

• Throughout the pregnancy journey, the app facilitates conversations with caregivers through Personal Care Plans (PCPs). The PCPs are a key interactive feature of the app which encourage women to think about their choices at all stages of their maternity journey, whilst documenting their thoughts and questions.

• The app directs women and clinicians alike to sources of evidence-based information provided by other reputable organisations.

• During the first five months since the launch over 6,000 downloads were recorded. The app has received very positive feedback from service users since launch:

  “This has done so much to help me understand what to expect during pregnancy and birth”

  “Clear and straight forward”

  “I never knew there was so much to know and this app helps to keep it all in one place”

Launching the app

• The app launched on 8 November 2018 and was endorsed in the press release by key figures: Baroness Julia Cumberlege and Jacqueline Dunkley-Bent (Head of Maternity, Children and Young People at NHS England and National Maternity Safety Champion for the Department of Health).

• The North West London communications team ensured that the release of the app was publicised widely through NHS channels, social media, print journals and the press.

• The North West London EA project team and trust consultant midwives held drop-in sessions to promote use of the app amongst midwives and maternity staff. The app has also been promoted through flyers and business cards placed in GP surgeries, pharmacies and children’s centres in the local area.

Case study A: Developing the “Mum & Baby” app
Hopes for the future

- There is significant potential for this app to be used nationally, expressions of interest have already been received from other LMSs.

Learning

- Ensure that all voices and opinions are heard
- be flexible when working with clinicians and service users, you will need a good understanding of their skills and expertise
- seek advice from other in your organisation who have already developed an app.


For more information about the app, contact mumandbaby.nwl@nhs.net
Case study B: Developing Maternity Voices Partnerships

Background

Arising from the National Maternity Review NHS England recommended that all women in the local area should be able to participate in a Maternity Voices Partnership (MVP) by giving feedback or becoming service user members of an MVP” (NHSE 2017). At the beginning of the maternity Early Adopters project in late 2016, only one functioning MVP (formerly known as Maternity Services Liaison Committee) existed within our local area. At this time maternity user feedback was limited to that received via the friends and family tests and individual feedback received during debriefs or postnatal reflection meetings.

When the Early Adopters project started an MVP had already been set up in Chelsea and Westminster Hospital NHS Foundation Trust. There is now an MVP present in all maternity trusts in North West London.

Getting started

- Women who had shown an interest in being involved in their local maternity service were approached to attend an induction meeting. The meeting was an opportunity for us to provide the women with an overview of the NHS and the vision for our maternity services. We invited members from the existing MVP in North West London to offer advice and support.

- All the new members were invited to attend the MVP Development Day, held in London, hosted by the London Clinical Networks on 2 October 2018. The content of this meeting was geared to offering advice and guidance on:
  - Undertaking the “15 Steps for Maternity” visit
  - reaching vulnerable groups
  - attracting new members
  - giving feedback
  - working collaboratively with maternity services to drive change.
With guidance and enthusiasm to start work, the service users set up MVP meetings at their local trusts, inviting the Early Adopters project team and senior midwives and clinicians.

Ongoing MVP meetings have been facilitated by the LMS to ensure that learning and experiences are being shared across North West London, with each MVP there to support one another. They have also made use of the national MVP website.

It was agreed that we would reimburse services users for their expenses.

**Going forward**

- When we set up the MVPs we agreed terms of reference and created job descriptions and work plans for the MVP chairs.
- Each MVP agreed to undertake the “15 Steps for Maternity” (NHSE 2018), an accredited toolkit developed by NHS service users and healthcare professionals. The output from this toolkit has been impressive and of great benefit to the maternity services involved.
- MVP members attend our monthly LMS meetings and continue to offer their perspective on decisions being made about our local maternity services.
- The MVP co-chairs are responsible for setting up their own meetings and agendas. They keep communication open via Facebook and WhatsApp groups.

*North West London MVP co-chairs*
Learning

- A North West London LMS business case has been submitted to the Clinical Commissioning Groups to provide continued and sustained funding for MVPs to work with us beyond March 2019. It is acknowledged that without commitment from commissioners to fund MVPs the LMS cannot depend on service user goodwill (NHS 2018).

- Ensure that a robust mechanism for reimbursing expenses is set up early on, as processing payments can be lengthy.

- Ensure that your senior leadership team are involved in the set up of the MVPs from the beginning so that the MVP work plans meet the local need.

- Although on going support was provided from the Early Adopter project management team, MVP members fed back that training early on in the process would have been helpful. They also said that it would be helpful to have a list of ‘who’s who’ from the maternity team in their local trust.

- Service users commented that events held in the community were a useful way to engage with ‘easy to reach’ groups of people but that we would need to be more creative to reach those voices that are less heard.

XX MVP work plan

<table>
<thead>
<tr>
<th>Goal 1: Insert goals of MVP aligned to Trust plans/ Better Births (e.g. Personalisation and choice, CoC.)</th>
<th>Key Action Steps</th>
<th>Timeline</th>
<th>Expected Outcome</th>
<th>Method, activities and evaluation</th>
<th>Person/Area Responsible</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define each action step on its own row. Define as many action steps as necessary by adding rows to the table.</td>
<td>An expected completion date (month and year) must be defined for each action step.</td>
<td>An expected outcome must be defined for each action step.</td>
<td>An evaluative measure must be defined for each action step.</td>
<td>A responsible person must be identified for each action step.</td>
<td>Comments are optional.</td>
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<th>Goal 2:</th>
<th>Key Action Steps</th>
<th>Timeline</th>
<th>Expected Outcome</th>
<th>Method, activities and evaluation</th>
<th>Person/Area Responsible</th>
<th>Comments</th>
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<th>Goal 3:</th>
<th>Key Action Steps</th>
<th>Timeline</th>
<th>Expected Outcome</th>
<th>Method, activities and evaluation</th>
<th>Person/Area Responsible</th>
<th>Comments</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Goal 4:</th>
<th>Key Action Steps</th>
<th>Timeline</th>
<th>Expected Outcome</th>
<th>Method, activities and evaluation</th>
<th>Person/Area Responsible</th>
<th>Comments</th>
</tr>
</thead>
</table>

Sample template for work plan
References


Case study C: Improving postnatal care

Background

One of the aims of the Early Adopters project was to improve postnatal care for women giving birth in North West London. The postnatal working group focused on improving the consistency of information received by women, and on streamlining the postnatal care offered by our four NHS trusts.

The working group agreed to develop a “personalised postnatal plan of care”, which develop a Postnatal Personalised Care Plan (PPCP) from 34-36 weeks onwards. This followed recommendation from the NICE postnatal care guideline (NICE 2015) and the Royal College of Midwives postnatal care planning recommendations (RCM 2014). Both documents suggest that postnatal care should be planned earlier in the maternity care pathway.

Getting started

The postnatal plan of care template (see sample pages) was co-designed with the Early Adopters clinical leads and service users. The intervention was a well-documented, individualised postnatal plan of care, to be given to each woman from 34-36 weeks of pregnancy. The plan included relevant factors from the woman’s notes taken in the antenatal, intrapartum and postnatal period, including the contact details of the healthcare professionals involved in the care of the woman and her baby. The intention was for the plan to be reviewed at each postnatal contact point.

Specifically the aims of this plan were to:

• Improve postnatal care by commencing the planning during the latter stages of pregnancy.

• Recognise and raise awareness of the importance of postnatal care and the impact on mother and baby, in terms of wellbeing and health outcomes.

• Promote conversations with women, by providing an opportunity to talk about their care and to support women to plan for after the birth.
How was the Postnatal Personalised Care Plan used?

The Postnatal Personalised Care Plan (PPCP) was piloted in the six maternity units between November 2017 and January 2018. Each site tested the plan with one community midwifery team. Approximately 250 plans were distributed in total.

How was the PPCP evaluated?

Service users

A sample of 30 women from all the North West London maternity units was contacted to get feedback about the PPCP. The majority of plans were given out at the 34 or 36 week appointment. Most felt this was the “right” time to start thinking about postnatal care.

Fifteen women within the sample had the plan discussed at multiple points, including before and after they gave birth.

<table>
<thead>
<tr>
<th></th>
<th>Preparation to feed baby</th>
<th>Prepare for the transition to parenthood</th>
<th>Prepare for newborn’s wellbeing and needs</th>
<th>Prepare for my care following birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree/slightly agree</td>
<td>70% (19)</td>
<td>78% (21)</td>
<td>88% (24)</td>
<td>88% (24)</td>
</tr>
<tr>
<td>Disagree</td>
<td>30% (8)</td>
<td>22% (6)</td>
<td>12% (3)</td>
<td>12% (3)</td>
</tr>
</tbody>
</table>

The majority of women felt the plan helped them prepare for key elements of postnatal care. Results showed the PPCP plan particularly helped women consider both their own and their babies health and wellbeing.

The overarching themes that emerged from the free text feedback and from one focus group held at Chelsea and Westminster Hospital Foundation Health Trust were:

- **Appropriate information**: the majority of women reported the information was useful and helped to prompt discussion.

- **Easy to read**: several women reported it was easy to read and concise. One woman reported that it prompted her to search for more information.

- **Space to input into plan**: Most women felt that the questions included in the form should only be used to start an open discussion. However, they liked the selection of topics to focus the discussion. One lady was particularly keen on the pre-set questions. Another said she would have liked more spaces to write information.

- **Topics within the plan**: Some women felt that the questionnaire repeated topics already covered at the National Childbirth Trust classes, especially the first section - ‘Personalised plan of care’.

- **Using questions to generate a care plan**: Some women felt that the questions were too generic. One respondent explained that she uses an app that gives her very detailed questions with a ‘tick box’ options for answers. The answers are then summarised and emailed back to her in a form of a plan- e.g. birth plan.

Case study C: Improving postnatal care
• **The need for more detail on coming into unit:** There were comments that the ‘Coming to maternity unit section’ needed to be more descriptive, e.g. a checklist of things to bring with you or to guide where to get this information. Some mums felt it would be helpful to have relevant instructions/ specific directions included/ guidelines.

• **The time of the plan:** Most women liked the second part of the form and were happy to talk about it in their antenatal clinic appointment in preparation/ anticipation for after the birth, however 3 of them felt it was overwhelming and would prefer to only touch on these topics after the baby is born (i.e a step by step approach).

• **Consideration of emotional well-being:** Most women felt it is very important to talk about the wellbeing. Several mentioned fear of postnatal depression, feeling emotional, lonely, and anxious. Also information on how to get help (e.g. contact numbers, how to get support).

• **Dual approach:** face to face and PPCP: All women felt it was very important to have the face to face (1:1 or in groups) conversation with staff, rather than a paper or electronic leaflet only.

**Midwives**

Community midwives from all trusts were contacted for their feedback on delivering the PPCP and speaking about this with women. Feedback was collected in a survey and small focus groups, representative of each trust.

Comments included:

• Can add a time pressure to appointments if women end up wanting to discuss many more topics.

• Helpful for fathers / partners.

• Particularly useful for first time mothers, but not as relevant for women with children already.

• PPCP should be expanded to women under obstetric led care – as often these women do not have a chance to talk to a midwife about postnatal matters.

• Further training on how to use the booklet would be useful.

• Recognised it as a useful and important tool to plan for postnatal care.

• More space to write in the plan.
Suggestions for wider rollout

- The PPCP should be used for all women, including those under obstetric-led care, therefore obstetricians would need training to use it.
- Create a digital version to avoid loss of paper copies.
- Provide more space for women and midwives to make written comments.
- More medical information needed (e.g. “how to prepare your body for delivery” and “what happens after a caesarean section?”).

Outcomes and learning

The postnatal working group reflected on the feedback received about the PPCP, particularly on the comments received from users about what they expected from their postnatal care. Arising from this detailed feedback the working group felt that the solution would be to develop a series of materials:

- Sector-wide evidence-based antenatal, postnatal and labour information booklets
- Team photo booklets, and
- The expansion of a sector-wide maternity app.

In addition it was considered that the Better Births ambition of “personalising care” should be extended to facilitate care planning right across the maternity pathway from antenatal care right through to birth reflections. In North West London we achieved this by producing four personal care plans. (See case studies A, D and E for more information.)

There was invaluable learning for all involved. We started by developing a postnatal personal care plan and finished with much more.

References


Case study D:
Maternity information booklets

A project to co-produce four maternity information booklets providing women with evidence-based information on personal care planning, pregnancy, labour, birth and early parenthood.

Background

Following extensive service user engagement via our purpose built feedback website, during face to face sessions at local children’s centres and via the members of our local Maternity Voices Partnership (MVPs) we found that women were unhappy with the inconsistency and unreliability of the information they were being given regarding their pregnancy and maternity care. We also learnt that the quality and volume of information being provided varied widely between trusts, and that this information could often be conflicting or confusing. Women often access care in boroughs outside of their own, increasing the importance of consistency of information. Professionals from across the sector also agreed that the information provided to women required improvement.

The aim of the booklets was to provide a single source of evidence-based, reliable and easy to understand information to all women, in both paper and digital formats. All content was written and produced with input from service users and clinical specialists from across the sector. The accessibility and quality of the information remained the most important factor.

The design and printing of the booklets was funded by the Early Adopters project.
Case study D: Maternity information booklets

Getting started

• Scoping of current provision of written information from each trust within the North West London Local Maternity System. Clinicians from each site gathered all of the written information provided to women and their families, and this information was reviewed by the project team.

• Review of websites/national resources to ascertain variety of information provided/sought out by women and their families (NCT, “Baby Buddy”, Tommy’s, NHS Choices etc.).

• List of topics and suggested content reviewed with service user group. Topics to be written by/in collaboration with service users identified.

• The content of four information booklets was drafted, reviewed and approved by the Local Maternity System (LMS).

• Once approved, the booklets were designed, printed and circulated to all the maternity units for implementation.

Going forward

In the short term, the information within the booklets will provide women with easy to access, evidence-based and relevant information for each stage of their journey through pregnancy, birth and early parenthood.

Our aim is for women and families to feel supported with consistent and relevant information that signposts them to NHS trusted sources.

In addition to English the booklets are available in Arabic, Gujarati, Polish and Punjabi to ensure that the information is accessible to as many families as possible.

The information provided within the booklets will ensure women have access to advice in the case of emergency, contributing to timely access of care and overall safety.

Making the the booklets available online also supports our objective to reduce the use of paper and contributes to the long-term cost savings associated with printing patient information.

The booklets will support professionals to have personalised conversations with women, including the completion of care plans, whilst also supporting the provision of information regarding choice and continuity of carer and contributing to local and national targets for service transformation.

Feedback from women and their partners on the booklets has been overwhelmingly positive. Women have expressed the importance of having consistent information that is easy to access and digest. Expectant and new fathers have expressed similar views, reporting an increase in confidence in supporting their partners.

Feedback from maternity staff has also been extremely positive, with midwives and doctors reporting how useful the booklets have been in supporting conversations and ensuring that women have access to the ‘need-to-know’ information.
Case study D: **Maternity information booklets**

**Learning**

What worked well:

- Working with service users. This was done locally at a place and time of convenience for the women and their families. Expenses were paid and refreshments were provided.

- Collaboration on content from a broad range of professionals. Engagement from the majority of those asked to contribute was achieved ensuring the accuracy and reliability of information and a truly multidisciplinary approach to the project.

- Our central communications team provided invaluable support, input and advice in creating the booklets and also promoting them following publication.

What we would do differently:

- Exercise stricter control on deadlines for submission of comments on content, whilst also ensuring input from all professionals is gained. Two week deadlines were used, however three to four weeks may have been more realistic for otherwise busy health care professionals to provide feedback.

- Get early and consistent input from infant feeding specialists, due to complexities around language used to ensure content is ‘baby-friendly’.

- Create the English and alternative language versions at the same time.

- Work with harder to reach service user groups through MVPs and engagement events.

The booklets can be viewed and downloaded at:
https://www.healthiernorthwestlondon.nhs.uk/documents/maternity
Case study E:
Development and use of photo booklets

**Background**
In response to feedback from service users gathered via engagement sessions during the Early Adopters project, a team photo booklet was developed, to increase the familiarity of women to the maternity teams caring for them.

**Getting started**
A template was designed by one of the midwifery teams at Hillingdon Hospital, to be easily tailored and adapted by the other local teams. Project managers worked with each maternity unit to aid consistency in format and structure. Midwives were involved in the development of the booklets, by writing their own biographies.

The team photo booklet is an evidence-based intervention designed to improve continuity of carer by increasing service users sense of familiarity with the team providing care. Building trusting relationships and receiving continuity of care within the same team is known to improve women’s experience of maternity services.

**The expected benefits** of the photo booklet are increased satisfaction and improved experience of maternity services for women, via an improved familiarity with their maternity team at the particular trust.

**How is it being implemented?**
The booklet was trialled by maternity (hospital, community and specialist) teams across each of the North West London maternity sites for the duration of the Early Adopters project.
A template photo booklet was developed by the Amber team at The Hillingdon Hospital. This template is designed to be easily tailored to local community maternity teams.

The Early Adopters team facilitated the initial print run and is exploring ways in which the booklets can be transmitted electronically. Team leaders will be responsible for keeping the booklet up to date as members of the team change.

Going forward

The photo booklet helps to provide consistent information about the service and the maternity staff providing care. It also enables the woman to develop an ongoing relationship of trust with her midwife.

Learning

Some maternity staff were not keen to have their photo taken due to concerns about their identity being shared with service users. This was a valid concern. However, after structured focus groups consensus was reached on the benefits.
Case study F: Maternity service transformation
Producing a plan for workforce transformation

Background
At one trust the working group (consisting of consultant midwives, service leads, matrons and a project management lead) agreed to form an ambitious and responsive plan to transform services in order to meet the NHS England target of booking 20% of women onto a continuity of carer pathway.

The trust had previously launched two teams providing a caseload continuity model of care, and wanted to use the lessons learnt and the continued momentum of this to achieve a ‘big bang’ transformation of services, directly in response to workforce engagement. In order to do this it was agreed that a transformation plan, based upon local requirements and capacity, along with workforce engagement and establishment mapping would be required in order to create a watertight and robust plan that could be taken to Board level for consideration and implementation.

This work was supported by the multidisciplinary team, administrative teams (who provided the data) and the senior midwifery management team, who were consulted and asked to contribute at certain gateway points throughout the process.

Practice development
The steps taken to complete this piece of work were as follows:

- A survey was designed using SurveyMonkey https://www.surveymonkey.com/ and disseminated to all maternity staff (midwives, midwifery managers, obstetricians, students and support workers). The aim of the survey was to establish:

  1. The number of staff interested in working in a continuity of carer model (and where they currently worked, how much experience they had etc.)

  2. The cohort of women staff felt would benefit from continuity of carer versus the cohort of women staff actually wanted to care for.

- Barriers to working in continuity models and ideas on how to meet continuity targets. Following analysis of survey results, engagement with managers/lead clinicians on local
need and several planning meetings, a working preferences form was sent out to all midwifery staff to complete. This form included five different options (caseloading, inpatient midwifery-led unit (MLU) continuity team, socially complex community, integrated MLU community or no change). All staff were encouraged to complete the forms, and the consultant midwifery teams engaged with staff on a daily basis to encourage completion by all.

- Data from the staff preferences form was collated and analysed, leading to a picture of what teams could be launched, and who would work within those teams. Two alternative models were identified as a direct output from staff ideas.

- Data was extracted to begin mapping caseload size, number of women eligible for certain models of care and level of complexity. Data sets collected included:
  1. Total number of bookings (2017-2018) and total number within this that live in-area versus out-of-area
  2. Total number of women ‘low-risk’ at booking. Total number of women birthing in each birth setting (home, MLU, obstetric unit)
  3. Attrition rates
  4. Total workforce establishment by clinical area and vacancy rates
  5. Booking data by postcode/community area.

- Using the data on activity and workforce establishment, the movement of staff into new models of care was calculated against the movement of activity/workload. An example of this calculation:

<table>
<thead>
<tr>
<th>Current “As-is”</th>
<th>Proposal “To-be”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current establishment in WTE</td>
<td>&quot;New&quot; establishment in clinical areas (WTE)</td>
</tr>
<tr>
<td>No. of WTE who move into caseload service</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>B6 – XX</td>
</tr>
<tr>
<td>B7 – XX</td>
</tr>
<tr>
<td>B6 – XX (based upon a reduction in community antenatal/postnatal care activity, attrition and hours spent attending homebirths)</td>
</tr>
<tr>
<td>B7 – XX (based upon one less team in community requiring a team leader)</td>
</tr>
<tr>
<td>B6 – XX</td>
</tr>
<tr>
<td>B7 – XX</td>
</tr>
</tbody>
</table>

In order to launch a caseload team of six full time midwives, it was estimated that 240 episodes of antenatal/postnatal care (from booking until postnatal discharge) would be removed from community workload. Intrapartum care would also be removed from the core services (labour ward and midwifery led unit (MLU), as a proportional representation, i.e 80% of women birth on labour ward and 20% on MLU). The percentage of this activity against the total activity for the clinical area was calculated and that percentage applied to the establishment in order to identify the number of whole time equivalent staff that could be moved from an existing service into the new proposed model of care.
• This process was repeated for all of the proposed models in order to ensure each clinical area remained safely staffed and to maintain appropriate midwife to women ratios in the community based upon BirthRate Plus recommendations.

• Based upon the large number of women coming out of traditional community care, the boundaries for community teams were re-mapped to equally distribute the remaining workload across smaller and reconfigured teams.

All of these steps were then written up in a clear and concise transformation plan, which was shared with senior managers and used to present the ‘case for change’ at trust board. The document also supported with recruitment objectives. The document remains the main source of accurate data, establishment and activity mapping throughout the reconfiguration and launch of the new service.

**Going forward**

In the short term, creating a transformation plan will:

• Ensure proposed service changes are directly influenced by the needs of the local population and the will and enthusiasm of the workforce.

• Support conversations with senior managers and create a vision of shared responsibility and ownership.

• Provide the project team with an understanding of the challenges around staffing, establishments and the movement of staff and activity.

• Ensure that any identified risks to the transition into a new way of working are mitigated through comprehensive and careful planning.

| Benefits |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| • Provide continuity of carer to an increased number of service users, through a model that is considered the gold standard of care when it comes to the provision of continuity | • Improved birth outcomes (as per Sandall, 2016) | • Reduction in interventions and attached costs (as per NHSE guidance, 2018) | • Increased use of midwife-led setting for birth (to 21.5%) of all births at CWHT | • Positive draw for newly pregnant women, may increase booking numbers and overall activity | • Opportunity to up-skill midwives in intrapartum/antenatal/postnatal care | • Improved staff satisfaction |
| • Improved service user satisfaction | • Transferability of model to expand to wider groups |

In the long term, creating and implementing a transformation plan will:

• Ensure the timely and successful launch of new ways of working that positively impact women’s experience of maternity care.

• Ensure a positive and seamless transition into new models of care, ensuring staff feel listened to, considered and at the centre of the maternity service’s future.

• Provide a framework for future waves of transformation work, through a tried and tested approach to re-configuring service provision.

• Support the setting of long-term objectives, trajectories and aspirations for continued service transformation.
Learning

We found that engaging with staff at the beginning of the process provided a wealth of useful insights into the future landscape of maternity care at the trust. The team committed to regularly walking the floor in the clinical areas/out in the community during the process, talking to the maternity team about the proposed changes, dispelling myths and listening to concerns and ideas. This engagement led to the formation of care models that directly reflected midwives’ preferences, which ultimately contributed to the successful launch of the models. Working with staff when planning transformation has been vital to the success of many of our continuity teams.

We found the process of working through the establishment and activity created a wider understanding of the service. Prior to this, project team had minimal understanding of the complexities of safe staffing. Developing this understanding created fluid dialogue between matrons, managers and service leads and an ethos of shared responsibility and trust.

The plan was considered a “live” document, with continual adaptations and versions developed in response to changes within the service. This was important when keeping the information in it up to date, relevant and accurate as the plan moved forward into the implementation phase.
The document has been used as a means to provide an overview of how continuity of carer models can be implemented, and has been used as a teaching resource. The framework can be used in other trusts and to support second/third waves of transformation work.

Thinking about what could have been done differently, the plan took a considerable amount of time and effort to finalise, and therefore it may be useful to assign a set project plan with gateway points and milestones against the proposed timeline for completion. This would support timely completion of outstanding actions in order to move the plan forward.

Access to data was also challenging and time consuming, therefore engagement and involvement from a very early stage with administrative teams is crucial to the success of putting a transformation plan together.

Finally, tapping into those who have experience in service change and reconfiguration to guide the process can contribute positively to forming and delivering on a plan that meets the objectives of service redevelopment.

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Case study F: Maternity Service Transformation

The document has been used as a means to provide an overview of how continuity of carer models can be implemented, and has been used as a teaching resource. The framework can be used in other trusts and to support second/third waves of transformation work.

Thinking about what could have been done differently, the plan took a considerable amount of time and effort to finalise, and therefore it may be useful to assign a set project plan with gateway points and milestones against the proposed timeline for completion. This would support timely completion of outstanding actions in order to move the plan forward.

Access to data was also challenging and time consuming, therefore engagement and involvement from a very early stage with administrative teams is crucial to the success of putting a transformation plan together.

Finally, tapping into those who have experience in service change and reconfiguration to guide the process can contribute positively to forming and delivering on a plan that meets the objectives of service redevelopment.
Background

Making Every Contact Count (MECC) is an approach to behaviour change that utilises the many day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. The aim is to increase confidence, knowledge and experience within the organisations, the workforce, and individuals in having meaningful effective conversations with the public on health choices.

MECC focuses on the lifestyle issues that, when addressed, can make the greatest improvement to an individual’s health:

- Stopping smoking
- consuming alcohol within recommended limits
- healthy eating
- being physically active
- keeping to a healthy weight
- improving mental health and wellbeing.

The North West London Early Adopters team worked together with colleagues who were focused on improving services in other areas of the local NHS to deliver maternity-focused MECC training to staff in each of the four maternity provider trusts. This training contributes to the strategic objective to reduce the number of stillbirths, neonatal deaths and intrapartum brain injuries.

To incorporate this with the objectives of the LMS and our maternity transformation plans, a bespoke maternity MECC curriculum was developed, specifically for frontline staff (midwives, obstetricians, sonographers and administrative staff).

The aims of this bespoke training for maternity were:

- To understand MECC and the potential impact of influencing health and wellbeing changes during pregnancy
- to provide an approach for frontline staff to deliver key lifestyle messages for expectant mothers (healthy eating, physical activity, stopping smoking, alcohol consumption and mental wellbeing)
- to identify opportunities and understand how to make effective approaches in promoting health and wellbeing.
Case study G: “Making Every Contact Count” training

Getting started
The two hour training sessions took place between April and June 2018 with sessions held at each maternity unit during this period. Over 112 staff received the training, the majority of whom were midwives (89%). The content included:

1) What is “Making Every Contact Count”? 
2) How to ‘myth bust’ common questions/assumptions women have around pregnancy and deliver factual lifestyle messages
3) In-depth discussions around healthy eating, smoking, perinatal mental health and domestic violence
4) How to have MECC conversations with women and use these communication skills in practice across the maternity care pathway.

Participants were asked to reflect on their learning at the end of the session and to consider how they might apply the new skills in their clinical practice.

Measuring the Impact
Overall participants felt they were more knowledgeable about MECC as a result of the training. They felt confident to have healthy lifestyle and public health conversations and also agreed that it was important to promote MECC to colleagues. Most notably 96% of respondents ‘strongly agreed’ or ‘agreed’ that they felt confident in MECC as a methodology to deliver public health messages after the training.

Summary of the feedback from participants:
- 98% felt it was important to have MECC conversations with friends and family
- 100% thought that it was important to have MECC conversations with partners
- 100% felt it was important to promote MECC with service users.
Case study G: “Making Every Contact Count” training

The graph below strongly indicates the change in the participants’ understanding of MECC and the confidence in having MECC public health conversations with maternity service users.

There was positive feedback from staff about the session:

“Trainer was well informed on pregnancy and our role. Lots of helpful tips/stats”

“Everyone was involved. Course content and information was useful and relevant. Course tutor explained info well. Clear and to the point.”

Learning

Following the training sessions, the North West London LMS expects that:

- Maternity staff will have more conversations around public health messages with service users, colleagues, friends and family
- higher numbers of women and partners will attend smoking cessation services and/or that there will be a reduction in smoking during pregnancy
- staff will feel more confident to talk to women about healthy eating choices
- staff will feel more confident to have supportive conversations with women around domestic abuse and perinatal mental health.

Reference

Case study H: Team coaching

Background
The National Maternity Review, Better Births identified the need to improve the way midwifery teams are managed, citing that teams of midwives working to provide continuity in autonomous units may need “educational support around how to work together successfully in a small team, how to be supportive, how to challenge, how to reach consensus, and how to self-manage.” (page 77, National Maternity Review 2016). Based on this premise the project management team set out to identify what the needs of team midwives were and how they could be addressed.

Within the profession, there is considerable concern about the potential for burnout of midwives working in continuity teams (RCM 2017, Taylor et al 2017). Team cohesiveness is fundamental to the sustainability of continuity of carer models. For many midwives, providing continuity throughout the maternity pathway is a new way of working. Whether fully caseloading with a buddy or using a team approach, reliance on buddies/team members requires a high level of trust and accountability amongst colleagues.

Methods used to explore the needs of the midwives in North West London included:

- Focus groups
- Individual interviews with team leads
- Training need analysis
- Staff surveys.

The project management team felt that coaching would be of benefit to the fledgling teams. Coaching supports teams or individuals to identify and address their own challenges. It promotes collective responsibility for modeling expected behaviors and achieving set goals. Through coaching, the team builds high levels of trust, understanding and commitment that provide a foundation capable of withstanding the challenges of working in complex systems (Thornton 2016).
How coaching was delivered

Over the course of 2018, team coaching was delivered to 15 teams across North West London, reaching over 100 midwives. Facilitation was provided by in-house North West London change coaches and an experienced midwife team coach from Neighborhood Midwives, commissioned by the project management team.

More than 70 midwives from community midwife teams across the sector each received one four hour team coaching session addressing:

- One page profiles, work timelines
- personality types, individual needs and styles of working
- agreeing team purpose
- agreeing team behaviours.

We also provided caseload midwives with four half day workshops addressing:

- Team agreement and ways of working together
- five ways to wellbeing - appreciation, gratitude, managing stress etc.
- cultivating a growth mind set
- giving and receiving feedback
- compassionate communication
- structuring team meetings
- how to raise tensions, challenges and problem solve
- action plan for the future together.

Learning objectives

The learning objectives for the one off workshops for community midwife teams were:

- To enable teams to create positive relationships and practices that facilitate supportive team working
- to create an environment where midwives can thrive and flourish.

In addition to the above, the 4 half-day workshops for caseloading midwives aimed to enable:

- Participants to learn more about each other, their preferred way of working and how they can work as part of a team of individuals.
- The team to agree their purpose and the values and behaviours that will help them achieve this purpose.
- Participants to understand and identify strategies for wellbeing and dealing with stressful situations.
- The team to develop and agree their shared values and how they will work together (team agreement).
- Participants to learn skills that facilitate positive communication and enhance the learning environment within the team.
• The team to evaluate how they are working together according their purpose, values and team agreements.
• The team to create goals for the future.

**Impact on practice**

Over 100 midwives received coaching. Most midwives felt that it is worthwhile to spend time building relationships, finding out more about how you prefer to work together and to reflect on team purpose and agreements. The midwives agreed that coaching improves team dynamics and felt that regular coaching would be beneficial. The teams found spending time getting to know their colleagues most helpful along with learning about how each other’s personality types can effect team interactions. Top three further interventions suggested included; more team building, more team meetings and team socials, indicating a clear need for more ‘team time’ beyond day to day clinical working.

**Future recommendations**

• To incorporate team coaching into “business as usual” for all midwifery continuity teams.
• To continue to support coaching as a model of team management that enhances the principles of collective leadership, namely; team trust, commitment and shared responsibility/accountability.
• Ongoing evaluation of the effectiveness of coaching as a tool to support the midwifery workforce.

**References**


**Case study I:**

**Developing the maternity support worker**

**Background**

Better Births (NHSE 2016) recommended that consideration should be given to how maternity staff are deployed and find new ways of using maternity support workers (MSWs) to improve the care of women. This recommendation would lead to better, creative workforce design, enabling providers and commissioners to work collaboratively in workforce planning.

The North West London LMS has been working to adapt the role of MSWs in our local area with the expectation that this would help to improve the care we provide our women, with a particular focus on postnatal care.

The project aims to deliver standardised and transferrable training through the Level 3 Healthcare Support Apprenticeship standards (maternity pathway), linked to Band 3 MSW roles. The project began with the vision of designing a North West London-wide formal learning programme, which will lead to MSWs making more of a contribution to maternity services.

While MSWs currently contribute to the delivery of services, the training, development and deployment of the role is inconsistent and not transferrable within the sector. We found inconsistencies in the job descriptions regarding tasks and duties. In some cases MSWs are undertaking tasks that are not appropriate. Although there are examples of comprehensive training programmes, there does not appear to be standard practice across our LMS.

Tasks to be undertaken:

- Work with North West London maternity services to identify enhanced knowledge and skills for MSWs, taking account of the new continuity of care models.

- Gain consensus in how the contribution of MSWs could be enhanced across the maternity pathway, with particular reference to postnatal care.

- Identify training needs and barriers to learning and career progression for MSWs and services.

- Produce common documentation and approaches to MSW learning and development by means of a skills passport and indicative job descriptions.

- Work with education provider(s) to design, develop and implement a standardised Level 3 Apprenticeship Programme.

- Identify other services outside North West London that have been creative in the use of MSWs.
Getting started

The planning process involved engagement with stakeholders, namely Heads of Midwifery (HOM’s) and senior midwifery staff, Royal College of Midwives (RCM), Health Education North West London (HENWL), LMS, MSWs and service users. The aim was to collate information on what is currently happening across the sector, noting any similarities, differences and evidence of good practice.

Focus groups with MSWs were held in six maternity units to identify their training needs and issues. An online MSW survey gathered feedback on how the workforce perceives their role.

What sector do you work in?

The questions related to the current training method for MSWs and how the workforce felt about the role, providing them the option to share any ideas that would enhance their learning.

Some of the comments given in response to the questions asked:

“What has given you most satisfaction in the current area you work in?”

“Being part of a team to make the mother to feel at ease and informed throughout her stay on the ward.”
A working group was developed with practice development midwives, antenatal, postnatal, community managers and Early Adopters project managers to build collaboration and improve consistency of working in practice. The Royal College of Midwives was also approached for information on the current recommendations for this workforce.

A fact finding exercise considered current job descriptions and person specifications, including the education material, such as competency booklets. Conversations were held with other sectors that had developed or were developing MSWs. Heads of Midwifery were asked to explain the operational deployment of MSWs in their maternity units, to gain an understanding of the current status of the role.

Arising from this review, the scope for MSW deployment was widened to include all areas of maternity, not simply postnatal care. It was thought that this would demonstrate greater benefit to maternity services to have Band 3 MSWs working in all areas.

Expected outcomes

The workforce will be empowered to work towards a career pathway in maternity services. The aim is to train all maternity support workers to the same standard and improve the consistency of skills across the local area.

The project, once complete, will enable employers to attract skilled new entrants to the role, invest in targeted development of current MSWs and deliver the vision outlined in ‘Better Births’. This work will ensure that:

- Mothers and babies have access to well-trained MSWs who have a defined role within the maternity team.
- Women will receive the same care across the sector aligning with the new models of continuity of care.
- Current and prospective MSWs will have access to refreshed role descriptions and a standardised career development structure. This will, in the long term, prepare a workforce that adapts to a changing environment and whose skills can be transferred into a pathway for a midwifery and nursing career (HEE 2018).
This pilot programme has not yet started so the full impact on service or workforce is yet to be fully understood. An evaluation process is being designed to gain information about:

- Service users’ experience
- Workforce views of how the training has improved their experience and job prospects.

**Learning**

- Early engagement with the workforce to establish their learning and development needs
- Regular conversations with service leaders to ensure adequate support is in place for managing change.

**References**


**Other references**


Case study J: Reflection of a caseload midwife: Daisy Team

Background

Following the Better Births report (2016) in which the vision was set out to improve maternity care for women, babies and their families, a maternity strategy was identified, including improving continuity of carer for women throughout their pregnancy.

Better Births stated that:

‘….. continuity of care and (the) relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience; and was the single biggest request of women of their services that was heard during the Review’ (National Maternity Review 2016).

I was fortunate enough to be working within a trust that had won their bid to become an Early Adopter in implementing new models of care to achieve this vision. At this trust it was decided that women with complex care needs in pregnancy would benefit from a caseloading model of care. Thus I applied to join the caseload team providing care to women with previous gestational diabetes.

Women who book with a history of gestational diabetes in a previous pregnancy are placed onto a pathway which consists of frequent obstetric appointments from 14 weeks gestation, and are seen by the multidisciplinary team including midwives, diabetic specialist nurses and endocrinologists at different points (usually fortnightly) until they give birth. This pattern, although consistent with NICE guidelines for diabetes care in pregnancy, proved very stressful for some women and consequently many missed appointments. It was hoped that providing caseload care by a named midwife, mostly in the home setting, would improve the experience for the women but also improve their outcomes through effective communication between the midwife and the wider obstetric and diabetic specialist teams.

The senior midwives in the unit who were spearheading the project were pivotal to the establishment of the team and provided guidance and support to all the midwives who expressed a desire to work in this way, from the first meetings through to the establishment and implementation of the team.
Development process

The process started with posters and emails being distributed throughout the maternity department. Midwives were provided with details of the plan to implement a caseload team to care for women with diabetes, as well as a team for women with socially complex pregnancies. Drop in meetings were then held to provide further information to midwives who were interested. Midwives with previous experience of caseloading attended to provide further information about the role.

Following this, a recruitment day of interviews and group assessments was held to formerly appoint midwives to the teams. The above process took approximately 3 months. The first few weeks mainly revolved around the recruitment and build up of each midwife’s caseload. The team was heavily involved and consulted in the operational policy that would be provided to the rest of the unit. This would form a benchmark for the expectations of the named midwife in her provision of care for the women. Meetings were held with the wider diabetes team (diabetes specialist consultants, nurses and midwives) to ensure that they were aware of and consulted about how the team would function in and around the endocrine clinic, so as to ensure effective working relationships.

In the early weeks and months of the team some adjustments needed to be made to the original plans as the working pattern of the caseload team became a reality. Initially the midwives within the team struggled to keep to their hours and often worked too many hours trying to “be there” for their women. Once this was recognised we all took a step back and learnt how to operate in a way that benefitted both ourselves and our colleagues. This required a much more flexible approach, which in turn relied on excellent communication and close relationships within the team.

It was also identified that the women did not utilise ‘meet the midwives’ sessions that were held each week, so they were subsequently cancelled and we continued to provide a more one to one, specific education approach for the women.

Going forward

The KPIs against which we have measured our success as a team are:

- Antenatal clinic attendance
- highest level of treatment (diet/metformin or insulin)
- mode of birth
- admission to neonatal unit following birth
- whether the named midwife was available for labour care.
Below are the statistics after eight months of operation as a caseloading team:

**Intrapartum continuity of carer**

- Named Daisy Team Midwife 65%
- Other Daisy Team Midwife 33%
- Core Midwife 2%

**Births attended by known midwife:**
Overall 98% of births were attended by a midwife from the Daisy team. When comparing data from a matched group of women, no births took place with a midwife the woman had met before.

**Average neonatal blood glucose testing readings:**
Women in the matched group had an average reading of 2.9 mmols.
Women being looked after by the Daisy team had an average reading of 2.2 mmols.

**Infant feeding (by intention to breastfeed):**
In the matched group 36% of women were exclusively breastfeeding at the point that care was handed over to their health visitor.

Of the women being looked after by the Daisy team, 85% were exclusively breastfeeding at the point that care was handed over to their health visitor.

**Number of postnatal appointments:**
On average women in the Daisy team required fewer postnatal appointments than women in the matched cohort.

**Continuity of midwife:**
Daisy team women met one to two midwives.
Core team (match data) met two to five midwives.
Overall, the Daisy team achieved lower levels of neonatal blood glucose monitoring, a reduction in postnatal appointments and improved breastfeeding outcomes.
We have concluded that improvement to the service provision has been easy to measure. Initial figures from our own audits have identified less antenatal appointments for the women, thus reducing the impact on antenatal clinic and the staff. Team sickness levels have been very low compared to the wider unit...with only two sick days taken in nine months.

Here are some quotes from the women cared for by the Daisy team:

“"They were always there for me, understanding and friendly, they saw me at home which was helpful because I have children”

“"This is my third baby, my first time being cared for by Daisy Team, and I wish I had had this care with all my children”

“I loved everything about the care. The home visits were very convenient. The continuity of the care by the same midwife, who was a wonderful midwife was also great”

“"I really built up a great bond with my midwife and instantly relaxed when she arrived”

**Learning**

There had previously been only one caseload team at the trust, but never for this cohort of women. It has been a huge learning curve for all involved. The team has exceeded my expectations in what it has achieved for the women. Having worked in the endocrine team environment prior to joining a caseload team, I had a good idea of what the journey was like for this group of women.

The frequent visits, crowded clinic waiting rooms, repetitive appointments and lack of continuity in caregiver were very challenging for many women, however for the most part they went with the flow, happy to follow the recommended path. Initially some women were a bit cautious of having their antenatal care at home, but they soon appreciated the ease this afforded them and found having access to their midwife was a huge benefit to them. Within the first few months women were accessing their midwife frequently, and in some cases disclosing sensitive information that they may not have done had they not built up that close relationship with the midwife.

The communication with the wider team has been hugely advantageous in coordinating the women’s care. The team has been able to book and change appointments which has also been very useful. This has also lightened the workload of the administrative staff in the antenatal clinic.

There are still challenges, one of which is managing to book the women who are suitable for the team. This is sometimes hampered by inadequate information about obstetric risk factors at the point of referral to maternity services. We do however make contact with the women as soon as we become aware of their previous gestational diabetes status.
Case study J: Reflection of a caseload midwife: Daisy team

The team has a weekly meeting which is essential in planning the following week, as well as providing an outlet for the midwives to discuss cases and share opinions. This has been a positive and useful tool in maintaining close working relationships within the team. As with many new groups there has been conflict and difference of opinion, which as a team we have resolved through good communication, facilitated by team building and coaching sessions provided to the team.

I hope we can continue building on our foundations within the team and close relationships with our colleagues in the wider unit. It has been an amazing first year, and I cannot honestly think of a more satisfying model of midwifery to practise in and feel fortunate to be a part of the first of many caseloading teams.

Daisy team 2018
Case study K: 
Reflection of a service user: Daisy team

**Background**

Having undertaken a survey of the midwifery staff at one trust, there was sufficient interest shown by midwives to develop two caseloading teams – one for women with previous gestational diabetes and the other for a cohort of women at low risk of complications in pregnancy wanting continuity of care.

A small team of six midwives, working in close collaboration with each other, came together to build a caseload of women previously known to have gestational diabetes, in the belief that by providing one to one care, this would improve the women’s experience, improve glycaemic control, reduce interventions and increase the number of women breastfeeding. (Read case study entitled J: Reflection of a caseload midwife).

**Impact on user experience**

One the women looked after by the Daisy team was called Meg (not her real name). Meg’s previous pregnancy had been complicated by a diagnosis of gestational diabetes at 28 weeks of pregnancy.

Meg is a business woman with a full time job in the retail industry. She recalls how complicated her first pregnancy became in terms of balancing the sudden increase in antenatal appointments with her work commitments. Whilst she appreciated the support and understanding of her work colleagues, the weekly attendance at antenatal clinic to meet the diabetic doctor, obstetrician, dietician or diabetic nurse resulted in significant disruption to her working day. She found it difficult to predict how many hours she would be away from work and was not always able to obtain appointments at a time to suit her. Her connection with the midwifery team was limited to those midwives working in the antenatal clinic. Whilst she appreciated the continuity of care she received from the hospital-based endocrine team, she was unable to make a connection with the midwives that would be looking after her during labour, or after the birth. She recalls seeing approximately 5 different midwives during this time and she felt that the choices she was given on how and where she could give birth were limited.
Case study K: Reflection of a service user: Daisy team

Meg required metformin and insulin to help control her diabetes and was scheduled for an induction of labour at 38 weeks. Meg felt that the choices she was given on where and how to give birth were limited. After around 70 hours of labour unfortunately there had not been much progress which resulted in an emergency cesarean section, from which mum and baby recovered well.

When Meg fell pregnant again approximately three years later, she realised that she was likely to face the same frequency of appointments in pregnancy and was a little concerned about the impact on her working life. She was delighted when she received the offer from the Daisy team to receive care.

By complete contrast to her first experience, Meg:

- Received focused attention from one midwife, with support from the small team. She has not had to repeat herself over and over to different people.
- Received all her antenatal and postnatal care at home, on a day and at a time that suited her and her family.
- Has had fewer appointments with the endocrine team better management of her diabetes.
- Has had improved oversight of her diabetes. This has been facilitated by her midwife being in regular contact with her for advice and support. The midwife was able to consult with the endocrine team and facilitate changes to her diabetic medication, in some cases without Meg needing to be present in the clinic.
- Was able to consider her options for birth with her midwife, weighing up the advantages and disadvantages of a repeat induction of labour versus an elective caesarean section.
- Was supported in her choice of an elective caesarean section. Her midwife was present to provide reassurance, working alongside the obstetric team.

Meg remained in the hospital for just twenty-four hours after the birth of a healthy baby boy and returned home to receive postnatal care from her midwife. Her blood sugars have stabilised. The baby boy’s blood sugars have been completely normal and breastfeeding is going well. Meg will have a glucose tolerance test in a few weeks’ time to ensure that her blood sugar levels remain stable.

Meg reported her delight with the care she has received in her second pregnancy and feels that this would be an ideal experience for all women.

As a team it was really rewarding to hear about the really positive experiences of one of our women.

References

The Early Adopter project in North West London came to an end on 31 December 2018. Throughout the project the maternity teams worked hard to engage with staff and service users to find out about what they want from maternity services. Feedback from staff on our new ways of working has had a positive impact on other colleagues. More members of staff are stepping forward to join new caseload teams which will launch in due course.

These new ways of working are now considered to be ‘business as usual’, as trusts strive to meet the NHS England target of at least 20 per cent of women booked onto a continuity pathway of care by March 2019 and 50 per cent by 2021.

The North West London maternity dashboard now reflects the NHS England metrics for continuity of care and choice and personalisation:

<table>
<thead>
<tr>
<th>North West London maternity dashboard</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Green Flag</td>
</tr>
<tr>
<td>1 CHOICE &amp; PERSONALISATION: Number of women who have a personalised care plan</td>
<td>≥50%</td>
</tr>
<tr>
<td>2 CHOICE &amp; PERSONALISATION: Number of women offered choice of all three birth settings</td>
<td>Target 100%</td>
</tr>
<tr>
<td>3 CHOICE &amp; PERSONALISATION: Number of women giving birth in midwifery settings (home births + birth centre)</td>
<td>≥19%</td>
</tr>
<tr>
<td>4 CONTINUITY OF CARER: Number of women booked onto continuity of carer pathway</td>
<td>≥20%</td>
</tr>
<tr>
<td>5 SAFETY: Number of still births</td>
<td>3.12% by 2020</td>
</tr>
<tr>
<td>6 SAFETY: Number of neonatal deaths</td>
<td>0.94% by 2020</td>
</tr>
<tr>
<td>7 SAFETY: Number of intrapartum brain injuries</td>
<td>Targets to be agreed</td>
</tr>
<tr>
<td>8 SAFETY: Number of SIs per month (excluding de-escalated SIs)</td>
<td>N/a</td>
</tr>
<tr>
<td>All bookings</td>
<td>Used as CoC denominator</td>
</tr>
<tr>
<td>Total births (number of babies) (before 37 weeks + after 37 weeks)</td>
<td>Used as MLU birth denominator</td>
</tr>
<tr>
<td>Total maternities (number of women (≥ 24/40 + live births &lt;24/40))</td>
<td>Used as PCPs denominator</td>
</tr>
</tbody>
</table>

Internally, trusts are tracking their own performance against these targets and addressing the barriers to achieving them.
The table below sets out the key areas of focus until 2021. These objectives have been reviewed in the light of the NHS Long Term Plan and will be adjusted in the light of any further Department of Health or NHS England guidance.

**Maternity transformation programme (2018 to 2021)**

| Work stream one - Choice and personalisation | • Increase midwifery-led births to 21.5% by 2021  
• All women to have a personal care plan  
• All women to have the choice of all three birth settings. |
| Work stream two - Continuity of carer | • 50% of women to be booked onto a continuity of carer pathway by 2021  
• 75% of women on continuity of carer pathways to come from a BAME background. |
| Work stream three - Safer care | • Reduce stillbirths by 50% by 2025  
• Reduce the numbers of neonatal deaths by 50% by 2025  
• Reduce the number of intrapartum brain injuries by 50% by 2025. |
| Work stream four - Postnatal and perinatal care | • Deliver national targets for improving postnatal care  
• Develop a social prescribing toolkit  
• First 1000 days of life project. |
| Work stream five - Multi-professional working | • Develop the Maternity Support Worker  
• Work collaboratively with GPs on a number of projects  
• Develop Maternity Voices Partnerships  
• Work with the London Ambulance Service  
• Work with Health Visitors and public health teams. |
| Work stream six - Digital | • Implement a digital personal health record  
• Implement the maternity services dataset  
• Work towards paperless maternity systems  
• Further develop and expand the mum & baby app. |


**Bibliography**


This document was developed by the NHS in North West London as part of the Maternity Early Adopters project. For further information, contact: maternity.nwl@nhs.net

Publication date: June 2019
(A) Workforce Survey Questions:

Dear Midwife

North West London is an Early Adopter site and our aim is to improve women’s experience by increasing the continuity of carer provision, as recommended by the Better Birth Report (2016). Please let us know which model you would prefer to work in.

1. Name (optional):

2. Organisation name:
   a. Xxxxxx hospital
   b. Xxxxxx hospital
   c. Xxxxxx hospital

3. Please select which model you would prefer to work in:

   **Model A**

   You will have significant autonomy in terms of your work schedule and diary management. Here is your suggested working model.

   - You will work in a team of six midwives and each midwife will support a minimum of 36 women per year.
   - You will provide and facilitate continuity of antenatal and postnatal care for the women in your care.
   - You may not have met the woman you give intrapartum care to.
   - There will be two midwives on call per night (weekdays and weekends) to provide care during labour (the intrapartum stage). This will equate to two on-call shifts per week (occasionally three), which is less time on-call than Model B.
   - You will have the opportunity to meet with the women who are cared for by your team in their 34-36 week of their pregnancies.
   - The group will decide which on-call shift each person covers.
   - You will decide if you would prefer a clinic setting or whether you will see the women at home for appointments, as you manage your own diary.
An example week in the life of this model is below:

**Monday 08.00-15.45**
Not on call – started at 08.00
1 x Booking appointment at home/children’s centre/GP
4 x Antenatal appointments at the women’s homes/children’s centre/GP
Day 10 PN check
Day 17 PN check and admin at the hospital/community-based office

**Tuesday 11.30-15.30**
Dropped kids at school
On call 16.00-08.00 (started at 11.30)
3 x Antenatal appointments at home
Day 5 PN visit
Day 8 PN visit (BF support)

**Wednesday 00.30-08.00**
Called at 00.30 (not known to woman), SVB at 07.10, colleague relieved at 08.00
2 x Antenatal appointments + 1 x Booking appointment re-arranged for weekend
Not on call

**Thursday & Friday: Off**

**Saturday 12.00-17.30**
Dental appointment (am)
On call 16.00-08.00 (started at 12.00)
Day 1 PN + EON (own caseload SVB with team yesterday)
Day 3 PN for colleague, BF support
2 x Antenatal appointments at home (from Wednesday) + 3 additional
Admin back at the base

**Sunday 09.00-17.45**
Not called, not on call, started at 09.00
10.30 own caseload called, P3 SROM – SVB at home 12.15
Day 10 PN visit
1 x Booking appointment at home (from Wednesday)
Model B

You will be completely autonomous in terms of your work schedule and have full control of your diary management. Here is your suggested working model.

- You will work in a team of six midwives and each midwife will support a minimum of 36 women per year.
- You will provide and facilitate full continuity of antenatal, intrapartum and postnatal care in partnership with a buddy midwife.
- You will know all of the women in your care.
- As a midwife, you will partner with another midwife and meet the women on each other’s cases at 34-36 weeks of their pregnancies.
- As a guide, you will be on-call three or four times per week, however, you can decide this with your partner midwife.
- You will not book any women during your annual leave.
- You and your partner midwife will decide which on-call shift you cover.
- You will decide if you would prefer a clinic setting or whether you will see the women at home for appointments and you will manage your own diary.

An example week in the life of this model is below:

**Monday 08.00-17.15**

- On call 16.00-08.00
- 08.00 relieved colleague at birth of won caseload, P0 in birth centre, SVB at 13.30.
- Discharged home at 17.00
- 1 x Booking appointment and 3 Antenatal appointments re-arranged

**Tuesday 09.30-15.45/21.00-02.30**

- Not called. On call 16.00-08.00. Started at 09.30
- 2 x Booking appointments at home (1 from yesterday)
- 4 X Antenatal appointments at home (2 from yesterday)/1 buddy MW (36/40)
- Day 1 PN + EON

Called at 21.00, own caseload, P2, SVB at home at 23.12 (home at 02.30)

**Wednesday 11.00-15.00**

- Not on call, started at 11.00
- 3 x Antenatal appointments at home (1 from Monday)
- Day 10 PN visit
- Day 1 PN visit

**Thursday & Friday: Off**
### Saturday 10.00-16.00
- On call 16.00-08.00, started at 10.00
- Day 5 PN visit
- Drop homebirth equipment to a woman
- Day 3 PN visit for BF support (own caseload gave birth with buddy midwife Wednesday evening)
- Admin back at base

### Sunday 10.00-14.30
- Not called. On call 16.00-08.00, started at 10.00
- Day 5 PN visit completed in late afternoon
- 36/40 appointment, birth plan appointment

### Model C
You will have reduced autonomy in terms of your work schedule and diary management. Here is your suggested working model:

- You will provide continuity of carer for a group of approximately 100 women in the antenatal and postnatal period as part of a team of 8 midwives.
- You will provide and facilitate continuity of antenatal and postnatal care for the women in your care.
- You will work on a shift basis on the birth centre to support intrapartum care, this will equate to one or two shifts per week on an alternating basis.
- The team will decide who covers each birth centre shift and this will be shared equitably.
- Antenatal care will be in clinics.
- Each midwife will provide 1-2 shifts per week in a hospital birth setting. The team will provide on call support with each other’s teams for homebirth cover.
- The team will have monthly coffee mornings for women to meet the midwives, but you may not give intrapartum care to a woman you have met.

An example week in the life of this model is below:

### Monday 07.30-15.30
- Early birth centre shift (looking after team woman if one is in labour)

### Tuesday 08.00-16.30
- 08.00 – own clinic for booking appointments and antenatal appointments
- 4 PN visits in the afternoon
- On call 16.00-08.00 for booked homebirth women
### Wednesday 08.00-16.30
- Not called
- 08.00-16.00 PN visits in the morning, own clinic in the afternoon for booking appointments or antenatal appointments
- Coffee evening for women to “meet the team”

### Thursday & Friday: Off

### Saturday 12.30-20.30
- Late birth centre shift (looking after team woman if one is in labour)

### Sunday 08.00-16.00
- 7 PN visits

4. If you do not wish to provide continuity and would prefer to work on the core team, where would you prefer to work?:

5. Do you have any other suggestions? We would love to hear from you.
(B) User Survey (website and face to face surveys):

**Commonplace website questions**
https://maternitynwlondon.commonplace.is

**Your pregnancy experience**
- Did you feel you were informed about the choices you had in regards to where you could book and receive maternity care?
- Did you have a named midwife or team?
- How many midwives did you see during the course of your pregnancy?
- Did you feel that care was personalised care according to your needs?
- What would have improved your antenatal care?
- How would you rate your overall experience of antenatal care and why do you feel this way?

**Your birth experience**
- What was important to you when choosing where to birth your baby?
- Did you know the midwife looking after during your labour and/or birth?
- What would have made your experience during labour better?
- How would you rate your overall care in labour and why do you feel this way?

**Your experience after birth**
- Did you have a personalised postnatal care plan?
- Did you receive the North West London’s “After your baby’s birth” booklet?
- During your postnatal stay in hospital, was there anything that could have been improved?
- Once discharged from hospital, where was your community postnatal care provided?
- Did you feel that your care was personalised to your needs and the needs of your baby?
- How do you feel your postnatal care could have been improved?
- How would you rate your overall experience of postnatal care and why do you feel this way?

**Your overall experience of maternity care**
- Do you feel there was consistency in the information you received at all stages of your maternity care?
- Did you use a maternity app for information on pregnancy, birth and caring for your baby?
- How was your overall experience of maternity care and why do you feel this way?
(C) Use a process map to track your current maternity pathways:
(D) Models of care launched in North West London:

**Model: Caseloading**

**Full CoC: antenatal > intrapartum > postnatal**
*Caring for women requesting homebirth, with social complex factors and requiring shared obstetric care*

<table>
<thead>
<tr>
<th>Team size &amp; structure</th>
<th>Ratio</th>
<th>On call commitment</th>
<th>In/out criteria</th>
<th>Other information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typically a team of 6</td>
<td></td>
<td>Agreed locally within the team. Teams are autonomous to manage their own on call commitment</td>
<td>Agreed in SOP when setting up new team</td>
<td>The caseloading team act as the midwife “navigator” and follow the women throughout each stage of the pathway</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Caseloading teams are NOT included in the escalation policy</td>
<td>Often designed for one cohort, and &quot;topped up&quot; with other cases to ensure sustainable numbers</td>
<td></td>
</tr>
</tbody>
</table>

*Example: Chelsea and Westminster, Sunflower Team*

- 6 WTE
- X1 Band 7 (Team Leader)
- X5 Band 6

<table>
<thead>
<tr>
<th>Team size</th>
<th>Ratio</th>
<th>On call commitment</th>
<th>In/out criteria</th>
<th>Other information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.36-40 per annum</td>
<td>1:36-40 per annum</td>
<td>Local to booking</td>
<td>Agreed in SOP when setting up new team</td>
<td>The caseloading team act as the midwife “navigator” and follow the women throughout each stage of the pathway</td>
</tr>
<tr>
<td>Team total 240 women per year</td>
<td>Team total 240 women per year</td>
<td>Caseloading teams are NOT included in the escalation policy</td>
<td>Often designed for one cohort, and “topped up” with other cases to ensure sustainable numbers</td>
<td></td>
</tr>
</tbody>
</table>

*Example: Chelsea and Westminster, Sunflower Team*

- 6 WTE
- X1 Band 7 (Team Leader)
- X5 Band 6

- 1:36-40 per annum
- 2-4 on calls per week
- Living in a traditionally ‘out-of-area’ locality
- Aim to increase MW led births (home and BC) and improve clinical outcomes
- 15% uplift on salary to ensure midwives are remunerated for on-call commitment
- Majority of antenatal care provided at home
- Complete autonomy and self-management
- Monthly ‘meet the midwife’ drop-ins held in Battersea Park

*Where?*
- Chelsea & Westminster, West Middlesex, Imperial sites, Hillingdon
- Hillingdon and Northwick Park – all other sites plan to launch

**Model 2: Birth Centre continuity**

**Full CoC: antenatal > intrapartum > postnatal**
*Caring for women who are low risk at booking and suitable for midwifery led care during pregnancy, labour and birth*

<table>
<thead>
<tr>
<th>Team size &amp; structure</th>
<th>Ratio</th>
<th>On call commitment</th>
<th>In/out criteria</th>
<th>Other information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typically a team of 6-7</td>
<td></td>
<td>No on calls</td>
<td>Low risk at booking</td>
<td>Women invited back for 1 PN check with named midwife, other PN care provided by community team</td>
</tr>
<tr>
<td>A caseload of 1:60 per year</td>
<td>A caseload of 1:60 per year</td>
<td>Each midwife works one set clinic shift each week, providing antenatal and postnatal care to women under caseload</td>
<td>Women contacted and offered model of care – opt in or out</td>
<td>Birth Centre remains staffed by core midwives who do not provide caseload care</td>
</tr>
<tr>
<td>Team total 360 per year</td>
<td>Team total 360 per year</td>
<td>Remainder of shifts are LD’s or N’s</td>
<td>If women become high risk during pregnancy they come out of model</td>
<td>Increases no. of women birthing in a midwifery led setting</td>
</tr>
<tr>
<td>Midwives work in buddy pairs, covering each other’s clinic during annual leave/study leave</td>
<td>Midwives work in buddy pairs, covering each other’s clinic during annual leave/study leave</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Model 3: Hybrid model

**CoC:** antenatal > intrapartum > postnatal  
*Linking community to labour ward for women with complex social factors*

<table>
<thead>
<tr>
<th>Team size &amp; structure</th>
<th>Ratio of midwives: women</th>
<th>On call commitment</th>
<th>In/out criteria</th>
<th>Other information</th>
</tr>
</thead>
</table>
| 6.5 WTE (community)   | 1:50 (antenatal & postnatal) | On call commitment for handover and advice from community team to labour ward team | RAG rating based upon social complex factors – high risk cases cared for in model | Named midwife for each woman  
Aim for all antenatal and postnatal care to be provided by named community midwife.  
Linked team approach enabling women to have continuity in the community and a known midwife on the labour ward  
Team photo booklets and classes/tours to ensure intrapartum team are introduced prior to labour |
| 0.5 8a 3 Band 7 3 Band 6 | Team total 325 per year | No on-call commitment for staff working in the labour ward team, service covered 24/7 through routine shift patterns | | |
| 6.0 WTE (labour ward) | 1 Band 7 5 Band 6 | | | |
| 1:50 (antenatal & postnatal) | Team total 325 per year | | | |