Standard Operating Procedure

Caseload Team Midwifery Practice

Key Document code:	WAHT-TP- 094	
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Approved by:	Maternity Governance Meeting	
Date of Approval:	15th November 2019	
Date of review:	15th November 2022	

Key Amendments

Date	Amendments	Approved by

Version	Date	Author	Reason
1.0	Feb 2019	Caitlin Wilson: Consultant Midwife Louise Turbutt: Matron for Community Midwifery	Commence Teams
1.1	01/11/19	Caitlin Wilson, Consultant Midwife	Change to escalation and sickness cover

Introduction

Purpose

The purpose of this standard operating procedure is to outline standards for the caseload continuity of carer teams in order to maintain the caseload midwifery service.

Function

The Standard Operating Procedure is for all midwives working in a “caseload” model of continuity of carer team in the community and all maternity staff working at WAHT.

Definitions

Term	Definition
BBA	Born Before Arrival of Midwife
NIPE	Newborn and Infant Physical Examination
Caseload Midwife	Midwife who works in a model where care is provided throughout antenatal, postnatal and intrapartum for a set number of women
Named Midwife	Midwife with overall responsibility for co-ordination and overview of care pathway. Will provide a majority of care to the woman and baby.
WAHT	Worcestershire Acute Hospitals NHS Trust

Role and Responsibilities

- Clinical Director and Director of Midwifery–have responsibility for the strategic provision of the caseload birth service and provide support as needed.

- Consultant Midwife: has responsibility for the strategic provision of the caseload midwifery service and provide support as needed.

- The Matron for Community Services–has the responsibility to facilitate the effective implementation of this protocol by ensuring facilities, equipment and staffing are in place and provides support as needed.

- The Matron for In Patient Services—has the responsibility to facilitate effective implementation of this protocol by ensuring facilities and staffing are in place to provide support to caseload midwives and continuity of carer midwives as needed.

- Caseload Team Community Midwives –have the responsibility of providing a 24 hour service model and to provide a case loading model of midwifery care to all women in their caseload during the antenatal, intrapartum and postnatal periods.

- All homebirth team and community midwives participating in the home birth service must hold a full drivers licence and have business insurance car use.

- Delivery Suite Coordinator–has the role to facilitate and support the caseload homebirth midwife when they are in the main unit providing care to a woman on their caseload. They will ensure that the caseload midwife is enabled to fulfil their role in providing a caseload model of care to women in this model. The co-ordinator will ensure adequate breaks are provided.

- Unit Coordinator and Manager On-Call–has the role of maintaining the safety of the day to day running of maternity services.

Equipment

- It is the responsibility of each midwife to ensure that they have the necessary equipment with them to carry out their duties safely and effectively

- Each midwife is responsible to report any damaged, non-functioning, stolen or missing equipment to their line manager as soon as possible.

- It is the responsibility of the midwife to ensure that they are trained to effectively and safely use any equipment required to carry out their duties and responsibilities.

E-Rostering and Worked Hours

- Contracted hours to be worked over 1 month period allowing flexibility to daily working patterns to meet the demands of caseload work and needs of the women in this model of care.

- Midwives are to monitor their daily working hours ensuring adequate rest and breaks.

- Caseload midwives are to ensure that that they do not breach European Working Time Directives (WTD). If approaching maximum hours, to inform team for support and Matron for Community Midwifery.

- Actual hours worked need to be recorded in personal diary or outlook calender

- Hours worked and time of day are to be submitted to the nominated person for entry onto e-roster at the end of each working week to ensure timely closure of the roster for payments. Issues to be escalated to Matron for Community Midwifery.

- Regular audits will be carried out on working time to ensure that caseload sizes are adequate.

General Team Principals

- All women booking onto the continuity of carer midwifery team will be allocated a named midwife.

- The named midwife will the main care provider and care co-ordinator.

- The named midwife will ensure that appropriate and timely referrals are made to other health care and social care providers as required whilst maintaining an overview of these referrals and any addition care plans created as a result of these referrals.

- The named midwife will work with a partner(s) to ensure there is a designated midwife overseeing care in the absence of the named midwife. Women will be made aware of who these midwives are at the time of booking.

- The named midwife will ensure that women on their caseload has the opportunity to meet other members of the team in a meaningful way (classes, meet the midwives, unit tours, joint appointments etc) so that at the time of labour the woman will know the person with her

- Caseload midwives will provide antenatal, intrapartum and postnatal care to women allocated to their team.

- The team will provide birth preparation classes, meet the midwife sessions, tours of the unit (virtual in future).

- The caseload community midwifery team will provide 24/7 care coverage for women on the caseload model of care including on call commitments. Team is to work together to ensure 24/7 coverage of workload.

- Allocation of women to the team is based on postcode and risk assessment at the time of referral.

- Individual assessment of suitability to remain on the caseload pathway where complications in pregnancy develop will be completed on an individual assessment after communication with other team members, Matron and Consultant Midwife.

- Any notes with personal identification of women will be securely stored at all times as per Trust Policy

- Newly qualified midwives (NQM) will be allocated a named mentor and co-mentor (for when named mentor is away).

- The mentor will support the NQM to achieve skills and standards required to move onto a Band 6 pay scale. NQM will link into the preceptorship midwife and will have a preceptorship document to be completed with their mentor.

- A Band 5 midwife should not attend a homebirth as the 1st on call and always attend a homebirth with another experience homebirth midwife until all competencies to be a 1st on call for homebirth has been achieved.

- Students midwives will be allocated a placement with CoC midwives. Students should be assigned a supervisor and assessor at the beginning of their placement. Students to follow their supervisor. If workload is limited the student can follow another midwife supervisor.

Bookings and Referrals

- Bookings to the caseload model will come from the community midwives via the generic team email. Each caseload team will have an allocated generic email.

- Email will be checked daily by midwives on duty. Any actions taken from emails will be communicated to the rest of the team by marking as read and/or forwarding email to most appropriate person.

- Distribution of new referrals to the team to take place at every weekly team meeting. Not all members will be in attendance due to caring for women in labour, annual leave and study leave.

- Fair allocation should take place in their absence and informed of their new referrals via their personal NHS email.

- When allocating new books, consideration needs to be made for holidays at the time of the woman's EDD.

- Where possible, booking should take place at the woman's home. Introduction to the philosophy and team model to be discussed to ensure that the woman has consented to this model of care and is aware that appointments may be changed at short notice if someone is in labour. She needs to be made aware that when she is in labour midwives will rearrange appointments to be with her.

- Women will be allocated to a named midwife. This midwife will be the co-ordinator of the woman's care, facilitating appropriate referrals to other health/ social care professionals as required while maintaining an overall view of the care pathway.

- The named midwife will ensure that other members of the caseload team will meet the woman during her pregnancy.

On Calls

Day time (8am-5pm)

- When scheduled to be available (ON day), named midwife will manage phone calls from own caseload and any from partner midwife or remaining team where the phone is diverted due to sleeping/off call/annual leave/study leave.

- Named midwife will be available to attend women in labour or second midwife at homebirth

Night: (5pm to 8am)

- 1st on call will take all calls for the team.

- The team is responsible for diverting their phones to the on call at 17.00 h or as agreed with the 1st on call.

- The 1st on call will be responsible for home assessments, triage calls and attend a woman in labour.

- Where there is a home birth, the 2nd on call will be alerted via/alternative phone number/ text by the 1st on call to attend.

- Where there are 2 women in labour at the same time the 2nd on call will attend the second woman if both women in labour are at/or planning birth at WAHT labour ward

- Where there are more women in labour than available midwives from the caseloading team the following process should be followed:

- If 2 caseload midwives are at a homebirth from same team and another women is in labour, backup from community midwife on call to attend homebirth can be arranged where possible.

- Other caseload team midwives should not be called in to cover long term sickness as this will impact on their work load and continuity, leading to burnout.

- If there is no available midwife inform site co-ordinator in day time or labour ward co-ordinator at night. Like peak activity on LW, there may be times where the workload outstrips the capacity of staffing on the individual CoC team and care will need to be handed over to the labour ward. If there are capacity issues then escalation policy to be followed.

- Woman to attend labour ward/MBC and caseload midwife will attend as soon as available. Non-essential work to be re-arranged or allocated if necessary to another caseload midwife on the same team where possible. Non essential work is routine AN/PN checks etc.

- Where 2 caseload midwives from the same team are at a homebirth the second midwife will be relieved by a community on call midwife to attend as the second midwife at the homebirth allowing the caseload midwife to attend subsequent woman in labour.

- Where there are no available caseload midwives or community midwives (to back up homebirths) caseload women will be required to attend the MBC/ labour ward for care. Unit co-ordinator/LW co-ordinator to be informed.

- It is essential that the 1st on call communicates activity to the labour ward co-ordinator as well as all essential details of the woman who will be attending for their care in labour.

- Datix to be completed for all women on caseload team who are not cared for by a caseload midwife citing reasons for the change of lead carer.

- Continuity midwives are responsible for ensuring that they are well rested and taking time off on their allocated days off. Any urgent work should be handed over to partner midwife where available or another designated team member

Escalation at times of peak activity/staff shortages in main unit

- Escalation Policy to be followed (See the escalation policy (reference needed))

- Caseload midwives should not be called into the main unit to cover sickness/staff shortages unless all traditional community midwives have been called in and/or the unit is at point of closure due to staffing.

- Manager on call will make the decision to call in a caseload midwife in the above circumstances and will be alerted to the situation as per the maternity escalation policy

- Datix to be completed by the caseload midwife who is called into to cover the main unit and ensure that the Matron for Community is informed when next on duty.

Antenatal Care

- Routine care to be carried out as per Antenatal Guideline (link inserted).

- Women should be offered choice of birth place based on her preferences, wishes and social, medical and obstetric risk assessment.

- Discussion about place of birth should be revisited throughout pregnancy with reassessment of preferences, and based on current risk assessment as above.

- Any woman requesting a homebirth or MBC birth who falls outside of the WAHT criteria necessitate a multidisciplinary approach to care planning and a fully documented discussion regarding care planning.

- Consultant Midwife and Matrons should be made aware of any homebirths/MBC births planned outside of current WAHT guidance.

- Women who deviate from normal midwifery scope of practice should be referred to the appropriate health care professional via appropriate antenatal clinic process. The caseload midwife, where appropriate, will remain the central care co-ordinator and be fully aware of any referrals and care planning.

- Any woman who is no longer suitable for caseload midwifery care, should be informed by her midwife of this decision, for example insulin dependent diabetics, twins, fetal medicine cases and appropriate support given. The woman should be informed of who whe will be seen by with full contact details. The local community midwifery manager should be informed by email of the transfer of care. Caseload midwife should ensure that there is a medical/obstetric referral in place before hand over of care to prevent women from becoming overlooked in the system.

- Home assessment in labour should occur where appropriate and safe to do so. All caseload midwives will carry birth equipment with them during working hours in case of being called to a homebirth or home assessment (homebirth equipment list appendix)

- Caseload midwives will triage own women in order to maintain overview of care planning and continuity of carer.

- If a women needs an assessment in DAU or triage the caseload midwife may attend if workload allows. If unable to attend to liaise with staff in clinical area to inform them of the arrival of the woman and what is required. Named caseload midwife to follow up any appointments where they are unable to attend.

- If a woman is admitted to the antenatal ward for observation or IOL, the caseload midwife in charge of her care at the time will liaise with the ward staff to ensure smooth and safe admission. If the caseload midwife is able to attend the unit she should do so dependent on time of day and workload.

- For women undergoing an IOL, the caseload midwife in charge of the woman's care will aim to attend the unit to begin the IOL process. The caseload midwife will liaise with ward staff prior to attending to ensure that the capacity of the unit will allow the IOL to take place.

- Caseload midwives are not expected to attend all IOL initiation as times/dates may change and workload may not permit this attendance. It is essential that the

caseload midwife in charge of care maintains good communication with the wards and the woman and is aware of progress at all times.

- Named Caseload midwife should be informed of any woman transferred to labour ward for care in labour from the antenatal ward. If out of hours this call will transfer to the available on call midwife or partner midwife.

Intrapartum Care

- The care of the woman in labour should follow the appropriate Trust clinical guideline. Meadow Birth Centre, Homebirth, Care of a Woman in Labour Guideline, Lone Working Policy etc.

- The care of the woman in labour should be documented as per Trust policy for documentation

- It is the responsibility of the caseload midwife(s) finishing their "shift" to handover care to the next midwife taking over care

- When handing over care of a woman in established labour/early postnatal period, use of the SBAR tool is to be used and documented in the appropriate records

- The caseload midwife ending their care must inform the appropriate caseload midwives coming on duty of any pending or actual:
  admissions to the unit AN/PN/Neonatal
  home birth/labour assessments
  PN discharges
  1st day checks or NIPE exams/emergency postnatal visits.

- Roster and team calender to be updated with all changes of shift patterns to ensure effective handover.

- Where a woman requires specialist and/or intensive input on the labour ward the caseload midwife can hand over care to core staff where appropriate for ongoing observation and care.

- The named caseload midwife or caseload midwife co-ordinating the intrapartum care of the women should ensure good communication with the labour ward staff and attend the ward on a regular basis for an update and pastoral care for any woman who is admitted. They are not required to stay during the time of ongoing observation.

Postnatal

- Postnatal care should follow the postnatal care guideline

- Once women are transferred to postnatal ward, the caseload midwife should handover care to ward staff following SBAR.

- Women and babies on the caseload model should have clearly documented postnatal care planning in the woman's notes and this care plan handed over to ward staff.

- Approximate time of follow up/next day discharge by the named midwife or team should be clearly handed over to ward staff. This should ideally be in the morning to assist with patient flow.

- Caseload midwives will be expected to communicate with the wards to ensure that they are aware when/if a caseload midwife will attend. Caseload midwives should aim to attend the unit depended on other women in labour/urgent care.

- Follow up may mean attending women for observations and basic care and updating the care plan with ward staff.

- Ward staff are responsible for care of caseload women when they are on the ward. Non urgent communication should take place between normal day time working hours (8am-5pm)

- Ensure the Newborn and Infant Physical Examination (NIPE) is arranged within 72 hours. This should be carried out prior to discharge from the inpatient ward if appropriate. In the community, where possible, a NIPE qualified caseload midwife will carry this out. If this is not possible,refer to the woman's GP or postnatal ward if unable to be seen by GP.

- Postnatal care for women having a homebirth should initially follow the homebirth guideline and then the postnatal guideline

Monitoring

- regular audits will be carried out to ensure adequate caseload size.

- Audit will benchmark outcomes against local and national standards and targets.

- All caseload midwives are expect to engage and complete required audit data