

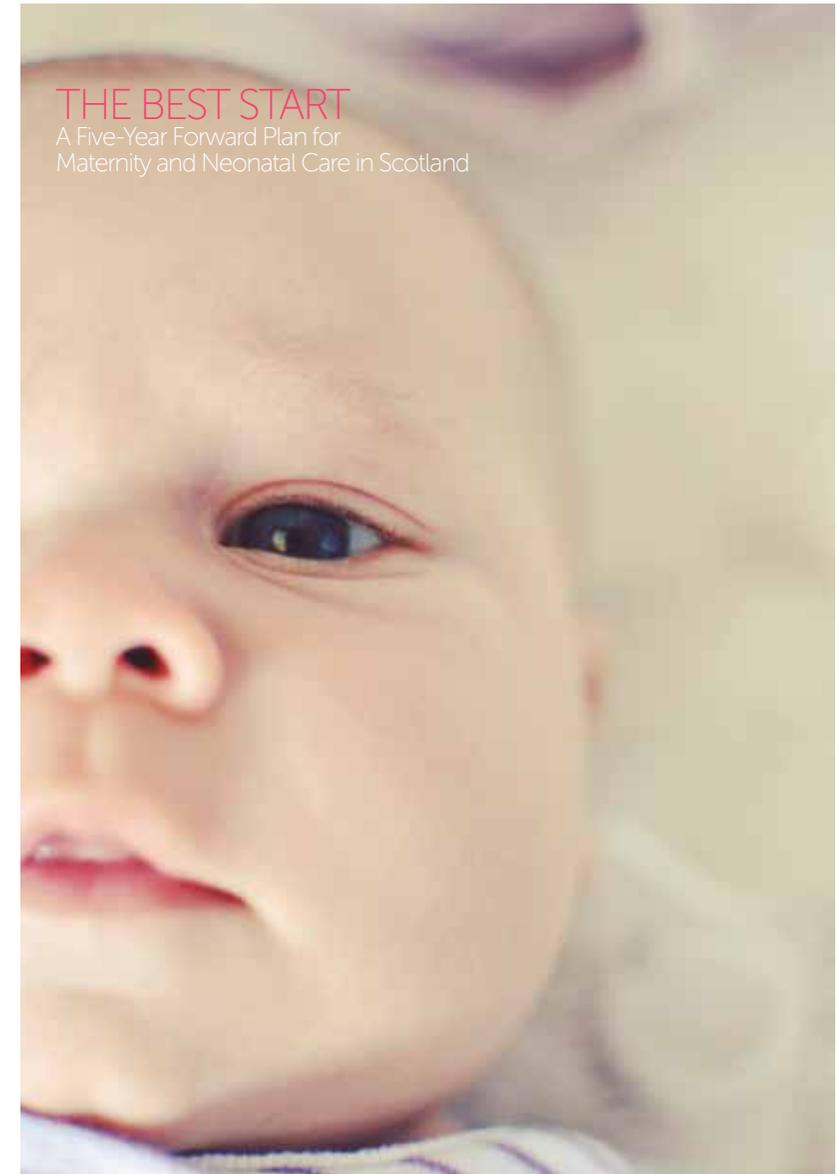


CONTINUITY OF CARER AND LOCAL DELIVERY OF CARE –

IMPLEMENTATION FRAMEWORK

FRAMEWORK TO SUPPORT THE IMPLEMENTATION & MONITORING
OF CONTINUITY OF CARER & LOCAL DELIVERY OF CARE

PRODUCED BY THE CONTINUITY OF CARER AND LOCAL DELIVERY OF CARE SUB
GROUP OF THE BEST START IMPLEMENTATION PROGRAMME BOARD



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Introduction



[The Best Start Five-Year Forward Plan for Maternity and Neonatal Care in Scotland \(2017\)](#) was the result of a Strategic Review of Maternity and Neonatal Services in Scotland. The Review group was tasked with making recommendations for a Scottish model of care that would contribute to the Scottish Government's overall aim of delivering person-centred, safe and effective care.

The Best Start aligns with the National Clinical Strategy for Scotland (2016) and sits within the context of Realistic Medicine (2014-15) requiring transformational change to redesign services with a focus on local care, built around families and communities and the key concept of continuity of carer. Reflecting Scotland's asset-based approach to promoting the wellbeing of families and children through the Getting it Right for Every Child (GIRFEC) model, the Best Start recognises that maternity and neonatal care services matter to the health and wellbeing of Scotland's people. The health, development, social, and economic consequences of childbirth and the early weeks of life are profound, and the evidence shows that this is felt by individual families and communities, as well as across the whole of society.

- All mothers and babies are offered a truly family-centred, safe and compassionate approach to their care, recognising their own unique circumstances and preferences.
- Fathers, partners and other family members are actively encouraged and supported to become an integral part of all aspects of maternal and newborn care.
- Women experience real continuity of care and carer, across the whole maternity journey, with vulnerable families being offered any additional tailored support they may require.
- Services are redesigned using the best available evidence, to ensure optimal outcomes and sustainability, and maximise the opportunity to support normal birth processes and avoid unnecessary interventions.
- Staff are empathetic, skilled and well supported to deliver high quality, safe services, every time.
- Multi-professional team working is the norm within an open and honest team culture, with everyone's contribution being equally valued.



Continuity of carer

Continuity of carer will see women building strong relationships with their midwife and receiving care tailored to their individual needs and circumstances. Evidence shows that outcomes for both mothers and babies are improved when they receive continuity of midwifery carer.

The vision is that:

- Maternity and neonatal care will be co-designed with women and families from the outset, with information and evidence provided to allow each woman to make informed decisions in partnership with her family, her midwife and the wider care team as required;
- All women will have continuity of carer, regardless of their individual circumstances or risk status;
- Midwives will deliver the full continuum of care and provide continuity of carer; with the majority of midwives working in a continuity of carer model, regardless of their base;
- Women who need the input of an obstetrician will have continuity of a primary obstetrician throughout their antenatal and postnatal care;
- Separation of mothers and babies will be minimised through the development of neonatal transitional care and neonatal community outreach;
- Boards will offer the full range of choice of place of birth which includes homebirth, Alongside Midwifery Unit/Freestanding Midwifery Unit (AMU/ FMU) and obstetric unit, appreciating that geographical considerations will restrict some Boards, such as island Boards;
- High performing, multi-professional teams in place in every Board.

[The new Nursing and Midwifery Council Future Midwife Standards](#) outline proficiencies and educational preparation for midwifery going forward and [have a key focus on continuity of carer](#). Domain two of these standards focuses on safe and effective midwifery care promoting and providing continuity of care and carer. Therefore all newly qualified midwives will be prepared to work in this way.

This document provides maternity services with practical guidance for implementation of continuity of carer and local delivery of care, neonatal transitional care and community hubs, and summarises policy expectations. The document is the output from the Continuity of Carer and Local Delivery of Care Sub group of the Best Start Implementation Programme Board, informed by learning from the five Early Adopter Boards (EAB) – (NHS Forth Valley, NHS Highland, NHS Lanarkshire, NHS Lothian and the Clyde area of NHS Greater Glasgow and Clyde), Royal College of Midwives (RCM) listening events and stocktake visits by the Best Start Executive Team. The document describes not only the structural but also the cultural shift required in order to effect change. It reflects the experience of those midwives providing care in the new model and also the experience of those leading the change.

In reflecting the findings from the five EABs, it is important to note that they were chosen to reflect the diversity of Scottish NHS Boards in terms of population, geography and demographics, therefore all started from a different baseline.

CHAPTER ONE – FRAMEWORKS



Background

Five Early Adopter Boards (EAB) were agreed by the Best Start Implementation Programme Board (IPB) further to a process of selection from a large number of Boards who volunteered. These are: NHS Forth Valley, NHS Glasgow & Clyde (Clyde only), NHS Highland, NHS Lanarkshire and NHS Lothian.

EABs agreed to lead the way in implementing a suite of recommendations including:

- the midwifery continuity of carer model for all women;
- a new model for hospital based maternity services, including transitional care; and the associated core workforce;
- aligned and co-located midwifery and obstetric teams;
- enhanced roles for support workers in the community and in community hubs;
- Community Hubs for the delivery of maternity care and, in-time, neonatal outreach; recognising that different models of neonatal outreach care will be suitable for different contexts across Scotland and may include being delivered in the family home.

Funding was allocated in 2017/18 to support planning for implementation, and in 2018/19 and 2019/20 to support the transitional work required for local service redesign. The EABs were identified in September 2017 and have been taking forward implementation work since then.

EABs are core members of the Best Start Continuity of Care and Local Delivery of Care Subgroup, driving national work required, reporting progress, sharing experiences and committed to sharing learning across NHS Scotland (NHSS) to inform national roll-out.

The implementation learning resource is structured in stages that will be familiar as they are based on the strong foundations of using improvement methodology across Scotland. The specific stages best reflect the learning from the early adopter boards as it emerged and borrow from Audit Scotland (2016) and the Health Foundation (2017) in design and terms used.

Aims of the Implementation Framework

This framework is designed to enable maternity services to access useful tools, resources and information to implement continuity of carer and local delivery of care, and track progress.

This document includes:

- Agreed framework: this defines the agreed parameters for consistency across Scotland;
- An acknowledgment that implementation across Scotland can involve innovation in how that is applied;
- Implementation lessons collated from the EABs;
- Monitoring and Evaluation Toolkit; (as part of Chapter 3 which will follow);
- Links to resources.

Continuity of Midwifery Carer Framework

BEST START RECOMMENDATION 1

Continuity of Midwife and Obstetrician: Every woman will have continuity of carer from a primary midwife who will provide the majority of their antenatal, intrapartum and postnatal care and midwives will normally have a caseload of approximately 35 women at any one time. Where women require the input of an obstetrician in addition to midwifery care, they should have continuity of obstetrician and obstetric team throughout their antenatal and postnatal care. Midwifery and obstetric teams should be aligned around a caseload of women and should be co-located for the provision of community and hospital-based services. Early adopter NHS Boards should be identified to lead the change in practice. Implementation should ensure appropriate education, training and development and realignment of resources is achieved, recognising the potential for additional resources to be required during implementation.

With regard to implementing continuity of carer, the following parameters have been identified. These incorporate evidence from the Best Start, as well as learning from the EABs.

Every woman will:

- have a recorded primary midwife;
- receive the majority of scheduled antenatal and postnatal midwifery care from her primary midwife;
- meet/get to know the primary midwife's buddy midwife, who may also provide some scheduled care;
- meet/get to know the members of their defined team;
- receive care during labour and birth from her primary midwife or buddy midwife; with the support of the wider team to cover leave and days off;
- know the midwife who cared for them during labour and birth.

Every caseload midwife will:

- be the primary midwife for a defined caseload of women, approximately 35 women at any one time. This may be lower if the midwife is caring for vulnerable women with medical, social or psychological needs, or due to rurality and distance;
- manage her caseload of women, at whatever points the women books with the service;
- undertake the initial booking history, and plan and provide most of the woman and baby's care throughout the maternity care journey;
- work in a small team with a buddy midwife;



- may be the primary caregiver for women having elective caesarean sections;
- work in partnership with the wider health and social care team as required to coordinate care around the woman;
- provide care for women in either a community setting, or in the woman's home or hospital setting.

Every team will:

- test the optimum team size to ensure an effective balance which ensures achieving continuity of carer and service cover, with all leave built into the modelling;
- consider the skill mix to support the team;
- work together effectively to provide support for each other and facilitate continuity of care;
- develop mechanisms to provide triage that enable continuity, access to the service and mitigate against risk;
- have access to a team leader;
- use/access clinical supervision to support team wellbeing and reflection.

Each Team Leader:

- should ensure that midwives in their teams have access to and utilise clinical supervision;
- may oversee one or more teams in an area;
- may hold a small caseload;
- will make use of local arrangements to oversee quality and safety of care and feedback from service users, based on their own data;
- will ensure rotas and leave are well planned.

Every Hospital based (Core) midwife:

- may provide support to caseload midwives accompanying their women in labour;
- may provide support for the antenatal and postnatal wards;
- may provide a triage service and/or day care;
- may be the primary caregivers for women having elective caesarean sections;
- may be part of a caseload team to provide support for medically complex women, or where geographical distance is a factor.



EABs found it was important to:

- ensure that midwives have the equipment, Information Technology (IT) and transport they require;
- ensure that midwives have access to the learning and clinical supervision they require to effectively manage a caseload or work in the core hospital based team;
- ensure that Human Resources (HR) processes and nationally agreed terms and conditions are adhered to;
- work in partnership to plan and monitor the move to the new model;
- ensure there is cover 24 hours a day, 7 days a week, using either an on-call rota which is part of contracted hours, or a rostered model;
- develop a plan for implementation that meets the principles described in this document;
- support implementation by facilitating access to the necessary stakeholders: planning, eHealth, IT, estates, HR;
- ensure that caseload teams have suitable community based accommodation/hub from which to work;
- ensure that there is the right level of support infrastructure in place to support the new model of care;
- support culture and behaviours that prioritise the wellbeing of all staff at every level of the organisation based on mutual respect; and encourage devolved decision-making and autonomy with agreed parameters;
- support staff and managers to implement the change recognising that at times a level of organisational change may be required.

Each EAB found the support of Executive Director Leadership at Board level important for successful implementation.

Continuity of Obstetric Care Framework

BEST START RECOMMENDATION 1

Where women require the input of an obstetrician in addition to midwifery care, they should have continuity of obstetrician and obstetric team throughout their antenatal and postnatal care. Midwifery and obstetric teams should be aligned around a caseload of women and should be co-located for the provision of community and hospital-based services.

The Best Start recommends that:

“Women who need the input of an obstetrician, will have continuity of a primary obstetrician throughout their antenatal and postnatal care. For most women antenatal care will be offered in their local community. For some women the most appropriate place to have their antenatal care will be in hospital-based clinics.”

Every linked Consultant Obstetrician will:

- be aligned with a caseload of women and team(s) of midwives;
- provide support and advice to midwives within their linked area;
- provide direct care to women in their caseload during the antenatal and postnatal period.

Obstetric services are currently structured with obstetricians working with trainees who take clinics as part of their training. In addition, obstetricians have, and will continue to have a significantly higher caseload than midwives in the new model.

The Best Start recommendations will result in a significant but proportionate change to the way obstetric services are delivered. This change is necessary for the transformation required for the multidisciplinary continuity of carer model. In the new model under Best Start:

- There will be a named link Consultant Obstetrician for every midwifery caseload team in order to implement the multidisciplinary continuity of carer model;
- There will be a named primary Consultant Obstetrician for all women who require obstetric care during their antenatal and postnatal care;
- Women who require the input of an obstetrician and require multiple (more than 2) scheduled antenatal and/or postnatal obstetric clinic appointments, should receive direct care from their primary obstetrician at least 50% of the time;
- If a woman's care requires a specialist high-risk clinic, the named primary Consultant Obstetrician may change but the expectation remains the same, i.e. that the women should receive direct care from that primary obstetrician at least 50% of the time.

Community Hub Framework

BEST START RECOMMENDATION 14

NHS Boards should redesign maternity services with a focus on local care, built around the concept of multidisciplinary community hubs, with the majority of women being offered routine care and services through these hubs. Each NHS Board should undertake a local assessment of the viability, scope and potential impact of hubs identifying local needs balanced with maximising benefit from resources. A review of the functioning of these hubs should be conducted, following an agreed national framework, after a defined period of operation.

NHS and other public sector community services are continually evolving and are likely to change more rapidly over the next few years as a result of the integration of health and social care. Families have indicated that routine services should be delivered as close to home as possible, to minimise disruption to normal family life and separation from social networks. This is consistent with national policy direction to shift the balance of health and social care close to home where possible.

In maternity and neonatal care, it is intended that integrated team care will, over time, take place in local community 'hubs'. These hubs would be local care settings for a range of services, designed around the needs of the local community. A community hub would become a facility where people feel they can identify with the services delivered from the hub, in an environment where they feel comfortable.

Services provided in the Hubs could include maternity services and a range of community support services according to local need. These could include, but not necessarily all, of the following according to local context:

- Day assessment, antenatal care;
- Providing women with the majority of their antenatal care;
- Postnatal care, including support for well babies after discharge;
- Scanning facilities;
- Diagnostic services;
- Obstetric and specialist clinics; physically or virtually;
- Neonatal outreach; physically or virtually;
- Wider community support such as breastfeeding support and other infant care support;
- Antenatal parenting classes held during extended opening hours at the weekends and evenings;
- General Practitioner (GP), Health Visitor, Perinatal Mental Health, Immunisation, Sexual Health services, Local Authority support and third-sector services;
- Early years' support;
- Birthing facilities.



Neonatal Transitional Care Framework

BEST START RECOMMENDATION 22

Well, late-preterm infants and infants with moderate additional care needs should remain with their mothers and have their additional care needs provided on a postnatal ward by a team of maternity and neonatal staff. Clear pathways of care, admission criteria, discharge planning and clinical guidelines will be required, underpinned by education and training.

BEST START RECOMMENDATION 27

A revised staffing profile for inpatient postnatal maternal and neonatal care should be developed collaboratively by maternity and neonatal care providers, underpinned by staff education and training in relation to postnatal maternal and neonatal care.

The greatest proportion of babies currently admitted to neonatal units comprise late-preterm (34–36 + 6 weeks' gestation) and term infants with moderate additional care needs. Late-preterm infants commonly require a moderate additional level of support to maintain temperature and establish breast, or formula feeding, and more commonly require treatment for jaundice.

Currently, many babies in these groups are admitted to neonatal units, but most of them could be cared for with their mother on postnatal wards, or even at home, with additional support. This type of transitional care arrangement would keep mother and baby together and reduce neonatal unit admissions of both late-preterm and term infants.

Boards may want to consider how effectively their current service pathways ensure that mothers and babies are able to stay together, as much as possible, throughout the postnatal period.

Services currently providing **Neonatal Transitional Care (NTC)** may consider how effectively their model is working to keep mothers and babies together, and identify any additional pathways and/or clinical guidance required to further reduce admissions of term and late-preterm infants to the Neonatal Unit.

Services that do not currently provide NTC should bring together Maternity and Neonatal care teams to plan jointly the establishment of a NTC service that will minimise separation of mothers and babies. It is helpful if such planning addresses:



- Pathways of care to minimise separation of mothers and their babies throughout the postnatal period;
- Criteria for NTC;
- Clinical guidelines for the safe delivery of effective NTC;
- Discharge criteria from NTC;
- Escalation policy and pathways of care for babies developing additional care requirements beyond those that can safely be delivered by NTC;
- Review of education and training requirements for Maternity and Neonatal staff relating to the delivery of NTC;
- Where mother and baby have additional needs, care should be flexibly provided, in any care setting, according to individual circumstances.

Boards already report on National Neonatal Audit Programme (NNAP) audit measures which include specific measures relating to maternal infant separation for late-preterm and term infants so this can be used to establish movement to transitional care to assess the impact that the establishment of transitional care has on admissions to neonatal units. In addition, the impact that this policy has on maternity beds will also be monitored to understand the consequences.

Resources from Boards –

Transitional Care Information leaflet – NHS Forth Valley

<https://drive.google.com/open?id=18MKXnWIGIBuBT6Fk3PNGdkFdcDx3h9iW>

Transitional Care Parent Feedback poster – NHS Forth Valley

<https://drive.google.com/open?id=1XpHLEk7jQLVHgc2KTNENYK3yYgK9Fv4w>

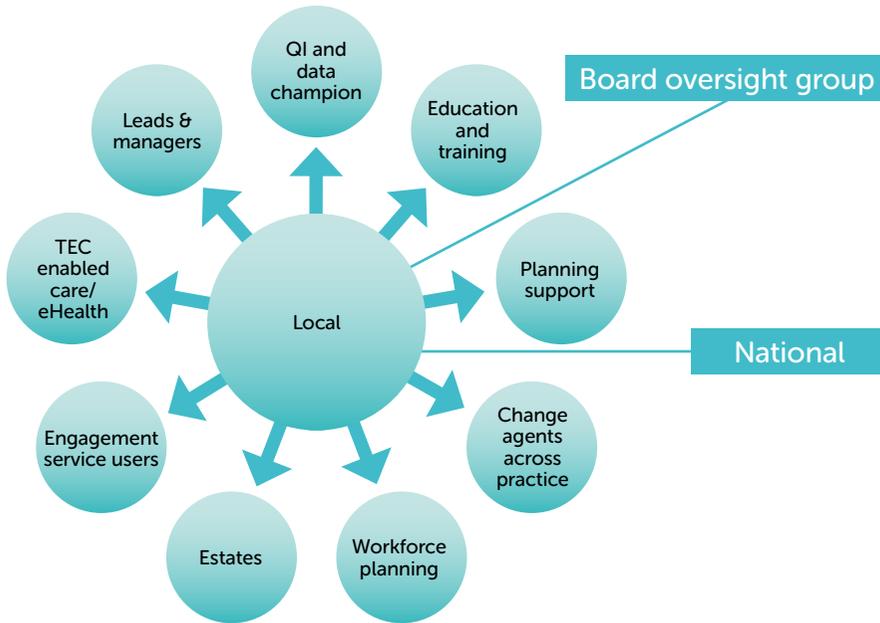
Resource document – ‘A Framework for Neonatal Transitional Care’ (BAPM: 2017):

CHAPTER TWO – IMPLEMENTING CHANGE



Enabling Change

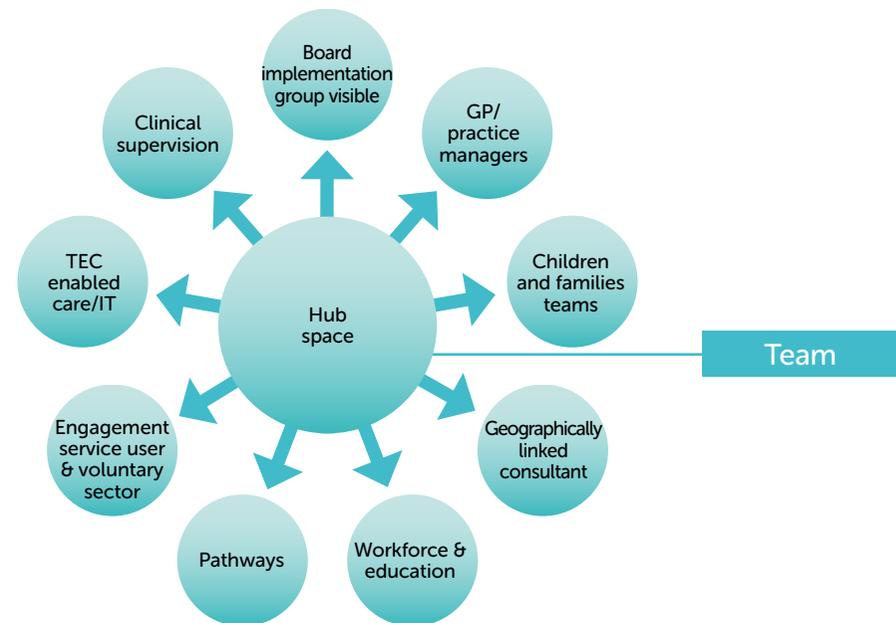
Enabling change – Board level



This chapter of the Implementation Framework focuses on the lessons learned from the EABs with regards to implementing the continuity of midwifery carer model and includes links to resources that Boards might find helpful.

A wide group of stakeholders and service users will have an interest in implementation. It was clear from the EABs that it was important to have engagement from an early stage with this wide range of stakeholders and service users, and these groups will differ at both a Board and team level.

Enabling change – team level



Women receiving continuity of carer have been positive about their experience and a selection of their feedback is shown below

What women said:

"I felt at ease with everything. I really do think this change is a great step forward. My experience this time felt so much more personal and I wasn't afraid to ask questions this time round."

Second time mum, NHS Forth Valley

"I've just had my baby last week at the RAH. The whole pregnancy experience with my midwife Stephanie has been great as she was very flexible with appointments, coming to see me at home, and we communicated easily by text in case I needed something. This was my second pregnancy and all this was not in place during the first one. I couldn't be happier with the whole experience I've had."

Second time mum, NHS GG&C

"It was nice knowing who you were going to see at every appointment and helped build a relationship with our midwife making us feel comfortable at appointments."

Second time parents, NHS Forth Valley

"My experience was really good when I was pregnant because it was my first time and I was quite nervous about it but I had the same midwife all the way through and we grew quite a good bond with each other."

First time mum, NHS Tayside

"The benefit for me is that I have felt heard and that my concerns and wants have been taken on board."

Second time mum, NHS Lanarkshire

"My third pregnancy, I was part of the best start initiative in the community which was fantastic from start to finish... This was a much more holistic, patient focused approach and the outcome was a much happier mum, dad and baby."

Third time mum, NHS Lanarkshire

"I've been part of the Best Start Pilot and been under the care of midwives from the Blue Team, in particular Holly. She made me feel comfortable and relaxed at every appointment and I had complete confidence in her throughout."

NHS GG&C

"I felt safe and confident that my wishes were being met and while my birth was far from what I had imagined or planned it was calm and I felt fully supported that Nicky was there beside me."

First time mum, NHS Highland

"I felt particularly close to my named midwife...having a friendly and familiar face there was not only important for me but also my husband."

First time mum, NHS Highland

Midwives working in a continuity of carer model had a range of views and a selection of their feedback is shown below

What staff said

“Because you have so much freedom in arranging your diary you really can individualise the care and give them what they need.”

Midwife, NHS Lothian

“The benefits are that we can build that relationship and build rapport which means we can recognise deviation more quickly.”

Midwife, NHS Forth Valley

“What works for one midwife won’t necessarily work for another so that’s why there is scope within teams to manage that.”

Midwife, NHS Lothian

“My challenge at the moment is learning when to shut off and have some downtime.”

Midwife, NHS Lanarkshire

“One of the biggest challenges is on-call, especially with children and families. Midwives are worried that they will be on-call and what if they don’t get called out. Do they have to have childcare when they are on-call and if they don’t get called out they have to make up the hours.”

Midwife, NHS Forth Valley

“It’s the reality of work life balance that most midwives worry about.”

Midwife, NHS Lothian

“I feel I now have a better work/life balance. Even though I am working more days, my time is more flexible and I feel working less nightshifts is having a positive effect on my mood/relationships and social life.”

Midwife, NHS Lanarkshire

“I have such great job satisfaction now that I have not had for a long time.”

Midwife, NHS Lanarkshire

“It’s much more autonomous now and I’m really enjoying it.”

Midwife, NHS GG&C

“It’s just such a completely new way of working, it’s a big change for everyone.”

Midwife, NHS Lothian

“Very fulfilling day spent as a Named Midwife, following my Red Pathway patient and her partner to the Consultant Unit being actively involved in her birth process and care in the immediate postnatal period.”

Midwife, NHS Highland

“Transport was a bit of an issue in the beginning but that’s ok now.”

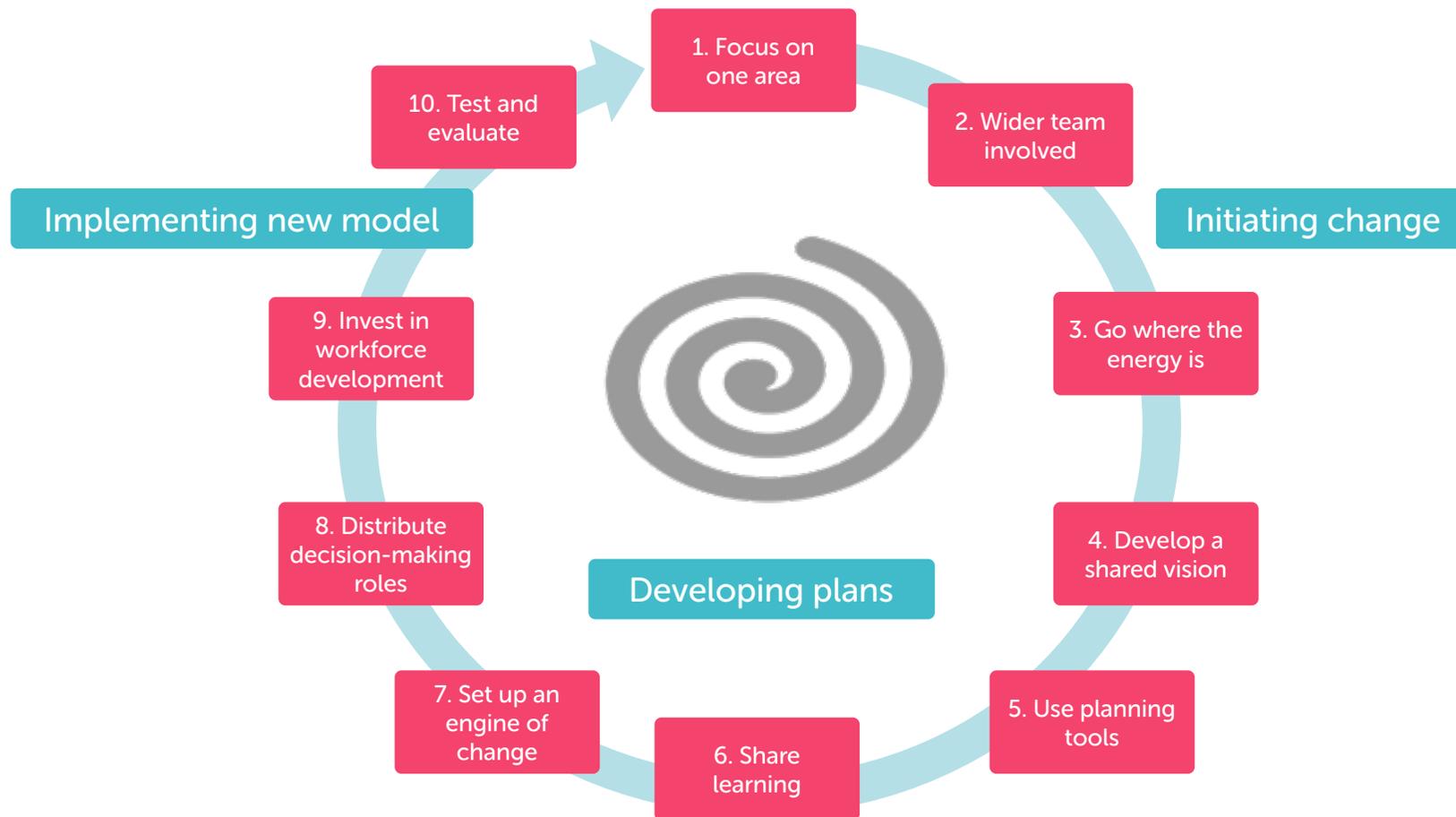
Midwife, NHS GG&C

“You actually feel really invested in your women, you really feel that professional relationship. You want to see them, you want to visit them at home, you want to hear how they’ve got on.”

Midwife, NHS GG&C

Implementation Framework

This implementation wheel best represents the experiences and learning from the EABs and reflecting models outlined by The Health Foundation (2017) and Audit Scotland (2016). The following sections outline what EABs found helpful at local level, alongside some key messages and lessons learned.



INITIATING CHANGE

Preparation: Before starting the implementation, getting the ground work right at the start really helps later on.

Communication and engagement with staff and service users is key and cannot be emphasised enough! There are many ways to engage with staff, and a variety of different methods will be needed. Meetings, buzz sessions, newsletters, organisational development sessions, question boxes, internal intranet pages and one-on-one chats should all be considered. Hearing from staff working in the new model of care or even buddying up with a unit of a similar size can be valuable to understand practicalities, answer questions and make the model real for staff. Ensuring that staff have the opportunity to input and shape changes locally is a major part of ensuring success. Engage early and regularly with the partnership structures and staff side representatives in your area.



Explicit, visible support and commitment to new models of care from the senior leadership team, at Director and Chief Executive Officer (CEO) level, as well as including partnership/staff side to support implementation is crucial for success. Starting to think about the key people to get engaged and starting to make connections both inside and outside the Board to make sure the right people are involved in the implementation. This is the start of a journey that will shape the future of maternity services for years to come.

Before initiating change, the EABs undertook a scoping exercise to understand their baseline position. Process mapping current services helps to engage staff and identify potential barriers at the beginning of the change process.

A key way to engage staff at all levels is to ensure that they are fully aware of the key evidence in relation to the benefits of continuity of carer on outcomes for women and babies. It is also helpful to share the research evidence available about the positive impact on job satisfaction of continuity models of care for staff.



At a board level EABs found it helpful to identify where their starting point is and obtain baselines in terms of:

- current models;
- workforce – both numbers and also staff readiness (surveys, cultures);
- current outcomes;
- current levels of continuity; and
- feedback from women.

At a team level gather baseline data from the current population demographics for the area and the characteristics of the population health (see the monitoring tool) as well as the skills and make up of the teams.

Creating a clearly defined project plan is an essential part of implementation and without initial scoping at this stage, and gathering baselines, it is difficult to identify key milestones, goals and the trajectory towards achieving the stretch aims. Each Board will be asked to produce a trajectory based on their current starting position with the goal of full implementation. Boards may wish to focus on rolling out continuity to sections of the Board area and gradually building up the number of women receiving a continuity model of care. Alternatively, a Board may wish to focus on delivering a continuity of care model to an entire Board area, then gradually building up the rate of continuity received within that model.

Were there any resources that were helpful?

- Nationally produced information factsheets (includes links to videos) –
Best Start Factsheet – Continuity of carer
https://drive.google.com/open?id=11pXiprKPgbr_58g5vQitljXdluhEniZS
Best Start Factsheet – Transitional Care
https://drive.google.com/open?id=124kl4otvOhwpy-zPE8DNvtzGPSDfBvw_
Best Start Factsheet – Overview
<https://drive.google.com/open?id=19hiFDefHZoz-HokHklopQrOo5MaDJqui>
Best Start Factsheet – Using Technology to Bring Care Closer to Home
https://drive.google.com/open?id=1YZ1RUiYPnVD5sM_QwAricKNpoGUi7Wy-

- FV Staff information packs for Neonatal TC – NGT feeding/IV antibiotics
Competency Based Training for Enteral Tube Feeding – Record of Achieving Competency by Staff
<https://drive.google.com/open?id=1cC64Dt72dEBGPlmq2SU1koYipa0Uzp71>
IV antibiotic workbook –
<https://drive.google.com/open?id=19V8kPR4hjpzqOf-nTVvF9FO1ZJOD09nP>

- Neonatal Transitional Care – Presentation for Staff – NHS Forth Valley
<https://drive.google.com/open?id=1h-ir53HQLzoM1yEzWpcjoR3GCzTfqSmJ>
- Admission Criteria for Transitional Care – NHS Forth Valley
<https://drive.google.com/open?id=1EU7HvWp4D1ZY4tzedJc8wxRfPtKdABeD>
- Midwifery skills passport – NHS Forth Valley
<https://drive.google.com/open?id=1GKv-x9rl9VfxStbydYaEgftsEetZ9pkD>
- Monitoring and evaluation tool (part of this document)
- Quality Improvement Zone on Turas
- London Strategic Clinical Networks (2015) Increasing the number of women who receive continuity of midwife care: A best practice toolkit
<http://www.londonscn.nhs.uk/wp-content/uploads/2014/11/mat-coc-toolkit-042015.pdf>
- Starling A (2017) Some Assembly Required: Implementing the new care models program accessed 12042019
<https://www.health.org.uk/publications/some-assembly-required-implementing-new-models-of-care>
- NHS England (2017) Implementing Better Births: Continuity of Carer
<https://www.england.nhs.uk/publication/implementing-better-births-continuity-of-carer/>
- Ross-Davie M (2016) Rapid evidence review on Continuity of Carer
<https://blogs.gov.scot/child-maternal-health/wp-content/uploads/sites/14/2019/03/Models-of-care-evidence.pdf>
- Royal College of Midwives (2017) Can continuity work for us? An interactive workbook
<https://www.rcm.org.uk/media/2267/can-continuity-work-for-us.pdf>
- Royal College of Midwives (2018) RCM Position Statement on Midwifery Continuity of Carer
<https://www.rcm.org.uk/media/2946/midwifery-continuity-of-carer-mcoc.pdf>
- Royal College of Midwives (2018) i-learn introductory module on continuity of carer and interactive game 'Continuity Counts' (available from RCM Scotland team and workplace representatives).
- Royal College of Midwives, Jane Sandall (2017) The contribution of continuity of midwifery care to high quality maternity care
<https://www.rcm.org.uk/media/2265/continuity-of-care.pdf>
- Royal College of Midwives with Jane Sandall (2018) Measuring Continuity of Carer: an implementation and measurement framework
<https://www.rcm.org.uk/media/2465/measuring-continuity-of-carer-a-monitoring-and-evaluation-framework.pdf>
- Sandall et al. (2019) Implementing Continuity of Care – What we still need to find out, Evidently Cochrane
<https://www.evidentlycochrane.net/midwife-led-continuity-of-care/>
- Sandall et al. (2016) Cochrane review. Midwife-led continuity models versus other models of care for childbearing women
<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004667.pub5/full>

INITIATING CHANGE

1. Focus on one small area/locality or a particular group of women

Key Messages:

Board areas can be segmented in different ways, based on caseloads, demographics, patient flow or General Practitioner (GP) practices.

Getting to know the community that the continuity of care team is going to be based in, and the demographics of the current and future pregnant population in that area can help. Some areas may choose to test continuity of carer with a defined group of women or building on an existing team, for example, women living with social complexity and deprivation; or women with significant clinical complexity requiring obstetric led care throughout pregnancy, such as multiple pregnancies and women with diabetes.

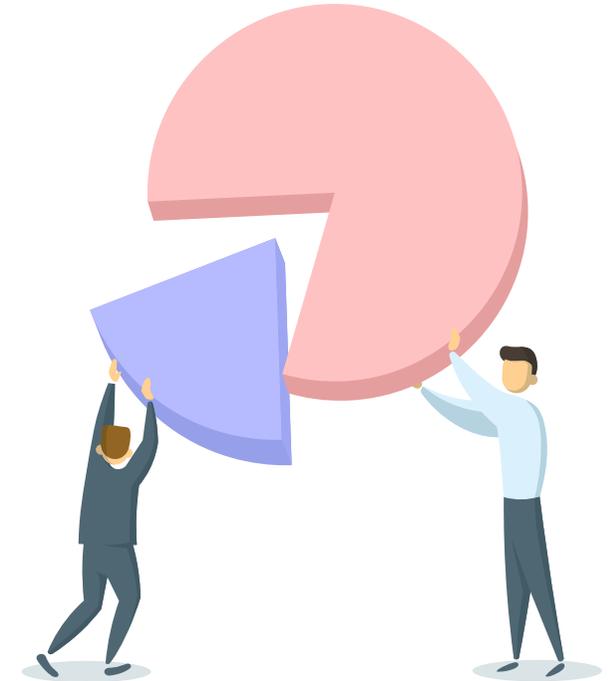
The first team will be implementing not only continuity, but how to set up the service. This takes time but their testing will produce all the learning for the following teams with regard to: engagement, what support is required and what infrastructure needs developing. This team will have the greatest learning so keep a record of how they do this.

It was really valuable to involve the women and families from the local area in design of service for the locality. The Scottish Health Council are a great support in engagement work.

<http://scottishhealthcouncil.org/home.aspx>

What worked?

- Understanding the local community, making links and learning where services are currently available and where they are accessed. This supports meeting key people e.g. GP Practice Managers, health visitors, partner agencies, voluntary and community organisations representing and supporting women and families, wider health and social care teams and leaders;
- Building innovative models between rural areas and the referral maternity units developing Standard Operating Procedures (SOP), guidelines and feedback on experiences;
- Taking into consideration long travel distances in remote and rural areas, and finding innovative ways to bring midwives from the referral hospital into a rural team;
- Encouraging and supporting more local births in remote and rural areas to improve continuity of carer;
- Equipping staff with all necessary items to facilitate caseloading, e.g. mobile phones/iPads/Doppler Fetal Monitor/Community bag/Jackets/Fleeces/stethoscopes/Blood pressure (BP) monitors, baby scales and bilirubin meters for each team. Implementing a small number of pool cars to address transport issues for some staff;
- Having more than one project lead, e.g. separate for Neonatal Transitional Care, Alongside Midwifery Unit and Continuity of Carer, ensures continuous leadership and overview throughout implementation phase. Covering annual leave and sickness to maintain momentum of project implementation;
- Identifying lead obstetric and neonatal medical staff to support the implementation process.



What didn't work well?

- Focusing on the previous year's caseloads rather than current and potential future caseloads when identifying an area covered by a team;
- Staff not being involved in co-producing the model;
- Teams that started before the infrastructure to support them was in place, e.g., transport, equipment, IT, office space, clinical space;
- Developing rotas that were inadvertently not compliant with required guidance – consult with staff side and HR;
- Not considering the need for backfill for staff joining the continuity teams and therefore putting additional strain on remaining community and hospital core staff, this can lead to resentment and stress;
- Using rostered model didn't work well in some areas for community based continuity teams, as their local context required them to cover core duties in the maternity unit. Providing intrapartum care for women not in their caseload. This had the potential to reduce the amount of time continuity midwives had to provide care for women in their caseload.

CASE STUDY

Larkhall was chosen as our first pilot site due to the caseload size fitting into the 1:35 real-time caseload for midwives. The area had a very small proportion of women who lived in Lanarkshire who chose to birth elsewhere. We realised after a few months that the caseload size was too small and added an additional joining area to the team. Blantyre and Hamilton were then chosen as our next two teams as the staff share office accommodation and can support each other through the transition to the relationship based continuity model of care.

What do you wish you had known or had access to?

- The Impact of changes to GP Contracts having unintended consequences for hubs as primary care teams are expanded and developed. Identifying space to work from has been challenging in many areas, knowing how to access non-NHS venues and property, or getting access to spaces is challenging and time consuming;
- Understanding the workforce and population profile better;
- National workforce advisor;
- That it is possible to begin the continuity journey by initially focusing on women who are likely to benefit the most from continuity of carer or where there is a team keen to start implementing, while planning for full Board roll-out. For example women living with social complexity and deprivation; women with complex medical care needs; or to begin by setting up a home birth team;
- That HR and staff side and partnership organisations can be a source of guidance and information on organisational change approaches, staff views and issues around working hours, on-call rotas and pay.

What would you like to share in terms of approaches and why?

- Understanding the workforce and population profile; this cannot be left to teams to solve and Board and leadership support was found to be invaluable;
- The team needs to be agile as this is an ever changing environment and susceptible to other service changes;
- It is important to recognise the starting point of your particular Board or locality;
- Having more than one project lead, e.g. three leads, one for NTC, one for AMU and one for continuity of carer, ensures continuous leadership and overview throughout implementation phase was found to be helpful;
- Phased implementation for NTC;
- Liaising with other Health Boards, learning from others;
- Teams trialling different rota models, including on-call, rostered, etc. Taking into consideration external factors such as locality and distance;
- Have regular meetings between project leads, managers and staff side and partnership organisations representatives.

CASE STUDY

In Campbeltown Community Midwifery Unit (CMU) some women may make their own way to Paisley for birth, often travelling in very early labour due to distance, in these cases it is not practical for the primary midwife to travel 3.5 hours to follow the woman in early labour. One of the midwives working in the Royal Alexandra Hospital (RAH) in Paisley has joined the Campbeltown team and meets women who are coming from Campbeltown. So far this has met with very positive feedback. Oban CMU and Dunoon are arranging with RAH Paisley for their newly qualified midwives to spend a week a month in Paisley which again will support continuity from the team when the primary midwife is unable to be there.

Were there any resources that were helpful?

- Public Health: Population Projections: <https://www.opendata.nhs.scot/dataset/population-projections>
- <http://scottishhealthcouncil.org/home.aspx>
- <http://nationalmaternityvoices.org.uk/toolkit-for-mvps/gathering-feedback/>
- Rayment-Jones et al. (2015) An exploration of the relationship between the caseload model of care for disadvantaged women and childbirth outcomes [https://kclpure.kcl.ac.uk/portal/en/publications/an-investigation-of-the-relationship-between-the-caseload-model-of-midwifery-for-socially-disadvantaged-women-and-childbirth-outcomes-using-routine-data--a-retrospective-observational-study\(e3fbd28d-51f0-49e5-b4c8-e9855f182411\)/export.html](https://kclpure.kcl.ac.uk/portal/en/publications/an-investigation-of-the-relationship-between-the-caseload-model-of-midwifery-for-socially-disadvantaged-women-and-childbirth-outcomes-using-routine-data--a-retrospective-observational-study(e3fbd28d-51f0-49e5-b4c8-e9855f182411)/export.html)
- Caroline Homer C, Brodie P, Sandall J, Leap N (2019) Midwifery Continuity of Care 2nd Edition Book ISBN: 9780729587136

INITIATING CHANGE

2. Wider Team Involved

Key Messages:

Continuity of carer represents a fundamental change in delivery of care, and therefore communication and preparation with staff is key to managing concerns and achieving buy-in.

This not only impacts on midwives, to support the change it involves the wider multidisciplinary team.

EABs found it important to involve the wider team in terms of:

- **Establishing a Best Start Project Board chaired by a senior leader/Director supported implementation. Engagement of women as part of the wider team is crucial for success.**
 - to address barriers and challenges;
 - this includes IT, estates, workforce planning, HR, staff side, learning support to support the development of new infrastructures and routes for clinical governance.



- **The wider multidisciplinary team:**
 - the linked consultant;
 - health visitors/Family Nurse Partnership (FNP);
 - social work;
 - maternity care assistants;
 - administrative support;
 - community mental health teams;
 - GP, Practice Managers;
 - voluntary and third sector;
 - women/service users.

EABs found it helpful to develop ways of sharing learning and progress within the Board, between teams and within teams- these communication routes will be essential as more teams develop.



What do you wish you had known or had access to?

- How to get the right level of Board buy-in and ownership of the change;
- Knowing how to ensure progress and barriers were being shared at the right level within the organisation;
- National job description for caseload and core midwives; national guidance on key issues relating to on-call, on-call payments etc.

What would you like to share in terms of approaches and why?

- Developing effective communication structures that support the team to have the autonomy to develop.

Were there any resources that were helpful?

- Attend Anywhere (TEC) to facilitate virtual communication – see Best Start Factsheet https://drive.google.com/open?id=1YZ1RUIYPnVD5sM_QwArickNpoGUi7Wy-
- RCM Nuts and Bolts <https://www.rcm.org.uk/login/?returnurl=%2fmedia%2f22268%2fcontinuity-models-scotland-the-nuts-and-bolts.pdf>
- Telford CCG write up about their engagement event in relation to implementing continuity, 2018, <https://www.telfordccg.nhs.uk/who-we-are/publications/publications/engagement/4953-2018-09-25-continuity-of-carer-write-up-final/file>
- North West London early adopter toolkit (2019) https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/nw_ea_toolkit_final_june_19.pdf
- Forth Valley communications timeline <https://drive.google.com/open?id=1DP--k7L6weGbHg81Kr9bmQtTgcqLGKHM>

INITIATING CHANGE

3. Go where the energy is

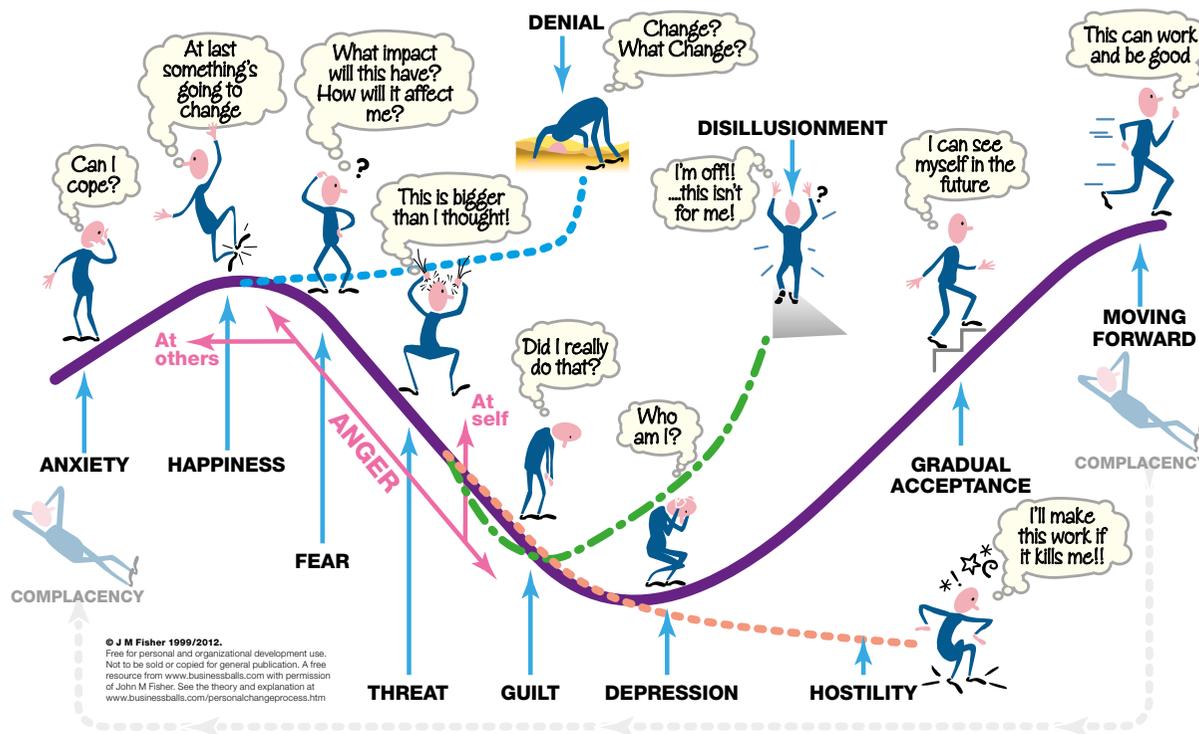
Key Messages:

Identifying change agents within the workforce was found to be helpful, and in the initial stages asking for volunteers has made all the difference to changing hearts and minds. Offering opportunities for taster sessions in early teams can really help the change process, as those that were initially reluctant can become the greatest advocates.



The Process of Transition - John Fisher, 2012

(Fisher's Personal Transition Curve)



ACSESSED 08082019 https://www.needpix.com/search/ENERGY_1

Make sure that the first team have a lot of support for their wellbeing as there will be many 'eyes' watching progress.

What worked?

- Expose midwives to new areas; offer trial periods to all midwives to test out new ways of working;
- Starter packs for teams going out into new model.

What didn't work well?

- Cross boundary – Boards working at different levels of implementation caused challenges for women and midwives. This was also evident when teams within an EAB were at different points of implementation. It is important to manage expectations and keep everyone informed;
- It is important to understand the culture locally as this can impact negatively on experiences;
- It is important to listen to staff, ensuring that there is a vehicle for feedback and facilitating networking. Mutual respect and professionalism needs to be paramount;
- During the transition phase of working between two models there was a need to keep a watchful eye on potential staff impact;
- People basing their feelings and judgements on myths or assumptions.

What do you wish you had known or had access to?

- Ensuring team has the right skill set – for example, caseload management, diary management and rostering, wider knowledge of GIRFEC across the whole team, as well as clinical skills;
- Considering non-caseloading team leaders so they have oversight of their teams and caseloads, can provide an assurance role, lead on education, support clinical supervision, peer review, caseload reviews and child protection oversight;
- Midwifery passport detailing skills and competencies of the holder – considering support for any midwives who are revalidating during this period of change;
- Addressing culture, mutual respect and values in order to build confidence and trust across teams.

What would you like to share in terms of approaches and why?

- Don't use the same people all of the time and expect these people will change over time.

CASE STUDY

NHS Lothian

In NHS Lothian, we put up posters seeking volunteers to join the team. This allowed us to identify our change agents
<https://drive.google.com/open?id=1Axlr3HdHaoew826fLI42d3TYvxmIWhKy>

NHS Forth Valley

Despite lots of planning it wasn't until we were actually immersed in the caseloading model that issues we hadn't considered were highlighted and it was only through trial and error we found solutions working with the midwives.

We currently have a 'You said We did' feedback sheet with questions from staff that we populate monthly and send out attached to our 'Best Start' newsletter.

Were there any resources that were helpful?

- Skills passports (link on page 21);
- SOP, honorary contracts (samples available from NHS Highland and NHS GG&C);
- NHS Forth Valley staff information packs for NTC – NGT feeding/IV antibiotics FV Admission criteria for TC (links on page 21);
- Caroline Homer C, Brodie P, Sandall J, Leap N (2019) Midwifery Continuity of Care 2nd Edition Book ISBN: 9780729587136.

INITIATING CHANGE

4. Develop a shared vision

Key Messages:

EABs reflected that this step is often missed, but was really helpful within Boards. Women and families voices were really valuable in developing a shared vision. Engage with women and families with recent experiences of local maternity and neonatal care to focus on what matters to them.

At Board Level:

- What is the vision for maternity services?
- What outcomes do you want to achieve for the women and families?
- What is the vision for the workforce and the service?
- Is the vision co-produced and is everyone signed up to it and owns the vision?

At team level:

- What is the teams' vision for their community, caseloads and for each other?
- What are the values of the team?
- How are they going to work together?
- What tools or skills do they have to develop the culture of the team and vision for the care the women receive?
- Manage expectations around timeframes for implementation – this is transformational change and will not happen quickly;
- Teams are empowered to lead changes locally within the parameters agreed with management and staff side;
- Teams can develop solutions to test, underpinned by programme management and planning support;
- Consider goals both within the team, but also that contribute to the overall Board plan for implementation;
- Teams work together to devise their rota and continue to test different models; this will support the impact on work/life balance and continuity offered.

What worked?

- Team-building days to encourage the team to get to know each other;
- Clinical supervision to support conversations, reflection and wellbeing of staff;
- Maternity Care Assistant (MCA) based in hubs to support caseloading midwives, MCAs support the midwives in a variety of ways such as breastfeeding support, Phenylketonuria test (PKU) and additional parenting support;
- The MCAs have electronic diaries than are accessible to all caseloading midwives to book appointment times.



What didn't work well?

- There was not always a wider understanding amongst colleagues that this is transformational change and takes time;
- Team leaders holding full caseload;
- Trying to implement the model when there are vacancies;
- Backfill for maternity leave for caseloading midwives proved challenging.

What do you wish you had known or had access to?

- Better engagement with the whole multidisciplinary team – understand that the continuity model is not just midwife focused;
- Understanding workforce and population;
- Understanding that frequent meeting and revisiting is important as staff often focus on what appears relevant at the time.

What would you like to share in terms of approaches and why?

- Ensure that unintended and intended positive and negative consequences are going to be captured to enable learning;
- Management approach: needs to strike a balance between direction and autonomy;
- Share the learning as you go, both nationally and locally;
- Team leaders can provide an assurance role, lead on education, support clinical supervision, peer review, caseload reviews and child protection oversight;
- Supervision and support is required at all levels throughout teams, including managers.

Were there any resources that were helpful?

- Best Start Rapid reviews
<https://blogs.gov.scot/child-maternal-health/2019/03/18/best-start-evidence/>
- Rocca-Ihenacho L et al. (2018). Midwifery Unit Standards. City University London
<http://www.midwiferyunitnetwork.org/wp-content/uploads/PDFs/LY1309BRO-MUNEt-Standards-PRINT-opt.pdf>

DEVELOPING PLANS

5. Using planning tools

Key Messages:

- Process and skills mapping carried out at the baseline stage are important for informing this stage;
- Developing a clear overall project plan with attached timescales and process measures is essential;
- To individualise plans to meet population and staff needs; developing logic models/theory of change with indicators, agreed inputs, outputs and outcomes, both short and long-term help to describe the steps to achieve the agreed vision and to test assumptions was helpful. These do not have to be complicated;
- Teams need to have ownership of their plans and be equipped with the right quality improvement skills and feel comfortable in taking on new tasks;
- Using data to evaluate as plans develop and adjusting plans appropriately;
- Structured oversight of the programme, including clear clinical governance structure and process was found to be instrumental for success by the EABs;
- It is important to recognise that every Board has a different starting point, so project plans will acknowledge this and show the individual steps that the Board will take along the journey towards full implementation.

What worked?

- Undertaking a baseline to measure progress against – for the service model, views of staff and views of women;
- Using Project Initiation Document (PID) document and other project planning tools from outset;
- Teams developing their own improvement plans/driver diagrams.

What didn't work well?

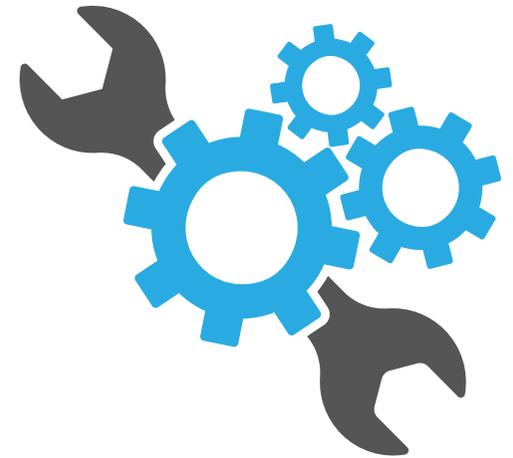
- Not getting planning and project management input from the start;
- Not developing an overall project plan from the outset.

What do you wish you had known or had access to?

- Planning and project management document earlier.

What would you like to share in terms of approaches and why?

- Process mapping ;this was a good way to get everyone involved in visualising current systems and barriers to care being efficient.



Were there any resources that were helpful?

- NHS Education Scotland. Quality Improvement Zone <https://learn.nes.nhs.scot/741/quality-improvement-zone>
- Programme/Project Management Tools: e.g. PID, Gant chart, 5 year step plan, Logic models.
- Accessing a Project Management Office (PMO) or similar in your Board.

Attached are links to the Project Initiation Document and Strategic Engagement Plan NHS Lanarkshire used.

PID – <https://drive.google.com/open?id=1eB7l7LzdSGQiVvc0pNR8jrepNNShn8M>

Strategic Engagement Plan – <https://drive.google.com/open?id=1z4P-NPfc8ezaDdkCvUWtBCxOvN9nkI5>

DEVELOPING PLANS

6. Share learning

Key Messages:

EABs realised that it is important to capture learning as you go. The focus will be on reaching the end point, but keeping a note of the journey, what was tested, what worked, what didn't work and any unintended consequences is all important learning to log.

Peer support across Boards can also help to share different approaches and develop new ideas. Buddying up with a unit of similar size or with similar geographical challenges can help to develop solutions and learning what worked elsewhere. Regular feedback from staff and service users should also be heard.



What worked?

- Sharing the learning as you go, both nationally and locally;
- Using data to evaluate as plans development – adjust plans appropriately and share learning as you go through the change process;
- Evidencing what you have done from the outset –it helps to look at the overall picture, e.g. impact of plans on workforce.

What didn't work well?

- Not keeping a note of ideas tried as we went;
- Engaging staff too early – wasn't until pilot teams started that there was better information to share on how the new model operates.

What do you wish you had known or had access to?

- Accessible support for staff with access to shared learning.

What would you like to share in terms of approaches and why?

- Ensure that unintended and intended positive and negative consequences are going to be captured and to enable learning.

Were there any resources that were helpful?

- Local resources, for example using clinical or quality improvement expertise to present data for senior Health Board staff, maternity staff and service users.
- NHS Lanarkshire collected data from their continuity teams. Below is the Larkhall one year on data and their highlight report to demonstrate what has been gathered and how it is informing future movement of the model through the Health Board.

Larkhall one year on <https://drive.google.com/open?id=1xlx9fOmCcy3YbApKWPIGtZyXtQjsxkn0>

Highlight report https://drive.google.com/open?id=1Nm6w-qtj_n3lvuuiG1b3vi8o37zrVMSb

DEVELOPING PLANS

7. Set up an engine of change

Key Messages:

In change of any sort there are people who are more engaged initially than others. The EABs found that in order to support these early enthusiasts, grouping them for peer support, linked with the key people who can practically move change forward is important – this is the engine for change.

The engine for change is the group who are visible and builds momentum by driving forward practical changes. This group will support testing and be integral in overcoming barriers and sharing wins with their colleagues. Their feedback and enthusiasm will be useful in helping others understand how the new model works in practice.

The core of the engine is the implementation team and project team working closely with the early change agents – it is also important to build up the next wave of change. People get tired and their enthusiasm can dip. Therefore it will be important that others around them can take over and carry on leading the change. Offering trial periods within teams can be a good way of exposing midwives to the new model and has proven successful in reassuring concerns, and helping them embrace the change.

What worked?

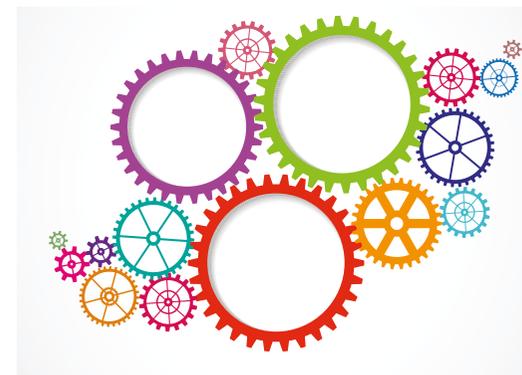
- Expose midwives to new areas – offer trial periods to all midwives to test out new ways of working;
- Identify change agents – EABs found that staff who were initially less enthusiastic for the change could be strong advocates once they had experienced the benefits;
- Starter packs for teams going out into new model;
- Don't use the same people all of the time and expect these people will change over time;
- Bear in mind the student experience and harness their enthusiasm – ensure they have the right support and clinical support in a changing landscape.

What didn't work well?

- Midwife resource availability for backfill was a challenge in some EABs in order to keep current model running while transitioning to new model.

What do you wish you had known or had access to?

- Understanding that frequent meeting and revisiting is important, as staff focus on what appears relevant at the time;
- Better understanding and knowledge of Agenda for Change (AfC) terms and conditions of employment and organisational change processes;
- Understanding more about the concerns of the workforce about a continuity model and the barriers to change;
- Having a whole team in place ready to go prior to developing plans.



What would you like to share in terms of approaches and why?

- The benefit of regular communication and drop-in sessions for midwives.

CASE STUDY

In NHS Lanarkshire, long-term staff sickness created a challenge for both early teams. This provided an opportunity for two midwives to trial caseload model of care on a temporary basis, as both were unsure they wanted to work in this new model. Both midwives embraced the challenge and have now joined Best Start teams. This is the poster used to advertise trials https://drive.google.com/open?id=1zoMPhDj_JPKvTO5q4-vrdBtKR69NRKfK

Were there any resources that were helpful?

- RCM State of Maternity (linked previously in this document).
- RCM Nuts and Bolts publication (linked previously in this document).

IMPLEMENTING NEW MODEL

8. Distribute decision-making roles

Key Messages:

Changing the model of care can impact on where decision-making needs to sit. In order to make this transformational change, there is a balance between getting the buy-in at Board level and enabling the midwives and teams on the ground to have forums for decision-making.

Devolving decision-making and leadership to the appropriate level gives ownership of the change and promotes collective leadership and autonomy. This requires effective systems for communication and governance.

What worked?

- Individual teams being supported to find the rota that worked for their team and given the ability to be flexible;
- Developing a shared vision for clarity and expectations for all – at Board and team level;
- Having a strong multidisciplinary oversight group that is visible and approachable;
- Having structures for oversight of the programme, including clear clinical governance was helpful;
- Using clinical supervision at team level to support the team to develop, reflect and look after the team wellbeing;
- Using RCM local workplace representatives and the national team to provide advice on the appropriate employment relations guidance and regulations, and to explore whether new rotas being tested are compliant;
- Using local HR departments to offer support and guidance on appropriate processes.

What didn't work well?

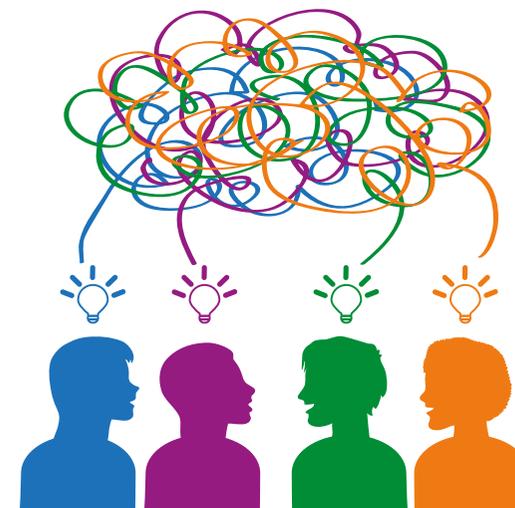
- Not taking time to understand the culture locally, as this can impact negatively on experiences.

What do you wish you had known or had access to?

- Accessible support for staff with access to shared learning.

What would you like to share in terms of approaches and why?

- Understanding different cultures, building mutual respect and values in order to build confidence and trust across teams was fundamental for success.



CASE STUDY

The ownership for the model, rota and improvement plan in the CMUs in Argyll, sit very much with the teams. This means that there is local variation in how teams work, often reflecting the geography and team make up. The team leads work together to support their teams to find the best way to work but come together to develop agreed parameters that they work within. Only if there are workforce or unforeseen challenges do team leaders seek additional support from senior managers.

Were there any resources that were helpful?

- Clinical supervision.
- RCM resources previously referenced in this document.
- West M, Eckert R et al. (2017) Caring to change: how compassionate leadership can stimulate innovation in health care
<https://www.kingsfund.org.uk/publications/caring-change>

IMPLEMENTING NEW MODEL

9. Invest in workforce development

Key Messages:

- EABs found that training and education is crucial. Clear arrangements for backfill to release staff to undertake training, education and shadowing to feel confident to work in new ways was very helpful;
- Regular team meetings, one-to-ones with managers and clinical supervision built in to all new team work plans worked well;
- Monitoring and resolution of unintended consequences was found to be useful.

What worked?

- Induction for newly registered midwives;
- Exposing midwives to new areas – offering trial periods to all midwives to test out new ways of working;
- Starter packs for teams working in the new model;
- Providing focused information sharing workshops and events, such as the RCM Continuity days, the National Education for Scotland (NES) caseload management workshops and inviting midwives from existing caseload teams to come and talk to midwives;
- Agreeing and formalising the role of core hospital midwives in supporting caseload midwives when they provide intrapartum care.

What didn't work well?

- Cross boundary – Boards working at different levels of implementation caused challenges for women and midwives. This also was evident when different teams within an EAB were at different points of implementation;
- Team leaders holding a full caseload;
- Caseload midwives working in teams before their training and support needs had been identified and addressed.

What do you wish you had known or had access to?

- Engagement with Higher Education Institutes in order to understand what they could offer for postgraduate education as well as better understanding of their preparation of undergraduate midwives.



What would you like to share in terms of approaches and why?

- Ensuring the team has the right skill set – including elements such as caseload management, diary management and rostering, GIRFEC, as well as clinical skills;
- Considering non caseloading team leaders so they have oversight of their teams and caseloads, can provide an assurance role, lead on education, support clinical supervision, peer review, caseload reviews and child protection oversight;
- The benefit of supervision and support at all levels throughout teams, including managers;
- Exposing staff to various areas they will be expected to work in a structured way – a starter pack for new teams was helpful;
- Midwifery passport detailing skills and competencies of the holder – supporting midwives who are revalidating during this period of change is important;
- Addressing culture, mutual respect and values in order to build confidence and trust across teams..

CASE STUDY

Listening to midwives who change to the new model of care will help understand what is needed to prepare new teams. Using skills gap analysis and one-to-one discussions with each midwife will help identify the individual learning needs prior to becoming a caseload midwife. In NHS Lanarkshire we now commence preparation of midwives two months before the new team is rolled out. Planned Supernumerary opportunities for midwives to 'shadow' colleagues in areas of midwifery care are accommodated in order to gain experience. A midwives resource book is distributed to each midwife along with an individual skills gap analysis.

We now have a team leader who is non-caseload holding, who provides individual one-to-one supervision on a monthly basis to all staff to identify individual learning needs (1 leader = 24 midwives) people don't know what they don't know. She also provide support in areas such as child protection cases, to ensure women and families continue to receive appropriate support; gathering of monthly statistics and facilitation of weekly team meetings.

Were there any resources that were helpful?

- Make better use of Technology Enabled Care (TEC);
- NHS education for Scotland resources;
- Skills passports;
- Standard operating procedure (SOP);
- Clinical supervision – for example, building into team meetings;
- RCM educational resources

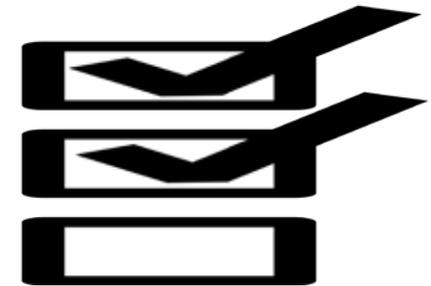
IMPLEMENTING NEW MODEL

10. Test and Evaluate

Key Messages:

The EABs found it helpful to continue to test and evaluate any change as you go. Continually assessing whether a change is working for both midwives and women is important and making small tweaks can make big changes.

They also found it helpful to have agreed measures and an electronic method of collecting data to reduce the burden on those providing care. Don't assume that everyone has the same understanding of what is being measured.



Positive messages –

NHS Forth Valley – midwives may not like the on-call requirement of caseloading but they ALL like having a caseload of their own women and building relationships.

Early Learning –

- Communication and staff engagement is essential
- Workforce planning and testing the core helped with evaluation of models tested
- Plan and do it! Staged approach to implementation has been challenging.

What worked?

- Teams with an even number and testing the optimum team size, depending on the model being tested; for example, rostered or on-call;
- Regular evaluations of how the new model is working, making small tweaks along the way;
- Engaging early and actively with staff side and partnership representative organisations, and inviting partners to all key meetings.

What didn't work well?

- It was difficult to collate all evidence, both positive and negative, as you go along without an electronic system;
- Some challenges when using a rostered rather than on-call model for continuity teams. This has, on occasion, meant that continuity team midwives are using a significant proportion of their hours covering care of women who are not in their team, in labour areas – this can undermine the level of continuity, and working additional hours which is likely to lead to burn out;
- Challenge of setting up new model vs testing element of model vs getting up to full caseload. Resulted in stress and potential burnout for team;
- Caseload midwives prematurely working in teams without always having the appropriate equipment, transport arrangements and clinical and office space, including fully functioning IT support including web-enabled mobile phones, and personal computers or tablets for each midwife.

What do you wish you had known or had access to?

- Better understanding and knowledge of Agenda for Change (AfC) terms and conditions of employment and organisational change processes.

CASE STUDY

Setting up a new system of service provision is not without its challenges. The Blue Team in the Clyde area of NHS Greater Glasgow and Clyde commenced at the beginning of January 2019, setting up a weekly meeting held by the team, Senior Charge Midwife, Lead Midwife, with occasional attendance by Chief Midwife and Clinical Services Manager. Attendance at this meeting is considered mandatory unless on annual or sick leave, or having been called out to a labourer. This meeting enables the team to report any challenges they have faced, and resolution is discussed and then implemented.

An action log of challenges is kept, with items removed as solutions found. Logistical items included equipment, accommodation, transport, rosters, etc., but also the development of team parent education classes, team leaflet and antenatal meet and greet sessions. Other assumptions made in the planning did not come to pass for example: women declined to be booked in their own home, preferring to attend an NHS facility, however, some were later happy to have antenatal care at home.

Several months in, a major issue became apparent. The team were over aspirational in their pursuit of continuity of carer and were attempting to provide total antenatal and postnatal care to their own caseload rather than utilising their buddy midwife. This resulted in a negative impact on their work/life balance, which could have led to burnout.

This issue was discussed within the team meeting and management reiterated that 100% continuity by the primary midwife was neither expected nor wanted, as the team had to be sustainable. The team were reassured and matters have now resolved, the team maintaining 100% continuity between both primary and buddy midwives.

Team meetings are also a time for communication – between the team, team leaders and management. Meetings provide a safe environment for the exchange of ideas, problems and their solutions. This learning can be shared with new teams going forward.

Glossary

| | |
|-----------------|---|
| AfC | Agenda for Change |
| AMU | Alongside Midwifery Unit |
| CCLD | Continuity of Carer and Local Delivery of Care sub group |
| CEO | Chief Executive Officer |
| CMU | Community Midwifery Unit |
| EAB | Early Adopter Board |
| GIRFEC | Getting it Right for Every Child |
| IJB | Integration Joint Board |
| NES | National Education for Scotland |
| NGT | Nasal Gastric Tube |
| NHSS | NHS Scotland |
| NTC | Neonatal Transitional Care |
| PID | Project Initiation Document |
| Process Mapping | An approach to improvement which shows all of the steps involved in a process and how they connect, with the aim of identifying areas for improvement |
| RCM | Royal College of Midwives |
| SOP | Standard Operating Procedure |
| TEC | Technology Enabled Care |

Appendix A: Continuity of Carer and Local Delivery of Care Sub Group Membership

| | | |
|-----------------|------------------|--|
| Co-Chair | Hazel Borland | Nurse Director, NHS Ayrshire and Arran |
| Co-Chair | Gillian Morton | General Manager, NHS Forth Valley |
| Members | Mary Burnside | Head of Midwifery, NHS Highland (EAB rep) |
| | Justine Craig | Head of Midwifery, NHS Tayside |
| | Elizabeth Duff | National Childbirth Trust |
| | Judith Falconer | Midwife, NHS Grampian |
| | Evelyn Frame | Head of Midwifery, NHS Greater Glasgow and Clyde (EAB rep) |
| | Ann Holmes | Chief Midwifery Officer, Scottish Government and Vice Chair, Best Start Implementation Programme Board |
| | Shahzya Huda | Consultant Obstetrician, NHS Forth Valley |
| | Jaki Lambert | Head of Midwifery, NHS Highland (EAB rep) and Professional Midwifery Adviser, Scottish Government |
| | Helen Mactier | Chair of Scottish Neonatal Consultants Group, NHS Greater Glasgow and Clyde |
| | Nirmala Mary | Consultant Obstetrician, NHS Lothian |
| | Rhona McInnes | Consultant Midwife, NHS Lothian |
| | Frances McGuire | Head of Midwifery, NHS Lothian (EAB rep) |
| | Maureen McSherry | Consultant Midwife, NHS Lanarkshire (EAB rep) |
| | Jackie Mitchell | RCM |

| | | |
|--------------------|-------------------|--|
| | Mary Ross Davie | RCM |
| | Jackie Rutherford | Senior Midwife, NHS Forth Valley (EAB rep) |
| | Barbara Sweeney | RCN |
| | Jane Telfer | Scottish Neonatal Nurses Group, NHS Lanarkshire |
| Secretariat | Beverley Lamont | Scottish Government |



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